



# DEVELOPING A MORE SKILLED CO-OCCURRING DISORDERS WORKFORCE

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**I**n an economic climate of rising poverty rates (37.3 million in 2007; up 20 percent since 2000) and scores of people without insurance (45.7 million in 2007; up 15 percent since 2000), individuals seeking treatment of mental health and substance use will face challenges of accessibility and affordability (Lavin, 2009). For families that have health care coverage, average annual premiums have doubled in the past seven years (Lavin, 2009). Unemployment across the nation is at a 16-year high of 7.2 percent with Rhode Island (the residence of the authors of this article) having the dubious distinction of the country's second highest unemployment rate at 10 percent (Jordan, 2009). In the

professional arena of mental health treatment, these trends suggest a mounting problem in the financial capacity of clients to afford adequate care.

Particularly distressing in this climate are a complex array of factors related to behavioral health care that impact the quality of care. This article considers factors such as decreased public funding and an aging workforce that impact the capacity of the behavioral health care system to treat the interrelated issues of co-occurring mental health and substance use disorders (COD). The authors propose a model for collaboration with higher education and international board standards that address, at all entry points

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of the service delivery system, the growing shortage of properly prepared behavioral health practitioners. Such a model will contribute to a system of well-trained professionals capable of meeting the interrelated treatment needs of individuals with co-occurring disorders.

### **Complex care for co-occurring disorders**

Care for COD is complex and complicated. Some research suggests that up to 80 percent of individuals entering publicly funded treatment for substance use disorders have one or more co-occurring psychiatric disorders, yet only 16 percent of adults and 26 percent of adolescents have a co-occurring disorder documented in their intake assessments (DASIS, 2004). Typically, someone seeking substance use treatment enters a program focusing on that issue in isolation and is referred elsewhere for treatment of any co-occurring psychiatric issues. This often results in clients being bounced from one treatment facility to another resulting in discontinuity of care and overburdening the treatment system. In many cases, clients fall through the cracks and do not receive adequate treatment (Center for Substance Abuse Treatment, 2005).

Treating CODs in this disjointed fashion can be ineffective because individuals with complex, overlapping conditions may be ill-prepared to negotiate fragmented systems of care (SAMHSA, 2002). In fact, “as many as 50 percent of persons with co-occurring disorders never receive concurrent treatment for both disorders” (McGovern, 2008). Far reaching results of such a treatment cycle can be

seen in overrepresentation of individuals with substance use and mental health disorders in the criminal justice system. For example, Bureau of Justice Statistics report 74 percent of incarcerated individuals have a lifetime prevalence of substance use disorders and 49 percent report symptoms consistent with a diagnosable mental health condition; rates that far surpass those found in the general population (Peters, Bartoi & Sherman, 2008).

### **Workforce capacity for co-occurring disorder treatment**

Individuals with substance use disorders generally rely on public funded treatment options to a much greater extent than people with other diseases (Abt Associates, 2006) a reality that may partly be related to higher rates of unemployment and a higher likelihood of being uninsured. In the current economic climate, funding for these public programs is declining. If accepted, national budget cut proposals for FY 2009 would slash the Medicaid program in excess of \$18 billion resulting in reduced funding for “discretionary” mental health and human services programs that low-income Americans need (Mental Health America, 2008).

The capacity of the behavioral health care system is further restricted by the availability of a qualified workforce. The existing substance use workforce consists largely of a generation of people who entered the addictions field not professionally trained, many themselves, in recovery from or impacted by alcohol or other addiction, who didn’t necessarily follow an academic track (White, 2001). In 2003, the average age of the addictions workforce was mid-40s to 50 years of

age (SAMHSA, 2002). Coupled with an average turnover rate of 18.5 percent among front-line addictions counselors and 53 percent for program managers and directors, the aging COD practitioners may be seen as a harbinger of a looming workforce crisis in the behavioral health field (Abt Associates, 2006; White, 2001). There is a growing need for skilled practitioners to provide integrated treatment to clients with COD. The need for these skilled professionals is quickly outpacing the number of new people being attracted to and remaining in this profession (Abt Associates, 2006).

