Resources and Professional Development Needs and Recommendations for Vermont Substance Abuse Workforce Development

VERMONT
DEPARTMENT OF HEALTH

June 19, 2015

For Department of Health, Division of Alcohol and Drug Abuse Programs

By Center for Health and Learning

Index

EXECUTIVE SUMMARY

Resources and Professional Development Needs and Recommendations for Vermont Substance Abuse Workforce Development

Introduction

The Vermont Department of Health Division of Alcohol and Drug Abuse Programs (ADAP) is interested in identifying sustainable strategies for growing, serving, and maintaining a workforce prepared to address substance abuse prevention across an integrated continuum of care, and across the lifespan. In order to inform this process, ADAP conducted assessments of substance abuse workforce development resources and needs. Two surveys were developed and administered by the Center for Health and Learning with input and advisement from the ADAP staff. The recommendations below reflect the data from these surveys. For a full set of recommendations, see the Recommendations section of this report.

The first survey, a Workforce Development Resource Assessment, was conducted In February 2015, and completed by a leadership representative of 10 ADAP partner organizations. The second survey, a Workforce Development Provider Assessment, was conducted in April-May 2015, and completed by 91 substance abuse professionals representing three primary work areas: Prevention (31%), Treatment (50%) and Recovery/Transitional Housing (19%). A limitation of the two surveys is that the Respondents were people in leadership positions and were generally experienced professionals, as indicated by more than 70% having seven or more years' of experience on the Provider Survey. There were few entry level or early career professionals surveyed, therefore, those needs are not well represented in the results.

Questions for the Provider Assessment were based on the IC&RC domains and approved by ADAP. IC&RC is the world's largest credentialing organization for substance abuse professionals across Prevention, Substance Use Treatment and Recovery.

Recommendation #1

Identify the Population Health Outcomes to which Professional Practice Improvement is linked, and the Measures that will be used to monitor the efforts.

- Use data, assessment and evaluation to inform workforce development activities.

Recommendation #2

Design the Framework for the Workforce Development System.

- Identify the Guiding Principles of a Workforce Development System to promote integration across a continuum of care.
- Identify a common core of professional development topics for *across the continuum of care.*
- Establish the pathway to obtain the professional knowledge and skills required for each primary area of work. This includes determining the role of Certification for each primary area, or the framework/s that the system will use to create opportunities for Workforce Development.
- Establish the core content, concepts and skills for each primary work area: Prevention, Treatment, and Recovery. (This may require action on Recommendation #3 first, and further inventory of current offerings and providers to identify overlap, gaps and opportunities.).
- Identify beginner, advanced and refresher levels of offerings, and professional practice supports for Early/Beginner, Mid-level and Advanced stages of career.
- Provide communications that cut across the continuum of care as well as within primary work areas around specific initiatives.

Recommendation #3

Address issues related to Certification and/or Credentialing for each work area.

Prevention

- Determine how to approach credentialing or certification, or what "framework" will be used for the Prevention field. For example, VT may create a state supported model of professional development based on the IC&RC credentials ***or*** commit to supporting the credentialing of prevention professionals as an IC&RC Certified Prevention Specialist.
- Identify ways to strategically support the linking of mutually supporting Prevention and Recovery efforts at the state and community level.

Treatment

- Clarify the role/position and status of LADC certification /requirement in Vermont as a qualifier for Medicaid reimbursement.
- Further identify barriers to licensure at all levels, e.g., LADC, Masters Level and Dual certification, and identify strategies to address the barriers.
- Address process issues related to obtaining education for the certified Alcohol and Drug Counselor, in order to increase access.

Recovery/Transitional Housing

- Consider the role of certification of Recovery Coaches. If Recovery Peer Coaches are essential to a population-based model, establish in Vermont the basic training needed to become a Recovery Coach, with or without certification.

Recommendation #4

Determine "how" the system will be delivered across the Continuum and System-wide.

- Create a system that facilitates Prevention, Intervention, Treatment and Recovery providers working together more seamlessly at the community level and to be more visible in how they work together.
- Create or expand an existing leadership group to coordinate so that priorities for different Departments and professionals are aligned, thereby leveraging resources.
- Create or expand an ad-hoc Advisory Group representing knowledge and skills across the continuum of care, and with Work Groups focused on Prevention, Treatment and Recovery/Transitional Housing, to provide input.
- Consider what resources from SAMHSA's Center for the Application of Prevention Technologies (CAPT) national training and technical assistance system, and the federal Addiction Transfer Technology Centers (ATTC) could offer to support a system of delivery.
- Assess opportunities for sharing of resources and collaboration among regional partners, e.g., Massachusetts, New Hampshire, Maine, etc.
- Identify appropriate formats and strategies for supporting professional knowledge and practices.

Recommendation #5

Define strategies for Recruitment and Retention.

- Explore ways to offer incentives to enter the field, including financial and logistical support.
- Commit to a professional development plan that insures sustainability of knowledge and skills in each area of workforce across all levels of experience and IC&RC domains, while at the same time ensuring offerings and support for appropriate entry level professionals.

FULL REPORT

Introduction

The Vermont Department of Health Division of Alcohol and Drug Abuse Programs (ADAP) is interested in identifying sustainable strategies for growing, serving, and maintaining a workforce prepared to address substance abuse prevention across an integrated continuum of care, and across the lifespan. In order to inform this process, ADAP conducted assessments of substance abuse workforce development resources and needs.

This work supports Strategic Direction 4.2 of the ADAP Strategic Plan:
Substance Abuse Expertise: *Recruit and maintain the highest level of substance abuse expertise available and make strategic investments to strengthen local community and partnership capacity.*

Two surveys were developed and administered by the Center for Health and Learning with input and advisement from ADAP staff. This report summarizes the data from these surveys. The information will be used to establish, implement, and reach workforce development goals and to inform ADAP's allocation of resources for workforce development moving forward.

This survey also supports regional discussions facilitated by SAMHSA which has added Workforce Development as a priority in their 2015 strategic plan. SAMHSA's Substance Abuse Workforce Initiative aims to find strategies to increase and supply trained and culturally aware preventionists, health care practitioners and peers to address the mental health and substance abuse needs in the nation. In Vermont, ADAP aims to support the workforce along the continuum of services: prevention, treatment and recovery, by using this and other data to inform discussions with partners, to connect to existing and related initiatives, and to integrate with health care reform in Vermont.

