

## **WORKFORCE COMPETENCIES IN BEHAVIORAL HEALTH: AN OVERVIEW**

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

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

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

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

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

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

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

## **SUBSTANCE USE DISORDERS**

### **Addiction Counseling, Linda Kaplan**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Interdisciplinary Health Professionals, Hoover Adger, Jr.**

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

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

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

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

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

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

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

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

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

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

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

## **DISCIPLINE-SPECIFIC COMPETENCIES**

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Professional Psychology, Frank L. Collins, Jr.**

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

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

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

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

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

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

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

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

### **Psychiatric-Mental Health Nurse Practitioners, Judith Haber**

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Psychiatric Rehabilitation Practitioners, Kenneth J. Gill**

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

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

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

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

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

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

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

### **Psychiatry, Zebulon Taintor**

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

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

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

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

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

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

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

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

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

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

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

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

### **Social Work, Anita L. Rosen**

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

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

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

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

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

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

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

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

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

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

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

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

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

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## POPULATION-FOCUSED COMPETENCIES

### Children's Mental Health, Marsali Hansen

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

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

The following is an example:

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

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

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

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

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

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

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

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

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

These core competencies are designed to address the specific integration of system-of-care values, professional standards of practice, and models of clinical best practice across mental health disciplines. As the professions cry out for models of core competencies, Pennsylvania's document serves as an example of a comprehensive effort to present the expectations for best practice for children and adolescents with SED and their families. Such a model can serve as a foundation for other efforts within disciplines, professions, and child-serving systems, and for other statewide approaches.

At the national level, current efforts focus on the widely recognized crisis in children's mental health, a crisis that includes concerns about recruitment and retention, as well as the recognition that the workforce

is poorly prepared to address the needs of children with SED. These efforts embrace core competencies as a foundation for future developments. Training initiatives on many fronts are increasingly starting with sets of specific clinical expectations for individuals who work with children who have SED. These competency expectations, when combined and integrated with professional standards, will serve as a foundation for curriculum revisions that will better prepare students for entry into the workforce and, through continuing education, better prepare those individuals already in the workforce.

### **Serious and Persistent Mental Illness, Alexander S. Young**

During the past decade, there have been remarkable advances in our understanding of how to provide care to people with SPMI. Clinical research has demonstrated that a wide range of well-defined pharmacologic and psychosocial interventions substantially improve outcomes in people with these disorders (Young & Magnabosco, 2004). Multi-disciplinary, team-based approaches have become widely accepted as an optimal structure for care. There is increasing agreement that care should be consumer-centered, and include attention to recovery, rehabilitation and consumer empowerment.

Researchers (Young & Magnabosco, 2004) have compared care in routine treatment settings with treatment practices that are known to be effective, and have found large discrepancies. Effective pharmacologic and psychotherapeutic interventions are used with only one-third of the individuals with depression and anxiety who could benefit from these treatments (Young, Klap, Sherbourne, & Wells, 2001). Evidence-based psychotherapies are often not delivered outside of academic and research settings. Among individuals with schizophrenia, many do not receive medications, such as clozapine, that could substantially improve their symptoms (Lehman, 1999). Effective psychosocial treatments, such as supported employment and family interventions, are provided to a small proportion of eligible individuals.

Projects have been conducted to improve care for people with severe and persistent mental illness, and have found that a substantial proportion of current providers and provider organizations do not possess necessary competencies (Corrigan, Steiner, McCracken, Blaser, & Barr, 2001; Drake et al., 2001; McFarlane, McNary, Dixon, Hornby, & Cimett, 2001; Young, Forquer, Tran, Starzynski, & Shatkin, 2000). For example, professionals often have negative attitudes toward rehabilitation, mutual support, and recovery, which can hinder the provision of client-centered care (Chinman, Kloos, O'Connell, & Davidson, 2002; Corrigan, McCracken,

Edwards, Kommana, & Simpatico, 1997). It has been estimated that more than three-quarters of providers in the United States caring for individuals in the public sector have a bachelor's degree or less education, with little training about severe mental illness or its treatment (CMHS, 2004). Even among the small proportion of doctoral-level professionals who work with this population, many have not been exposed to curricula or practicum experiences that are relevant to the care of people with serious mental illness (Hoge, Stayner, & Davidson, 2000).