The result of this shortage of alcohol and drug use counselors, high annual turnover and a crisis in leadership, all serve to further overburden a workforce ill-prepared to meet the demands of COD treatment (Powell, 2006). With enormous pressures on individual providers and the workforce as a whole, the current behavioral health service delivery system is inadequate to handle the growing number of people with less money, no or limited health care coverage and increasingly complex treatment needs.

Workforce capacity describes more than just the numbers of practitioners available to treat a condition. It also involves skills to recognize, diagnose and adequately treat COD. The Substance Abuse and Mental Health Services Administration (SAMHSA) recently reported to Congress that “(p)erhaps one of the most significant program level barriers, noted by consumers and family members as well as by providers . . . is the lack of staff trained in co-occurring disorders”

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(SAMHSA, 2002). Research supports the need for integrated treatment of substance use and mental health disorders such as depression, anxiety and post-traumatic stress disorder (Drake, Mueser & Brunette, 2007; Minkhoff et al., 2003; Najavits, 2002; Nunes & Levin, 2004), suggesting that the ability to provide integrated treatment should be the rule not the exception. Truly integrated treatment replaces parallel or sequential treatment and involves specific strategies in which interventions for both disorders are combined in a single session or in several interactions and more effectively treats the whole person (Drake et al., 1998; SAMHSA 2005; SAMHSA, 2007). Any effort to build capacity in the treatment of co-occurring disorders must include goals to increase the number of available professionals and to broaden the scope of their professional preparation in mental health and substance use disorders.

### **Promising developments for the preparation of a quality workforce**

Although we have painted a rather bleak picture of the current problems facing our field, there are some promising developments that can inform the preparation of a qualified behavioral health workforce. In September 2006, the International Certification & Reciprocity Consortium (IC&RC) adopted a resolution, by nearly unanimous vote, calling for the establishment of international standards in the credential of practitioners who treat individuals with co-occurring substance use and mental health conditions. This resolution has established a set of written guidelines for the certification of practitioners who specialize in the treatment of co-occurring disorders.

The IC&RC represents 73 organizations with more than 37,000 certified professionals, and the board's decision to develop these co-occurring treatment certification standards was based on a growing body of research, published federal government recommendations and applied clinical realities, all of which suggest a blending of addictions and mental health treatment principles into a "third technology." This emerging field of effective practice, suited for individuals with co-occurring disorders, stems from suggestions that addictions and mental health treatment models are fundamentally incompatible and that merely offering these two approaches is not sufficient (Cherry, 2008). The development of COD certification standards represents a step toward unity, rather than division, in behavioral health; moreover, it blends the best of treatment from both the substance use treatment and mental health.

A number of governing bodies are adopting these IC&RC standards as certification standards, thereby recognizing a unique specialization of knowledge and skills in mental health and substance use, necessary for best practice with co-occurring disorders. This impetus for change will not be successful in isolation. Simply adopting new standards does not create the infrastructure to meet those standards. Truly embracing COD standards requires the behemoths of certification boards, higher education, licensing boards and even insurance panels—separate entities that generally co-exist—to reduce silo thinking in favor of cooperation and communication. In order to develop the next generation of a skilled workforce and

increase capacity in the COD profession, the key constituents in the preparation and credentialing process need to operate in some degree of alignment. With this new incentive of international COD credentialing standards, a collective response will best answer the call for increased relevance, effectiveness and accessibility of education opportunities (SAMHSA, 2007) for a well-prepared work force.


### **Retrofitting an academic program with COD standards**

Policy and certification level changes reflect a commitment to delineate the skills important to define the COD profession, and can serve to move along the alignment process. In 2007, Rhode Island College's graduate counseling department was contacted to participate in the Rhode Island State Action Plan for an integrated COD system of care. Thus began the review of the existing Masters program in chemical dependency revealing several multilayered options to improve the educational fit to certification and licensing requirements.