Workforce Development Resource Assessment – February, 2015

The first survey was conducted In February 2015, and completed by a leadership representative of 10 partner organizations, eight of whom are based in Vermont (VT), one in Maine, and one in Massachusetts. Eight of these partners received ADAP funding, four specifically for workforce development activities. The partners represented various levels of the VT Substance Abuse System, e.g., Community Coalitions and/or Prevention Grantees, ADAP Prevention Consultants, Preferred Treatment Providers, Licensed Alcohol and Drug Counselors, Recovery Centers, Transitional Housing, Hospital Medical Services Provider, etc.

Three Respondents indicated receiving a Demonstration Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), two of which fund workforce development activities. In addition to ADAP and SAMHSA, six of these partners use other federal and state funding sources for substance abuse workforce development.

Trainings Offered

- **All Respondents reported providing statewide services**. Seven indicated that trainees include people from other states, including New Hampshire (4), Massachusetts (5), New York (2), Connecticut, Kentucky, and California.
- **The number of trainings offered with ADAP or SAMHSA funding during a one year grant term were** 1-25 trainings (7), 25-50 trainings (2), and 76-100 trainings (1).
- **Target audiences:** Respondents reported targeting workforce trainings to the following audiences:

  - prevention staff (8)
  - clinical supervisors (7)
  - intervention staff (6)
  - treatment staff (6)
  - directors (6)
  - coalition coordinators (6)
  - recovery staff (5)
  - educators (4)
  - volunteers (4)
  - business managers (3)
  - medical community (2)
  - Other audiences included behavioral health and the Vermont Agency for Human Services staff, peers, and college and graduate students.

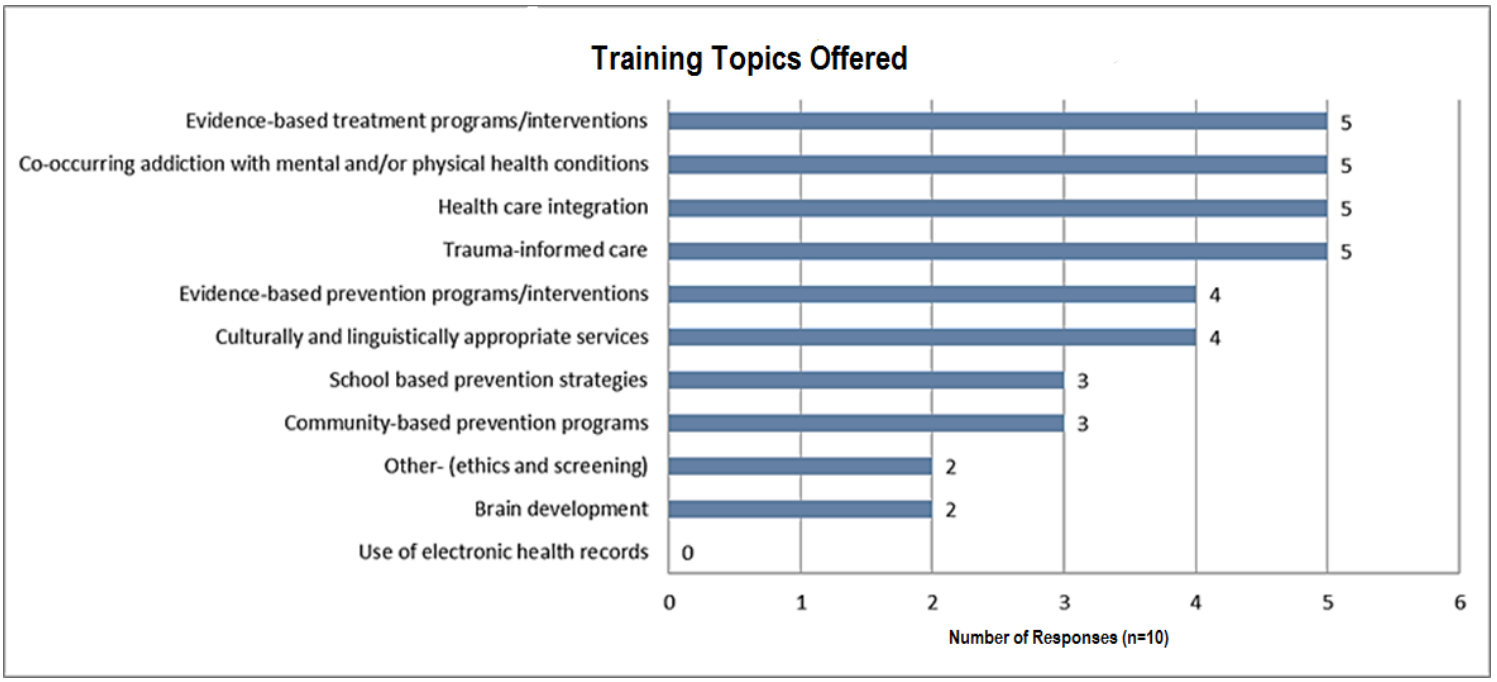
- **Attendance at trainings:** Ranged from 2-250, average low was 10 and average high was 78.
- **Cultural and linguistically appropriate services:** Seven Respondents indicated that trainers are educated in culturally and linguistically appropriate services and training environments, and that exercises promote the sharing of multiple perspectives.
- **All Respondents indicated tailoring trainings to a level of care, with Direct Service providers the target audience for most trainings.** There was much less focus on trainings for Organizational Leadership and Managers.

- **Training Format:** In-person trainings *often or always* include the following instruction methods: question and answer (9), written evaluation (9), discussion (8), experiential methods such as role-play and simulation (6), lecture (6), interactive evaluation (6) and evaluation by observation (6). Five Respondents reported using learning communities as part of their training methods.
- **Content:** Content varied with greatest focus on Evidence-based prevention or treatment programs or interventions, including co-occurring addiction with mental and /or physical health conditions, trauma-informed care, culturally and linguistically appropriate services, school and Community –based prevention, and ethics.