In the United States, two projects have used a national consensus process to define core competencies. One was funded by the SAMHSA, and coordinated by the Center for Mental Health Policy and Services Research at the University of Pennsylvania. This project convened a national panel of 28 experts from a broad range of stakeholder groups, including academia, clinicians, consumers, family members, state mental health agencies, and managed care corporations. They reviewed empirical research, standards of care, and clinical guidelines. A set of 12 core clinical competencies and 52 subcompetencies was developed (Coursey et al., 2000a, 2000b), and is available at: [www.uphs.upenn.edu/cmhpsr/cmhs\\_reports.htm](http://www.uphs.upenn.edu/cmhpsr/cmhs_reports.htm).

A second project was funded by the Robert Wood Johnson Foundation through the Center for Healthcare Strategies, and coordinated by the UCLA-RAND Health Services Research Center and the Department of Veterans Affairs Desert Pacific Mental Illness Research, Education, and Clinical Center. The project reviewed existing literature and competency statements, and conducted focus groups and interviews with similar stakeholder groups as in the SAMHSA project. A national panel was convened, and a structured process led to the identification of 37 core competencies in seven domains that are critical for providing recovery-oriented care (Young, Forquer, Tran, Starzynski, & Shatkin, 2000). The competencies are available at: [www.mirecc.org/product-frames.html](http://www.mirecc.org/product-frames.html). Both the UCLA-RAND and SAMHSA projects produced competency sets that cover a comprehensive range of important clinical domains such as the clinician–client relationship, assessment, rehabilitation, consumer empowerment, and caregiver support.

In the United Kingdom, a national competency development effort that focuses on severe mental illness was coordinated by the Sainsbury Centre for Mental Health, in conjunction with the National Health Service (U.K. Department of Health, 1999). This project was based on the concept of the “capable practitioner,” defined as clinicians who can adapt to change and new knowledge, and continuously improve their practice (Fraser & Greenhalgh, 2001). The project defined a set of competencies that enables clinicians to care for individuals with severe mental illness within the context of the National Service Framework for

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Mental Health, which defines national care models, standards, and plans for service provision in the UK. The resulting competency set, which includes 67 competencies clustered in seven domains, is designed to inform training and curricula within the field (Lindley, O'Halloran, & Juriansz, 2001). It is available at: [www.scmh.org.uk](http://www.scmh.org.uk).

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*Many of the competencies identified have not been adopted or incorporated by training programs, licensing agencies, and certification boards.*

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Other work is relevant to this field of competency development. The work on psychosocial rehabilitation, described in an earlier section of this article, focused largely on caring for individuals with severe and persistent mental illness. Similarly, SAMHSA has supported the development of a number of “Evidence-Based Practice Implementation Resource Kits” (toolkits) designed to help providers and agencies implement evidence-based practices for this population (CMHS, 2003). These toolkits focus on illness management and recovery, medication management, assertive community treatment, family psychoeducation, supported employment, and management of co-occurring substance abuse. By offering standardized training for various types of personnel, these toolkits focus on competencies deemed essential for this work.

Now that several comprehensive competency sets have been developed, the focus of work has moved to development of interventions that improve the competency of providers. While there have been some successes (Young et al., in press), substantially more work is needed to evaluate the effectiveness of novel interventions and approaches to improving competency. When evaluating the quality of mental health care, provider competencies are one aspect of the structure of care. Therefore, competencies have a direct effect on health care processes—the care that consumers actually receive. As such, the value and accuracy of competency sets and models will be best understood by determining the extent to which provider performance can be improved, and evaluating how this improvement can lead to better care for consumers.

## **SPECIAL APPROACHES TO CARE**

Work on competencies has begun in three critical areas that involve special approaches to care. These include the provision of recovery-oriented treatment, culturally competent care, and the delivery of services by trained peer specialists.

## **Recovery-Oriented Competencies, Janis Tondora and Maria J. O'Connell**

Improving our understanding about the process and possibilities of recovery from severe mental illness, fueled by consumer advocacy efforts, has contributed to a recent national focus on improving the capacity of individual providers and the systems where they work to deliver recovery-oriented care (New Freedom Commission on Mental Health, 2003). However, with the many and varied definitions of recovery (Ralph, Kidder, & Phillips, 2000) and few models of care that operationalize principles of recovery into concrete, objective practices (Anthony, 2000), the development of recovery-oriented capacities has been challenging at best.