First, we found a distinct and marked division within our counseling preparation programs and our chemical dependency program. Our own graduate level counselor preparation program was like many others across the country, with no required study in addictions treatment or co-occurring disorders. As an institute of higher education (IHE) providing formal education to mental health counselors and other allied professionals, we had degree programs of mental health and addiction studies co-located in the department with distinct strands for coursework in each degree. The recent adoption of the revised curriculum

standards of the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2009) has added “theories and etiology of addictions and addictive behaviors, including strategies for prevention, intervention and treatment” to its core expectations for a program that has CACREP approval. This change sounds like a step toward incorporating an addiction studies-related focus in counseling curricula. However, since CACREP is neither a mandatory accreditation nor universal in its adoption across higher education counselor programs, several hurdles remain for curriculum integrated with counseling and co-occurring disorders.

Second, there was relatively little guidance available to inform the transformation from parallel degree programs to plans of study that incorporate chemical dependency with mental health. It appears to be new territory to seek external validation for a plan of study that fully incorporates curriculum for co-occurring disorders with existing approval, accrediting and certifying bodies all focused on addiction studies. While CACREP has curriculum standards in addiction counseling, there is no CACREP accreditation for these educational programs. Education providers may seek certification through the National Association for Alcohol and Addiction Drug Counselors (NAADAC); however, only a small percentage of programs are graduate level academic preparation programs for substance abuse practice (SAMHSA, 2003). The International Coalition for Addiction Studies Education (INCASE) has goals for a program approval process that link a capable workforce with robust higher education training opportunities. To



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date, only a scattering of programs has been approved. As a result of this context for IHEs considering program change, the IC&RC certification standards for COD became a valuable guideline for program makeover.

A third challenge for the program’s revision arose as we reviewed local certification and licensure standards. Certification with a COD specialization requires either a bachelor’s or graduate degree with specific number of education hours in COD. We saw that we could tailor the graduate program by adapting course objectives to address identified COD professional competencies. However, in the broader perspective, the benefits gained by a student in the program were minimal if the program was not embedded in a continuum of professional credentials. Since COD certifi-

cation does not result in independent licensure, professionals considering this specialty area could easily dismiss it if licensure as an addictions professional or mental health counselor was not achievable in the long run.

These considerations of separate tracks within counselor education programs; program approval processes that do not include COD specific guidance; and disjointed degree program and licensing requirements, provided an important context to our work. We wanted to create a new plan that would attract applicants, and train them appropriately in addictions studies and mental health and co-occurring disorders, while easing their achievement of certification and licensure in their professional specialties. We worked from the assumptions that: a primary function of

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an academic institution is to adequately prepare graduates for effectiveness in the workplace; and faculty all strive to teach best practices. With this, we agreed our counselor education programs would embrace the teaching of traditional mental health and addictions counseling techniques, along with instruction in the knowledge and skills related to the treatment of individuals with co-occurring disorders. Tools at our disposal included curriculum change informed by practitioners in the field, and IC&RC-established standards.

### **IC&RC Job Task Analysis**

The graduate level counseling programs at Rhode Island College have found the knowledge component of IC&RC's Job Task Analysis (JTA) to be a good framework for this paradigm shift (IC&RC, 2008). The JTA, also known as a role delineation study, outlines the knowledge, skills and abilities required for competent COD practice, and it serves as a framework for successful performance in the job of Certified Co-occurring Disorder Professional. By using the JTA as an outline for course content, these authors and other department faculty tapped into the collective efforts of the IC&RC members who had previously determined knowledge and skills unique to co-occurring specialists.

The content domains include: Screening and Assessment; Crisis Prevention and Management; Treatment and Recovery Planning; Counseling; Management and Coordination of Care; Education of the Person, their Support System, and the Community; and Professional Responsibility. Collectively, these domains constitute the knowledge and skills inherent in a

professional adept at working with substance use related issues in the context of mental health. As such, there are both core expectations for proficiency in counseling skills as well as specific knowledge and skills in substance use disorders.