ADAP is interested in establishing consistent training opportunities related to established priorities, both across the continuum, and by areas of work: Prevention, Treatment, Recovery/Transitional Housing.

Chart 1: Training Topics Offered

The chart summarizes number of respondents providing training with specific topic focus.



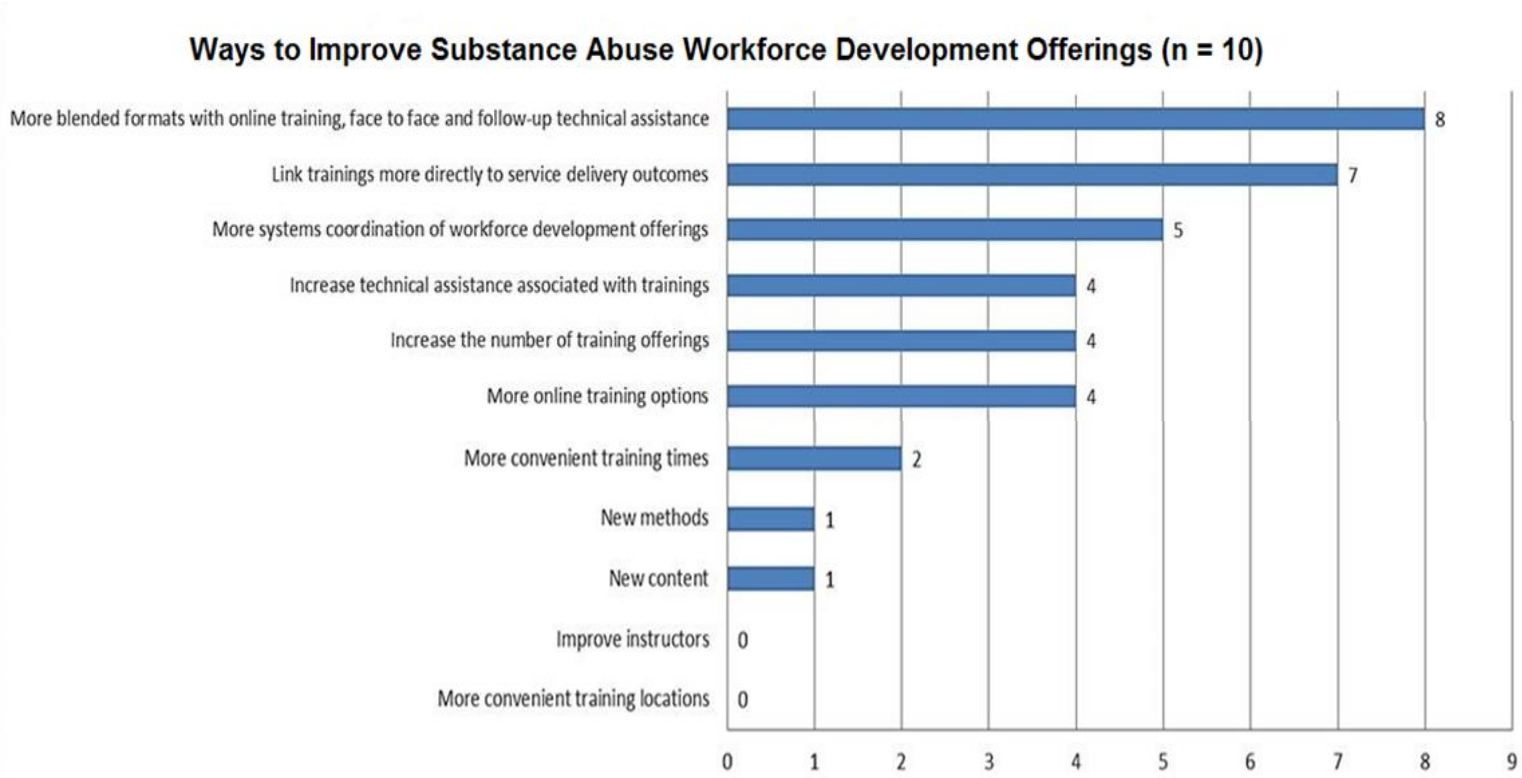
Strengths of Current ADAP Programming

All nine respondents indicated content as a strength in ADAP's current substance abuse workforce development offerings, and seven reported strong instructors as well. Only one respondent indicated online training options as a strength.

Suggestions for Improving Substance Abuse Workforce Development Offerings

Respondents offered a range of suggestions for improving substance abuse workforce development, including eight respondents indicating that they would like to see more blended formats with online training, face to face and follow-up technical assistance. In addition, seven respondents reported that they would like to link trainings more directly to service delivery outcomes. In addition to the suggestion for improvements indicated on the graph below, one respondent reported the need for a full-time workforce development staff dedicated to bringing trainings into the field.

Chart 2: Suggestions for Improving Substance Abuse Workforce Development Offerings



Another person, citing coordination with state affiliates of the National Association of Addiction Professionals and New England Addiction Technology Transfer Center, offered that a "regional meeting would be beneficial in planning future trainings." Another respondent urged for more instructors, commenting that "these questions relate to something that isn't happening."

Workforce Development Provider Survey – April, 2015

The second survey was conducted in April-May, 2015 with a focus on the Provider System that ADAP funds are supporting as outlined below. The focus of this survey was on collecting information about prevention development needs of professionals within three primary areas of work: Prevention, Treatment and Recovery.

Profile of Respondents

The survey was sent to 129 potential Respondents. Ninety-five (n=95) Respondents completed all or a part of the assessment comprising a 72% response rate.

> **Prevention respondents** included all Combined Community Funded, Partnership for Success, and School Based grantees (lead person for lead agency plus any sub-grantees) ,ADAP Prevention Consultants, and other Providers such as Vermont Association for Mental Health Addiction Recovery.
>
> **Treatment respondents** included Clinical Directors of all ADAP Treatment Provider Networks, Outpatient, Intensive Outpatient and Residential**,** as well as any LADC clinician who provides permission to forward information.
>
> **Recovery/Transitional Housing respondents** included all 11 Recovery Center Directors**.**

Providers not included were Schools-based Grantees**,** Youth Services, and SBIRT providers because separate needs assessments, briefly summarized below, were conducted with them.