In the past few years, several organizations have attempted to clarify the meaning of recovery and recovery-oriented care through research, training, and dissemination efforts. This work has placed considerable emphasis on the competency of systems versus individuals. In June 2000, the Evaluation Center@HSRI published a compendium of recovery-related instruments that assess important aspects of the recovery process and recovery-related outcomes (Ralph, Kidder, & Phillips, 2000). In 2002, the National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for state mental health planning (NTAC) published what is commonly known as the "What Helps, What Hinders" report on recovery (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). Drawing on 1000 pages of focus group transcripts from 115 consumers, this workgroup conceptualized an "emerging recovery paradigm" that focuses on the individual's unique identity, hope, strengths, and self-determination, while emphasizing holistic approaches to care, self-help, empowerment, choice, natural supports, community integration, active growth, normative roles, asset building, and self-efficacy. The second phase of this "What Helps, What Hinders" project involved the development of a 42-item self-report measure of recovery-oriented supports and an administrative-data profile containing 16 system performance indicators and 23 associated measures (Recovery Oriented System Indicators, ROSI; Onken, Dumont, Ridgway, Dornan, & Ralph, 2004). The ROSI is currently undergoing pilot testing and will be used to inform the development of a "report card" to assess recovery-oriented supports across state mental health systems.

A state-based effort has been conducted by the Connecticut Department of Mental Health and Addiction Services, in conjunction with the Yale Program for Recovery and Community Health. Drawn from an analysis of recovery elements identified through an extensive review of the literature and focus groups with consumers, the goals of this project have been to conceptualize the elusive construct of recovery, identify

measurable indicators of a recovery-oriented environment and recovery-oriented care, and provide competency-based training to behavioral health service providers, managers, and administrators (Davidson, O'Connell, Tondora, Kangas, & Evans, 2004; Davidson, O'Connell, Tondora, Staeheli, & Evans, 2004; [www.dmhas.state.ct.us/recovery.htm](http://www.dmhas.state.ct.us/recovery.htm)).

Common principles of recovery and recovery-oriented systems of care were first identified (Davidson, O'Connell, Sells, & Staeheli, 2003). These were followed by identifying separate models of recovery pertaining to mental health and/or addictions, which helped practitioners learn to differentiate recovery-oriented practices from non-recovery oriented practices. The assessment of recovery-oriented competencies was conducted through the creation of the Recovery Self-Assessment (O'Connell, Tondora, Croog, Evans, & Davidson, in press). Based on the literature reviews and information gathered from the focus groups, this tool was developed to provide state programs with a method of gauging the degree to which constituents believed that their *programs* implement practices that are consistent with the principles of recovery. Efforts are now underway to train individual providers statewide in recovery practices through a Recovery Institute. International efforts have been underway to identify recovery-oriented competencies. For example, the New Zealand Mental Health Commission developed such a competency set through a project that was led by consumers, and gathered data through focus groups with consumers and written comments submitted by providers and government employees (O'Hagan, 2001). The final product includes 39 competencies in 10 domains, and can be accessed at: [www.mhc.govt.nz/pages/publications.htm](http://www.mhc.govt.nz/pages/publications.htm).

Work has also begun on formally assessing the recovery-oriented competencies of individual providers. Investigators at UCLA-RAND developed a paper-and-pencil instrument to measure 15 competencies that are critical to recovery-oriented care. The psychometric properties of this Competency Assessment Instrument (CAI) were evaluated in 341 clinicians at 38 clinical sites in two western states. The 15 scales were generally found to have good internal consistency, test-retest reliability, and validity (Chinman et al., 2003). The CAI and instructions for scoring are available at: [www.mirecc.org/education-frames.html](http://www.mirecc.org/education-frames.html).

### **Cultural Competency, D. J. Ida**

Quality services must, by definition, be culturally competent. In other words, it is not possible to provide competent services if one fails to adequately address the cultural and linguistic needs of diverse populations. The President's New Freedom Commission Report (2003) identified the

lack of quality services for African Americans, Asian-American/Pacific Islanders, Latinos, and Native Americans, and stated that:

The current mental health system has neglected to incorporate, respect, or understand the histories, traditions, beliefs, languages, and value systems of culturally diverse groups. Misunderstanding and misinterpreting behaviors have led to tragic consequences, including inappropriately placing individuals in the criminal and juvenile justice systems. There is a need to improve access to quality care that is culturally competent (p. 49).