With the JTA as a crosswalking tool, the authors systematically reviewed existing graduate course objectives as they overlap with the knowledge statements in the JTA. This alignment resulted in: syllabi language that incorporates COD task expectations as part of the objectives of the course; co-occurring learning objectives that are fully embedded in a spectrum of counseling courses; the framework for a new Masters degree program in co-occurring disorders; and the update of several foundations course that are shared across degree plans of study in agency and mental health counseling. This comprehensive collection of course objectives for all counseling tracks within the department, including co-occurring disorders, provides a strong basis for understanding the myriad ways substance abuse and mental health conditions exacerbate one another and manifest themselves in the treatment setting. This is a powerful connection of the identified knowledge base needed for the COD profession and ways in which that can be accomplished in a preparation program. Taking these steps will better prepare graduates for the behavioral healthcare workforce.

The authors of this article then presented this cross walk to the Rhode Island IC&RC Member Board. Early in 2009, that certifying board approved four of the core courses in the Masters degree program as a way to satisfy the

education requirements for COD certification. This approval is crucial for candidates in the graduate program, and possibly, for others. Currently, continuing education for all segments of the workforce tends to rely on single-session, didactic approaches which have proven ineffective in changing workforce practice patterns (SAMHSA, 2007). We anticipate that it will become desirable to have a comprehensive and cohesive accumulation of well-designed academic courses to submit as evidence of 180 contact hours of COD specific coursework, rather than an accumulation of assorted certificates that document attendance in an array of workshops.

### **Higher education workforce realities**

Some may wonder why academic institutions have been slow to adjust addiction studies curriculum to match workplace realities. One significant factor contributing to slow progress in behavioral health integration includes the nature of the faculty in higher education training programs. Credentials for tenure track faculty positions in colleges and universities—those positions that ultimately develop, implement and teach counseling curricula—must be held by terminal doctorate degrees (PhD, EdD). Moreover, the hiring practices of IHE's preclude the tenure track employment of the non-academically trained experts in the substance use work force. Since counselor educators themselves—many of whom come from psychology or other related fields—are likely the product of silo-like graduate programs, they have not typically experienced integrated mental health and addiction related studies or practices. As a result,



of duplicative services and services that are not evidence-based. With this reality, counselor education must keep up the pace with best practice designed for co-occurring disorders.

Challenges remain in maintaining a responsive or even proactive higher education system. Reducing silo thinking and challenging distinct professional preparation strands meets resistance from all directions. Next steps at Rhode Island College include: the continuation of cross disciplinary discussion amongst counseling, social work and psychology departments that enhances preparation for work with co-occurring disorders. From a meta-perspective, the process of certification and licensure needs to be aligned with comprehensive COD academic training at all education levels, so that qualified professionals getting into the field faster. Finally, creating certification standards and higher education program curriculum objectives, no matter how well thought out and integrated, will not have an avid audience unless coordination is fostered between insurance panels and practitioners; reimbursement for this specialization needs to exist before it will appeal to many new practitioners.

Graduate program adjustments at Rhode Island College, alignment to internationally recognized standards, and approval from the local certification board discussed in this article were relatively easy processes. In many respects, accepting co-occurring disorders as the norm, rather than the exception, takes very little convincing. It is the coordination on the macro level that requires time and attention to be a more seamless system. The IC&RCJTA developed on evidence-based treatment models, serves as a fine guideline

to this process. Practitioners qualified in co-occurring disorders need three things in order to be successful in behavioral health: comprehensive pre-service training from higher education that prepares them for several credentialing tracks; credentialing standards that place them in a competitive position for employment; and programs that offer integrated delivery models. Higher education plays an important function in that system with its role in developing integrated plans of study that emphasize substance use and its co-occurring nature with mental health issues. The result of this shift will provide a well-conceived and thorough method for achieving COD credentialing that should ultimately benefit workforce capacity and skill in the field.



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