Questions for the Providers were based on the IC&RC domains and approved by ADAP. IC&RC is the world's largest credentialing organization focusing on Prevention, Substance Use Treatment and Recovery Professionals.

The rating scale enabled respondents to identify their current knowledge or skill level as follows:

> NONE - I am unaware of or have little knowledge or skill.
> AWARE - I have heard of, but have limited knowledge or skill to apply.
> KNOWLEDGEABLE/SKILLED - I can apply this knowledge and skill effectively.
> PROFICIENT - I am comfortable, an expert and could teach this skill to others.

In this report, Respondents are identified by primary area of work: Prevention, Treatment and Recovery/Transitional Housing.

Level and Primary Area of Work: Respondents indicated what level of the Vermont substance abuse system they represent and had to choose only one primary work area. Of the 91 people who responded to this question, 28 (30.77%) identified Prevention as their primary work area while 46 (50.55%) identified Treatment and 17 (18.68%) identified Recovery/Transitional Housing.

Experience: The survey asked for number of years' experience in the substance abuse field.
In general the Respondents are an experienced and knowledgeable workforce with 17.28% having 4 to 7 years' experience in their field and 70.37% having more than 7 years' experience. Ninety-four percent of Respondents describe their knowledge of ADAP system of care as moderate or extensive.

Certifications or Credentials: The survey asked what certification or credentials respondents currently hold based on the IC&RC's eight international reciprocal credentials. Twenty-five percent of all respondents indicated no credentialing. Almost all Treatment providers had some certification. Half of the Recovery / Transitional Housing Respondents indicated they were Peer Recovery Certified. Only two Preventionists hold certification.

Chart 3: Respondents by Area of Work Certification

Area of Work Certification	Responses	
Apprentice Addiction Professional (AAP)	1.23%	1
Alcohol & Drug Counselor (ADC)	38.27%	31
Advanced Alcohol & Drub Counselor (AADC)	3.79%	3
Clinical Supervisor (CS)	4.94%	4
Prevention Specialist (PS)	2.47%	2
Certified Criminal Justice Addictions Professional (CCJP)	1.23%	1
Certified Co-Occurring Disorders Professional (CCDEP)	2.47%	2
Certified Co-Occurring Disorders Professional Diplomate (CCDPD)	0.00%	0
Peer Recovery (PR)	9.88%	8

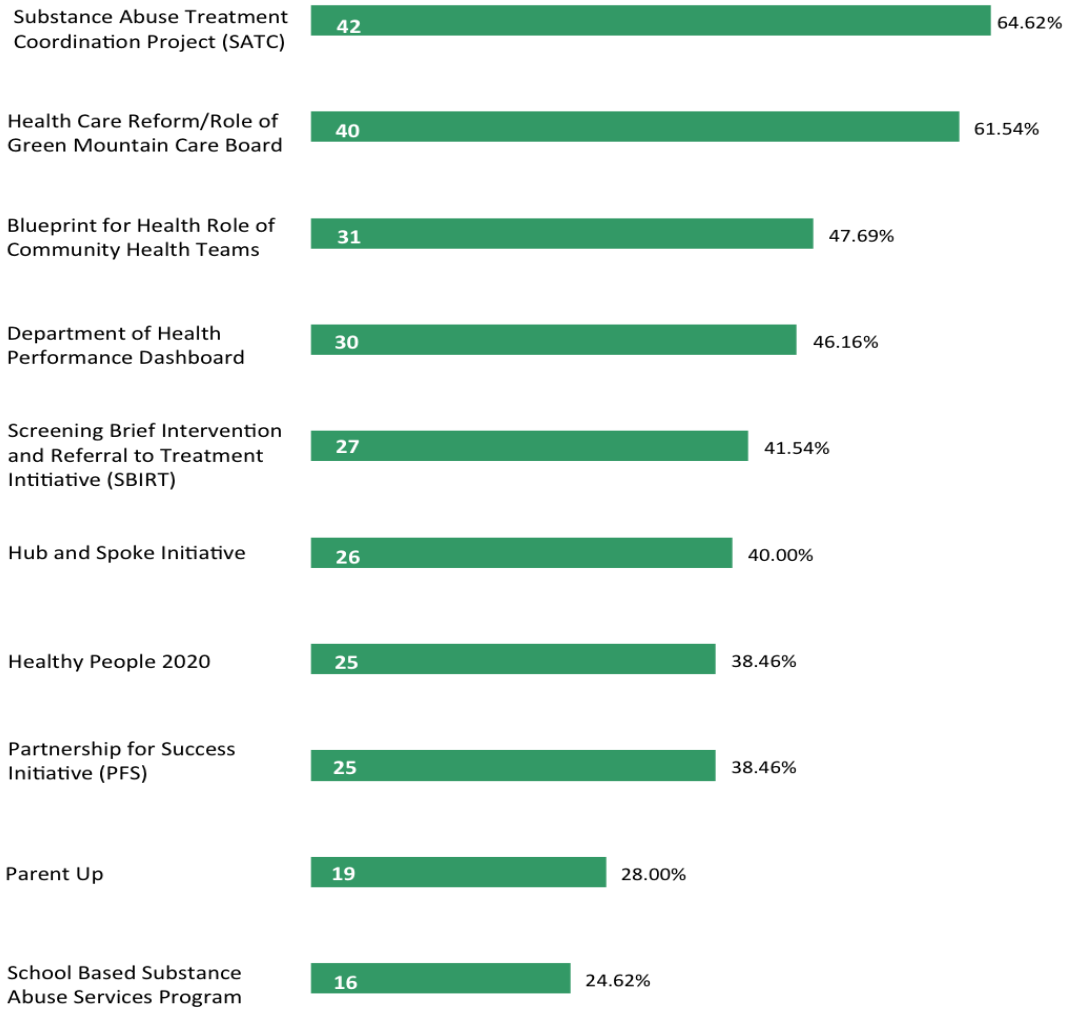
Prevention: Of the 28 Respondents who identified as Prevention, 2 are credentialed as Prevention Specialist. Three Respondents have related credentials (LCMC, CCJP & MCHES), and 18 indicated no credentials and 5 did not respond.