Similar conclusions have been reached in the Institute of Medicine's report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2003b) and the Surgeon General's Report on *Culture, Race, and Ethnicity* (U.S. DHHS, 2001).

The need to increase the number of bicultural and bilingual service providers is reflected in the glaring discrepancy between the growing number of Latinos, African Americans, Asian-American/Pacific Islanders, and Native Americans, and the number of service providers from each of these communities. According to the 2000 Census, the four major ethnic groups comprised 30% of the population, and by the year 2025 will represent almost 40% of the U.S. population. They are, however, greatly underrepresented in the number of available providers. Ninety-four percent of psychologists, 88% of social workers, 92% of psychiatric nurses, 93% of marriage and family therapists, and 95% of school psychologists are white (not Hispanic; Center for Mental Health Services, 2004).

The solution to making the workforce responsive to the needs of communities of color is complex, multifaceted, and goes beyond efforts to hire culturally diverse and bilingual individuals. It occurs at all levels and involves training paraprofessionals as well as professionals and consumers. It involves changing not only who we train, but also the "what" and "how" of our training. It is teaching how culture defines the problem, and the way language influences how the problem is articulated.

In 2002, the U.S. Department of Health and Human Services, SAMHSA, and the CMHS awarded four grants as part of the *Reducing Racial and Ethnic Disparities through Workforce Training* initiative. The four award sites are Drexel University, the National Asian American Pacific Islander Mental Health Association (NAAPIMHA); Our Lady of the Lake University, and the University of Medicine & Dentistry of New Jersey/Robert Wood Johnson Medical School. Each site is implementing a training program designed to improve the quality of service to diverse populations. Drexel University and the Robert Wood Johnson Medical School provide training to service providers currently working with multi-ethnic populations in the Philadelphia and New Jersey communities, respectively. Our

Lady of the Lake University trains interns to provide bilingual and bicultural services to the Spanish speaking Latino population in San Antonio, Texas.

The focus of NAAPIMHA's training is to improve the quality of services for Asian-American and Pacific Islander consumers. It brought together experts from a range of groups to write the first national training curriculum to improve services for Asian-American and Pacific Islanders. The groups included the Asian Counseling and Referral Services in Seattle, the Asian Pacific Development Center in Denver, Hamilton Madison House in New York City, Hale Na'au Pono of the Wai'ane Community Mental Health Center on Oahu and RAMS, Inc., and the Asian American Psychiatric Inpatient Unit of the University of San Francisco General Hospital in San Francisco. The result was the *Growing Our Own* curriculum (NAAPIMHA, 2002), which is designed to train interns at the master's and doctoral level in psychology, counseling, and social work, as well as psychiatric residents. In addition, an effort is underway to train consumers to assist in teaching Module II of the curriculum, which is called *Connecting with the Consumer*.

At the state level, California is in the process of completing the *California Brief Multicultural Competency Training Program* to increase the cultural competency of their mental health workforce. The project was funded partially by the California Department of Mental Health and also by an unrestricted educational grant from Eli Lilly and Company. It is a collaborative effort that brought together the California Department of Mental Health, the California Institute for Mental Health/Center for Multicultural Development, the Tri-City Mental Health Center, the University of La Verne, and Portland State University to write a curriculum based on the *California Brief Multicultural Competence Scale* developed by Richard Dana of Portland State University. This scale is a 21-item self-report instrument to determine the training needs of service providers. This curriculum will be piloted in several counties this fall to assess the need for making any modifications before rolling it out to other parts of the state.

Two additional resources that are useful in identifying and teaching competencies are worthy of note. The SAMHSA Center for Mental Health Services Cultural Competence Standards (SAMHSA, 1998) identify the KSA that comprise the basic elements of cultural competence. Information on these competencies can be accessed at: [www.uphs.upenn.edu/cmhpsr/](http://www.uphs.upenn.edu/cmhpsr/). The DSM-IV Outline for a Cultural Formulation and a related training video (U.S. DHHS, 2002a) provides the practical framework for teaching the impact and role of culture in the assessment, diagnosis, and treatment of diverse populations, and is used in both the California and NAAPIMHA training programs to help clinicians accurately assess, diagnosis, and treat consumers.