Recovery/Transitional Housing: Out of 17 total Respondents who identified as Recovery/Transitional Housing, 8 identified themselves as Peer Recovery certified. No other credentialing was identified by Respondents in Recovery/Transitional Housing.

Treatment: Eleven Respondents identified as having LADC certification although it was not indicated as one of the IC&RC credentials. Of those 37 Respondents who indicated LADC, AADC or CS, 3 indicated they were LADCs as well. Eight percent of Respondents have advanced credentials.

VT Health Initiatives and Other topics: The survey asked respondents to choose which Vermont Department of Health initiative they would like more information about. Respondents could choose as many initiatives as they would like.

Chart 4: Health Reform Information Needs



When analyzed by primary work area, *results indicate a need for information that cuts across the continuum of care as well as information about specific initiatives within their own primary work areas*. For example, of the 27 respondents indicating they would like more information about the SBIRT, 16 identified themselves as Treatment. Of the 42 respondents indicating they would like more information about Substance Abuse Treatment Coordination (SATC), 21 identified themselves as Treatment. One Prevention respondent asked for information about the prevention initiatives of Parent UP and PFS. With regard to "Other Topics", Prevention indicated highest proficiency in Grant Writing and lowest in Implementing Continuous Quality Improvement Practices.

Treatment indicated highest proficiency in Implementing Continuous Quality Improvement Practices and lowest in Developing Boards.

Recovery/Transitional Housing had equally low proficiency for all three choices.

Training Systems

The survey asked respondents to identify components of a training system that were important to them.

- Expert Facilitation was the highest shared priority among the three groups. Blended Learning Opportunities were also valued in
- While Certification Credits are important to Treatment providers, this is the lowest priority for Prevention and Recovery specialists at this time, reflecting the status of credentialing in those areas.
  All three groups value Training Designed for Work-related Competencies.
- Recovery/Transitional Housing have the greatest need for Ongoing Access to Learning Resources and Practice Support and Coaching.
- Treatment also prioritizes Ongoing Access to Learning Resources.

Chart 5: Ranking of Importance of Training System Components by Provider Type

Ranking	Prevention	Treatment	Recovery/Transitional Housing
#1	Training Designed for work –related competencies	Certification Credits	Ongoing access to learning resources
#2	Expert Facilitators/trainers Face to Face	Expert Facilitators/trainers Face to Face	Practice Support and coaching
#3	Blended Learning Opportunities	Ongoing access to learning resources	Expert Facilitators/trainers Face to Face
#4	Technical assistance	Training Designed for work – related competencies	Blended Learning Opportunities tied with
#5	Practice Support Coaching	Blended Learning Opportunities	Training Designed for work – related competencies

Prevention Results Summary

General Information

Twenty eight Respondents identified their primary work area as Prevention. One person signed in as Prevention but did not go beyond the first few questions. Eight Prevention Consultants, 8 Community Prevention Grantees, and 17 Community Coalitions were identified (Respondents could chose more than one answer for Role).

The majority of Respondents, 75%, have 4 or more years' experience in the substance abuse field. Fifty eight percent have 7 or more years' experience.

Of the 28 Respondents who identified as Prevention, 2 are credentialed as Prevention Specialist. Three have related credentials (LCMC, CCJP & MCHES), and 18 indicated no credentials and 5 did not respond.

Domains

Domains and the related knowledge and skills assessed were determined by ADAP and correspond to the IC&RC Prevention Specialist credentials.

Planning and Evaluation as well as Prevention Education and Service Delivery: 85% of Respondents reported being knowledgeable/skilled or proficient.

Communication: 100% of Respondents reported knowledgeable/skilled or proficient.

Community Organizing: 96% reported knowledgeable/skilled or proficient.

Public Policy and Environmental Change: One third of Respondents reported they have heard of but have limited knowledge or skill to apply in demonstrating knowledge of Theory of Change and the Public Health model. Twenty percent reported having heard of, but have limited knowledge or skill to identify Enforcement initiatives to affect environmental change.

Professional Growth and Responsibility: 46% of Respondents reported having limited knowledge or skill of Current Issues of Mental, Emotional and Behavioral Health while 82-92% reported knowledgeable/skilled or proficient in the other areas.

Other: Two thirds reported knowledgeable/skilled or proficient in Grant Writing and Board Development; but one third reported limited knowledge or skill or no awareness of Implementing Continuous Quality Improvement Practices.

<u>Comments</u>

Competencies/Credentials

> *Add benchmarks to the competencies identified in 1-7 above so that members and supervisors could assess more effectively.*
>
> *You might consider a career path where participants could accumulate credits toward some credential - the Prevention field is wide open in terms of skills and expectations.*
>
> *Certification program for Preventionists.*

Training offerings

> *Design Refresher or Advanced courses for those who have had the basic (intro) courses. Don't require people to repeat the same courses each year. Could alternate years and teach different things one year and others in a second or third year.*
>
> *Offer Key Message Development mini-trainings 2-3 times a year, so there are multiple opportunities to come together and address issues that the VDH Communications office would prioritize. We can build local capacity while learning from each other and it could increase efficiency for Communications responding to our requests separately.*

Treatment Results Summary

General Information

Forty six respondents chose Treatment as their primary work area. Depending on the question, 39 or 40 people completed the questions. Of those, 82% had more than 7 years' experience within the substance abuse field.

Eleven respondents identified as having Licensed Alcohol and Drug Counselor (LADC) certification although it was not indicated as one of the IC&RC credentials. Of those 37 respondents who indicated Alcohol & Drug Counselor (ADC), Advanced Alcohol & Drug Counselor (AADC) or Clinical Supervisor (CS), 3 indicated they were LADCs as well. Thirteen respondents have dual credentials. Eight percent of respondents have advanced credentials.

Domains

The domains and corresponding knowledge and skills assessed were generated by ADAP Treatment staff based on the IC& RC credentials for an Alcohol and Drug Counselor (ADC). In all domains, greater than 90% of respondents indicate knowledgeable/skills or proficient. The domains assessed were:

- Clinical evaluation, including screening, assessment, and diagnosis of Substance Use Disorders and Co-Occurring Disorders (CODs)
- Treatment Planning for SUDs and CODs
- Referral
- Service Coordination and Case Management in areas of SUDs and CODs
- Therapy, Care and Client Education
- Client, Family and Community Education
- Documentation
- Professional and Ethical Responsibilities

Comments

Professional Documentation Requirements

Reduce redundancy in (professional) documentation for folks working in multiple record keeping systems.

It would be helpful to have consistence expectations and examples of written documentation. For examples, what assessment tools should providers be using? Samples of preferred assessment, addendum, DAP notes and discharge summaries would be extremely helpful.

Medicaid Reimbursement

Create legislation that places the LADC in the position of "Board Certified" and only that credential can draw down state and federal (Medicaid) revenue for services provided. Currently a LMSW can draw down Medicaid funding for providing Substance Use Disorder treatment and LADC can only get reimbursed if associated with a designated agency. We know the extent of SUD training for the LADC, the LMSW does not have any SUD requirements for their training

Training and Professional Development

Assure that quality training is available to people entering the field. Work with the Certification Board to assure that qualified people enter the field, and that quality supervision is ongoing, especially in the early years of a counselor's career. Work with existing entities, and perhaps new ones, to assure that there is ongoing training throughout a counselor's career.

Making sure that there are trainings available that fit new educational requirements for apprentice credential

Require trained Clinical Supervisors, a frequency of training sessions, and training funds for clinical supervision in all contracts or grants

Incentives to Enter the Field-Financial and Logistical Support

There is a lack of young people entering the field. We DO NOT pay enough for people to come in or stay. HUBS are able to pay much more than the rest of the field, there needs to be equity. There is little/no retirement. It DOES NOT MATTER how much education/support, etc... we provide if we are not financially competitive. In my opinion, we are pouring money down the drain until we fix the real problem. Loan forgiveness would help.

Staff with LADC need to start being compensated appropriately... many high school and college students are coached to attend nursing school for 1yr for LPN as they will earn more than a Master Level LADC after 6-8 years of education... it is time for some equality in pay so that we can encourage young people to get into the field and stay here.

Examine licensure barriers, including Dual-licensing and address them.

It would be wonderful if there was a mechanism for financially and logistically supporting clinicians who would like to complete their Masters level academic work.

Finding ways to make it more attractive or less daunting to pursue an LADC. My greatest challenge is finding individuals who are interested/willing to pursue an LADC.

Recovery/Transitional Housing Results Summary

General Information

Seventeen Respondents identified their primary work area as Recovery/Transitional Housing. Sixty percent of Respondents have more than 7 years' experience in the substance abuse field. Of the 17 Respondents, 8 identified as Certified Peer Recovery. No other credentialing was identified by Respondents in this primary work area.

Domains

Domains and related knowledge and skills assessed were determined by ADAP and correspond to the IC&RC Peer Recovery (PR) credentials.
Advocacy: More than 94% of Respondents reported being knowledgeable/skilled or proficient.
Ethical Responsibility: 100% of Respondents reported knowledgeable/skilled or proficient.
Mentoring and Education: More than 94% of Respondents reported knowledgeable/skilled or proficient
Wellness and Recovery Support: Almost 100% of Respondents responded knowledgeable/skilled or proficient.
Other: 70% of Respondents reported being knowledgeable/skilled or proficient in board development and grant writing.

Comments

Professional Development

Coordinate the process for obtaining education for certified Alcohol and Drug Counselor to make it an easier system to access and an easier process. Certifying Recovery Coaches so they can be part of the treatment system and Medicaid reimbursable.

Training on RBA, funding raising, trust and foundation links and how to incorporate and take advantage of. College tuition or certification programs tuition, provided to dedicated individuals working for the nonprofits that are being supported ADAP funds. Internships for the same individuals. This will assist in making sure that there is a educate workforce as we move forward.

Support of regular trainings regarding motivational interviewing, Ethics, professional and boundaries focused. These trainings would assist in the development tracks for most individuals entering field.

Supervision

Statewide supervision and oversight for Recovery Coaches. Coordinate efforts with SAMHSA to build and improve the services for the co-occurring population.

Linking Prevention and Recovery

To have the ability to cross [link] the youth Prevention and Recovery services together: to utilize the coordinated need for both. With the high rate of substance use in our schools prevention gets the attention and so many kids/ youth utilize the Recovery programs before they got to the harder drugs and have peer support within their schools. This would be huge asset to them to have a chance at getting through without peer pressure. This could save kids from the wrong journey

Other ADAP Initiatives Needs Assessments

School-based Substance Abuse Services Grant Program (SBSAS)

In July 2012, 21 supervisory unions (SU's) were awarded a 3 year SBSAS grant to support school-based substance abuse prevention and early intervention services. The objective of the SBSAS program is to increase the school's capacity to carryout substance abuse prevention and early intervention strategies within the school's coordinated school health framework. A stakeholder survey of grantees was conducted in 2015 and included one question on training needs. *The results are:*

Coordination/collaboration within their schools & communities (including medical home) (3)
How to educate staff (how to recognize someone who is using substances) (3)
Knowledge of building youth protective factors (2)
Updates on emerging drugs (2)
Innovative programs (2)
Updated evidence based curricula training (Michigan Model is outdated) (2)
Providing successful, evidence-based, parent education (including how to engage families) (2)
Whole School, Whole Community, Whole Child (WSCC) 2
Training on how to collaborate with other members of the student support system (1)
Motivational interviewing (2)

General substance abuse and mental health information (1)
Peer support/mentoring programs (1)
How to measure outcomes (1)
Confidentiality, continued training on screening and assessment (1)
Training in dual diagnosis (1)

Youth Treatment Enhancement Grant (YSSAC)

In 2014 ADAP administered a survey related to the needs of youth serving organizations served by AHS. The Council workgroup refined the focus relating to topic and audience.