Finally, as a special issue, the need to train interpreters is another important workforce competency issue, as the growing number of individuals with limited English proficiency far outweigh the availability of bilingual service providers. Frequently, family members, including children, or other untrained individuals are inappropriately used to provide interpreting services, seriously compromising the quality of services. The National Alliance of Multi-Ethnic Behavioral Health Associations (NAM-BHA), located in Washington, DC, recently completed the development of a curriculum to train interpreters to work specifically in the mental health arena. The training will be piloted in California and Texas, which have high concentrations of bilingual or monolingual non-English speaking populations.

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***No single organization is responsible for competency promulgation in social work.***

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Future efforts must continue to develop integrated models that train service providers across all disciplines of mental health, primary health, and addictions. Services must be culturally, linguistically, and developmentally appropriate to meet the needs across the lifespan of an individual. More research is also required to measure the core competencies, such as the ability to complete a cultural formulation and establish a therapeutic alliance with linguistically and culturally diverse populations.

### **Peer Specialists, Larry Fricks and Cheryl V. Finn**

The President's New Freedom Commission Report (2003) on transforming mental health care in America proclaims a vision that all mental health consumers can recover. Recommendation 2.2 of the Report states:

Recovery-oriented services and supports are often successfully provided by consumers through consumer-run organizations and by consumers who work as providers in a variety of settings, such as peer-support and psycho-social rehabilitation programs... Because of their experiences, consumer-providers bring different attitudes, motivations, insights, and behavioral qualities to the treatment encounter... In particular, consumer-operated services for which an evidence base is emerging should be promoted (p. 37).

In pioneering Medicaid-billable consumer-operated services, Georgia has utilized consumer-providers, demonstrating both cost effectiveness and recovery outcomes that are transforming the system. In order to accomplish such a service implementation, it was critical to identify and foster the development of specific competencies for the consumer-provider workforce. In 2002, the Georgia Mental Health Consumer

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Network (GMHCN) was awarded a 3-year CMHS State Networking Grant, which provided the initial funding to develop and implement the training and certification of peers for the new Medicaid-funded peer support services. To implement proposed consumer-directed services, there had to be assurances that the consumer “providers” had adequate training to perform job responsibilities as set forth in developing guidelines, and to establish a base of professionalism recognized within the system among consumers, professionals, administrators, and funding authorities. Partnering with the state Division of Mental Health, Developmental Disabilities and Addictive Disease (DMHDDAD; [www2.state.ga.us/departments/dhr/mhmrsa/index.html](http://www2.state.ga.us/departments/dhr/mhmrsa/index.html)), through its Office of Consumer Relations, a training and certification program for a consumer “provider” was established.

Initial qualifications and competencies were established to identify consumers eligible for admission into the training program. Focus groups were held to determine specific competencies that were necessary for peer specialists to be successful in these new roles. Included in the focus groups were representatives of the GMHCN, the DMHDDAD, and service provider organizations. Consideration was given to the categories of service where peer specialists could be employed, and from that discussion, more specific peer specialist roles and duties in each service were identified. With a fuller understanding of desired roles and duties, the group began to identify specific competencies that peer specialists must either possess or be trained to develop. The identified competencies were then incorporated in the Certified Peer Specialist (CPS) job description that is utilized for recruiting peers for employment and their performance evaluation as staff members.

First and foremost, candidates must be willing to self-identify as former or current consumers of mental health or co-occurring MI/SA services. They must be well grounded in their own recovery experience, with at least 1 year between initial diagnosis and application for training. They must possess a high school diploma or a GED, and be able to demonstrate basic reading comprehension and effective written communication skills. Finally, they must have demonstrated experience with leadership, including advocacy or implementation of peer-to-peer services.

Competencies taught and developed through the training program can be grouped into several distinct categories: (1) understanding mental illnesses, (2) recognizing the possibility of change, (3) developing commitment to change, (4) fostering action for change, (5) the Georgia Mental Health System, and finally (6) professional ethics. Peer specialists learn about the development of mental illness and the phases through which an individual progresses from despair to hope. They are taught principles of recovery and elements necessary to foster a “recovery

environment.” Group process and facilitation as well as effective listening and the art of asking questions are critical competencies that are emphasized throughout the training program. The importance of spirituality and cultural competence are also vital components of the program. Perhaps the most important skills to be developed through the training program are problem-solving and goal-setting, and the ability to articulate the difference between the two.

Forty hours of training is conducted in two 4-day sessions. Approximately 1 month after the training, these peers sit for their 1-day certification exam, which is both written and oral. Finally, upon successful completion of training and passing the exam, the newly CPS is asked to sign the Professional Code of Ethics for CPSs. Understanding the importance of professional ethics is the foundation for quality performance in the role of CPS.

Continuing education is held quarterly to reinforce specific skills or tools and to address issues that emerge from daily practice experience. Some emerging issues lead to the development of additional training modules that strengthen the training curriculum. Recently, the Office of Consumer Relations held a week-long training in mediation for the CPSs, to further develop their communication skills. This was followed by the employment of two full-time staff trained in mediation, to provide onsite technical assistance to any CPS needing help with conflict resolution.

A work force of approximately 200 CPSs is currently employed in Georgia’s public mental health system, promoting outcomes of independence and illness self-management by teaching recovery skills that can be replicated and evaluated. Approximately 2500 consumers will receive peer support services in the states’ 2004 fiscal year, with an expected Medicaid billing of \$6 million for their services. Training and certification activities continue, with the costs now fully supported by DMHDDAD through Mental Health Block Grant funds. Further information pertaining to the CPS Project can be obtained at: [www.gacps.org](http://www.gacps.org).

The utilization of peers in service provision is growing rapidly across the country. South Carolina is already well underway with its own training and certification program modeled on the Georgia initiative. Hawaii is also moving in this direction, with staff from Georgia conducting initial training classes and providing technical assistance for developing a consumer-provider staff cohort. To further expand the growth of consumer-providers nationwide, a “Toolkit Manual” for replicating Medicaid-funded peer support services, and the training and certification of peer specialists was commissioned by CMHS and written by Georgia staff and other contractors.

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*The professions cry out for models of core competencies.*

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Another exciting new initiative is the Peer-to-Peer Resource Center, a National Consumer Self-Help Technical Assistance Center (TAC) sponsored by the Depression and Bipolar Support Alliance (DBSA; [www.dbsalliance.org](http://www.dbsalliance.org)) and funded by the federal Center for Mental Health Services. The DBSA TAC considers peers a key workforce to promote self-directed recovery, independence and community integration for mental health consumers. In a newly piloted training and certification program, 25 consumers from around the country were taught skills to promote both illness self-management and supported employment in the summer of 2004. Specific competencies for supporting consumers seeking to return to or gain employment were included in this training program. Participants took both a pre-test and a post-test to determine the effectiveness of the training. The long-range goal of this training and certification program is replication nationwide and creation of a national network of trained and certified peer supporters working side-by-side with other mental health service providers. DBSA is also working with its Scientific Advisory Board to develop further evidence for the effectiveness of using CPSs.

## DISCUSSION

A review of these highly varied efforts to identify and assess competencies in behavioral health yields an array of general conclusions. It appears that most of the work on this topic is relatively recent and remains in an early stage of development. The major focus in most initiatives has been on identifying the knowledge, skills, and attitudes required for practice, with some efforts to organize these requirements into manageable clusters or competency domains. To date, significantly less attention has been focused on developing and implementing strategies to assess the identified competencies among students and current members of the workforce.

There appear to be rather striking similarities in the content of competencies identified, at least in terms of the more general competency domains. Yet the work of the groups and organizations described above is occurring independently. Recognizing that inter-professional rivalries may impede collaboration, the question remains as to whether some level of collaboration around identifying, defining, and assessing *common* or *core* competencies would increase the resulting reliability, validity, and research base.

Several critical issues emerge from this review. First, it appears that consumer and family involvement in the process of identifying and assessing competencies needs to be significantly increased, as they do not appear to have played a major role in most of the work that has been done to date. Second, many of the competencies identified have not been adopted or incorporated by training programs, licensing agencies, and certification boards. Until this occurs, the work on competencies is likely to have limited impact on the field. Finally, there remains a question about whether the emerging competency sets, which have typically been identified by experts, are so comprehensive and idealistic as to be unachievable by the typical student or practitioner. To examine this question, the field must complement expert opinion with other data sources, such as observation of capable practitioners, to better define the competencies required to practice effectively.

These issues aside, the work that is underway in defining and assessing competencies is extraordinarily important. This work will be critical in guiding efforts to reshape and reform training and education for the diverse groups that comprise the behavioral health workforce. We must strive continually to define, with increasing precision, the knowledge, skills, and abilities that effective practice requires. Through the process of assessment, we must also ensure that those competencies are, in fact, developed.

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