Topics that rose to the top were:

- Adolescent brain development
- Emotional regulation for youth
- Evidence-based assessment, intervention, and treatment approaches

Most important core audiences identified by YSSAC were:

- Educators – primary, secondary, and post-secondary education
- MH/SA/COD clinical practitioners at a direct service/front-line level
- A broad swath of youth workers – any professional that comes into contact with youth/family

In December 2014 ADAP surveyed clinicians at 5 Youth Treatment Enhancement sub-grantee treatment sites. Their priority workforce development topics are:

- Agency teaming to support youth – making and managing referrals
- Trauma Informed Care
- Motivational Interviewing
- Emotional Regulation for Youth

Screening, Brief Intervention and Referral to Treatment (SBIRT) Initiative

SBIRT is an evidence-based protocol that is currently being delivered in nine grant-funded medical settings statewide. To implement any SBIRT protocol, primary care and behavioral health staff will need formal training on the SBIRT components. Over the years, numerous organizations have developed SBIRT-related training curriculums and resources that are readily available, which can be used to enhance in-person activities. All providers and staff participating in the SBIRT protocol would benefit from a foundations course to learn the basics of SBIRT. It is imperative that medical and behavioral health providers continue to receive training in motivational interviewing and facilitating an active referral to community-based treatment. Additionally, embedded behavioral health clinicians will require the clinical 12-hour Integrated Change Treatment training and subsequent ongoing case consultation for a year. A more extensive Training menu was provided with the assessment and included:

- Webinar tutorials - approximately 5 hours
- In-person fundamental trainings - 8 hours for medical and behavioral health providers and an additional 12 hours for Brief Treatment (ICT) training for behavioral health providers only
- Ongoing clinical coaching - 40 hours to be conducted throughout the year after initiating SBIRT

Recommendations

The recommendations are based on the sources of data reviewed in this report and other documents provided by ADAP. They are organized by area of continuum: Prevention, Treatment, Recovery/Transitional Housing, and by Workforce Development System.

Limitations

- ✓ A limitation of the two surveys is that the Respondents for the Resource Assessment were Program Coordinators or Directors, and Respondents for the Provider Survey were people in leadership positions. In both cases, the Respondents were generally experienced professionals, as indicated by more than 70% having seven or more years' of experience on the Provider Survey. There were very few entry level or early career professionals surveyed. Those needs are not well represented in the results.
- ✓ The Provider Survey focused on assessing Treatment by IC&RC domains. As the LACD is the predominant certificate held by Treatment providers in Vermont, there may be some need to look at the alignment between competencies.
- ✓ The providers who are delivering professional development in ADAP's system were involved in identifying the strengths of current offerings (see Chart 3), and may have some bias.

WORKFORCE DEVELOPMENT SYSTEM

In the Resource Assessment Respondents cited a number of strengths in ADAP's current workforce development training activities. One person commented that, "ADAP has worked hard to present relevant and timely trainings… many of them free," and another commented, "trainings are tailored to its audiences and grantees' needs." A third respondent shared, "the overall perception is that the system is underdeveloped." Based on the results of current assessments, there are many opportunities to create a more unified Workforce Development "System." The need for the system to improve health-related population outcomes and make use of resources efficiently is clear.

There are many *stakeholders* in this system aside from the public consumer: the Prevention, Treatment and Recovery specialists themselves, the Education, Health Care and Community Provider sectors, the numerous state agencies who rely on a trained and prepared workforce,
multiple "community partners" which ADAP funds or potentially funds to carry out the activities that support professional practices, and the Certification bodies, among others.
The process for developing a Workforce Development "System" requires oversight and coordination.

What will we structure a system for?

- ➢ Identify the population health outcomes to which professional practice improvement is linked, and the measures that will be used to monitor the efforts.
- ➢ Use data, measurement and evaluation to assess workforce development activities.

Who will the participants in the system be?
Assessments were conducted to evaluate the needs of professionals engaged in ADAP funded initiatives. The providers listed below are secondary target groups that may also benefit from system enhancements. ADAP can consider when and how opportunities are made available to those who provide service, though not necessarily under ADAP funding.

- Student Assistance Program Counselors
- School-Based Clinicians (Success beyond Six)
- School Guidance, Nurses, Faculty, Support staff
- College Health Centers
- AHS Employees
- Blueprint Care Coordinators
- Healthcare Providers
- Spoke Providers
- Recovery Coaches
- Youth Workers – Boys/Girls Clubs
- VT Kin as Parents
- Law Enforcement Officers/DLC Educators
- Drug Courts
- CRASH Group Leaders
- PCA-VT Staff

How will the system be structured?

Resource Assessment Respondents recommended: "More systems coordination of workforce development offerings."

- Create or expand an existing leadership group to coordinate across systems so that priorities for different Departments and for different audiences are aligned, thereby leveraging multiple funding streams toward core elements.
- Create or expand an ad-hoc Advisory Group representing knowledge and skills across the continuum of care, and with Work Groups focused on Prevention, Treatment and Recovery/Transitional Housing, to provide input on what the system will be.

What will the system be?

There is a need for Prevention, Intervention, Treatment and Recovery providers to work together more seamlessly at the community level and to be more visible in how they work together. ADAP's objective is to increase opportunities for professionals in the substance abuse field to: (1) build collaboration skills and a common understanding of how one level of the continuum needs to work with the other to be effective and (2) identify common skill development needs. This report established current strengths in ADAP's offerings including content, instructors, methods, technical assistance, and convenient training locations.

- Identify the Guiding Principles of a Workforce Development System to promote integration across a continuum of care.
- Identify a common core of professional practice topics for across the continuum of care.
- Establish the pathway to obtain the professional knowledge and skills required for each primary area of work. This includes determining the role of Certification for each primary area, or the framework/s that the system will use to create opportunities for Workforce Development.
- Establish the core content, concepts and skills for each primary work area: Prevention, Treatment, and Recovery. (This may require further inventory of current offerings and providers to identify overlap, gaps and opportunities.).
- Identify beginner, advanced and refresher levels of offerings, and professional practice supports for Early/Beginner, Mid-level and Advanced stages of career.

- Develop system-wide definitions for terms like workforce development, technical assistance, and learning community, so that trainees fully understand the intended meaning.
- Provide communications that cut across the continuum of care as well as within primary work areas around specific initiatives.
- Determine statewide supervision for each provider group.
- Reduce redundancy in professional documentation for providers working in multiple record keeping systems.
- Explore ways to offer incentives to enter the field, including financial and logistical support.
- Identify ways to strategically support the linking of mutually supporting Prevention and Recovery efforts at the state and community level.

Recommendations from the Respondents included:

- Use Learning Communities to supplement and enhance training and improve sustainability.
- Employ an ECHO model to disseminate knowledge and learning statewide.
- Build a statewide network of content experts, providers and consultants.
- Create a forum for substance abuse agencies and organizations to work together in identifying promising and evidence-based practices, such as a clinical practices advisory group.
- Increase alignment with the Vermont Cooperative for Practice Development.

How will we deliver the elements of the system?

- Consider what resources from SAMHSA's Center for the Application of Prevention Technologies (CAPT) national training and technical assistance system could offer and strengthen substance abuse workforce development in Vermont. Available online courses are included in Appendix 1.
- Consider resources from the federal Addiction Transfer Technology Centers (ATTC) to support a system of delivery.
- Assess opportunities for sharing of resources and collaboration among regional partners.
- Identify appropriate formats and strategies for supporting professional knowledge and practices. When asked on the Resource Assessment about ways to improve substance abuse workforce development, 8 of the 10 respondents identified, "More blended formats with online training, face to face, and follow-up technical assistance." Seven indicated "link trainings more directly to service delivery outcomes."
- Use the rankings of Training System Components in Chart 7 to prioritize strategies for Workforce Development for each provider type.
- Use providers in each work area to educate and inform providers in other work areas about areas of high proficiency. For example, a Prevention provider teach about Grant writing, and a Treatment provider teach about Continuous Quality Improvement.

What are the core concepts, topics and skills to be prioritized in the Workforce Development offerings?

- Once a common core of professional practice topics and activities across the continuum of care, and within each primary area are identified, use Chart 1 from this report, and further inventory current offerings and providers to identify overlap, gaps and opportunities.
- Identify core concepts, topics and skills based on the competency framework or Certification requirements established for each work area, as well as ADAP priority initiatives. For example, substance use disorders, co-occurring disorders, on-going clinical supervision, and a working knowledge of ethics is required for Clinician competency, while a working knowledge of SBIRT is critical for sustaining that initiative.

- Use the recommendations from the assessment of the SBIRT initiative (referred to on page 16) to map a Workforce Development plan that supports sustainability.
- Use the Recommendations below for each provider group to further determine key offerings.
- All three groups of Respondents indicated interest in training on Screening and Assessment.
- In previous assessments conducted by ADAP on School-based Substance Abuse Services Grant Program, Youth Treatment Enhancement Grant, and Screening, Brief Intervention and Referral to Treatment Initiative, there were some common themes between the three assessments related to professional development needs. These included:

  Motivational interviewing- YSSAC/SBIRT/SBSAS
  Screening and assessment-YSSAC/SBIRT/SBSAS
  Managing/facilitating referrals SBIRT/SBAS
  Brain Development and Emotional Regulation for Youth YSSAC
  Trauma Informed Care YSSAC
  Training in Dual Diagnosis SBSAS
  Evidence-based assessment, treatment approaches YSSAC/SBSA

  The most important core audiences identified by YSSAC were:
  - Educators – primary, secondary, and post-secondary education
  - MH/SA/COD clinical practitioners at a direct service/front-line level
  - A broad swath of youth workers – any professional that comes into contact with youth/family
- Provide health reform information to providers across the continuum, based on the results presented in Chart 6, indicating that all providers have interest in information on some health reform initiative/s.

PREVENTION

- Determine how to approach credentialing or certification, or what "framework" will be used for the Prevention field. For example, VT may create a state supported model of professional development based on the IC&RC credentials ***or*** commit to supporting the credentialing of prevention professionals as an IC&RC Certified Prevention Specialist.
- Expand professional development strategies that are currently in place and that have served to build a knowledgeable and skilled workforce.
- Commit to a professional development plan that insures sustainability of knowledge and skills in the Prevention workforce across all the levels of experience and IC&RC domains.
- As the prevention workforce is responsible to promote key messaging developed by Vermont Department of Health, provide special messaging updates for the field and offer them annually 2-3 times a year.
- Prioritize content needs for Prevention providers using the results summary in this report, including Public Policy and Environmental Change, Current Issues of Mental, Emotional and Behavioral Health, and Implementing Continuous Quality Improvement Practices.
- Consider whether the Prevention field could benefit by more formal opportunities for Non-Profit Leadership skills development, such as financial management/sustainability, knowledge management/transfer, results-based accountability, organizational development/change management strategies and succession planning.

Quote from a Prevention provider: "You might consider a career path where participants could accumulate credits toward some credential - the prevention field is wide open in terms of skills and expectations."

TREATMENT

- Review professional documentation requirements across certifications to reduce redundancy, to promote consistency of expectations, and to identify where sample exemplars for documentation can be provided, in order to support the process.
- Clarify the role/position and status of LADC certification /requirement in Vermont as a qualifier for Medicaid reimbursement.
- Address process issues related to obtaining education for certified Alcohol and Drug Counselor, in order to increase access.
- Define a continuum of training to support counseling at all career levels, including Apprenticeship and Clinical Supervisor.
- Further differentiate between needs at the clinical and management levels.
- Research and identify issues and strategies to address the compensation issue at all levels of treatment professionals.
- Further identify barriers to licensure at all levels (LADC, Masters Level and Dual certification) and identify strategies to address the barriers.
- Assure quality training is available on a multi-year calendar rotation, and on a continuum built to the needs.

Quote from a Treatment provider: "Assure that quality training is available to people entering the field. Work with the Certification Board to assure that qualified people enter the field, and that quality supervision is ongoing, especially in the early years of a Counselor's career. Work with existing entities, and perhaps new ones, to assure that there is ongoing training throughout a Counselor's career."

RECOVERY/TRANSITIONAL HOUSING

- Consider the role of certification of Recovery Coaches as part of the Treatment system and as qualifiers for Medicaid reimbursement. If Recovery Peer Coaches are essential to a population-based model, establish in Vermont the basic training needed to become a Recovery Coach, with or without certification.
- Provide training on critical topics in a cycle that supports the emergence of professionals in the field.
- Provide internships and innovative tuition arrangements for staff who have demonstrated some minimum time commitment to the field.
- Consider approaches to supervision and oversight of Recovery Coaches.

Quote from a Recovery provider: "What comes to mind is the building of a learning community. Currently we do not take advantage of lessons learned within the Recovery Center system."