Mental Health & Addiction
Certification Board of Oregon
(formerly ACCBO)

Behavioral Health Training Needs

Oregon Behavioral Health Workforce Survey

(n=1,302)

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Brent Labhart, MSW student-intern
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Data Analysis Consultants
Christi Hildebran, LMSW, CADC III
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Section 4: Behavioral Health Training Needs

Summary by Eric Martin, MAC, CADC III, PRC, CPS

ACCBO 2018 Behavioral Health Workforce Survey

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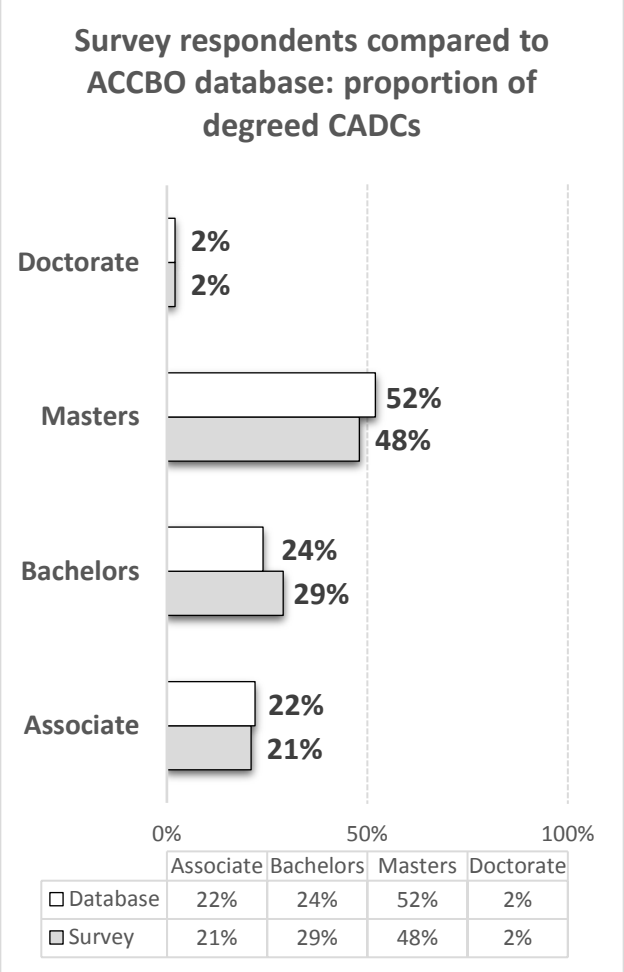
Survey Methodology

Collaborative Survey Development: This 2018 survey was developed and analyzed by 98 participants, representing statewide behavioral health organizations: ACCBO, AOCMHP, OPERA Portland State University, Oregon Health Authority, the MetroPlus Association of Addiction Peer Professionals, HealthInsights, the NW Instituto Latino, the African American Behavioral Health and Addiction Treatment Coalition, and the University of Colorado Farley Health Policy Center. Participants worked in core groups and with contributors to design survey questions to elicit information regarding disparity, wages, benefits, contemporary healthcare initiatives, caseloads, etc. The draft survey was emailed to over 100 program directors for their review, generating feedback regarding clarity and readability of questions. Flesch-Kincaid analysis ranks this survey at grade aptitude level 12.9.

Implementation: Survey was implemented through Survey Monkey. Survey was emailed to 4,400 CADC's/applicants (QMHA's/P's), CRM's, CGAC's, CPS, state approved addiction treatment program directors, and state approved mental health program directors. The survey was also distributed through AOCMHP, the Association of Oregon Community Mental Health Programs, and OPERA the Oregon Prevention Education and Recovery Association. Announcements through Constant Contact bulk email, and SMS text messaging encouraging participation were disseminated statewide.

Response: Survey data was collected from 1,306 respondents. 86% completed the entire general survey (questions #1 through #105), and 82.0% completed the additional role related questions.

Cross-Database Validation: Of 1,306 respondents, there were 776 degreed CADCs. These 776 CADCs were assessed proportionally by level of education and compared to proportions of nearly 3,000 degreed CADCs from ACCBO's database.



This cross-database comparison suggests baccalaureate CADCs are slightly over-represented in the survey. Overall, the proportion of CADC respondents closely approximates that of Oregon's entire CADC pool. It is important to note that ACCBO updates educational attainment of CADCs every two years upon recertification, and it is possible some individuals have completed a bachelor's degree since their last renewal of certification.

Survey Development Question Writing & Contribution:

- Michael Razavi, M.P.H., CADC I, PRC, CPS, *Addiction Counselor Certification Board of Oregon*
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- Cherryl Ramirez, M.P.H., M.P.A., *AOCMHP*
- Mark Davis, CADC II, *Addiction Counselor Certification Board of Oregon & Polk County Mental Health*
- Van Burnham IV, B.A., CRM, *Addiction Counselor Certification Board of Oregon & Treasurer, 4th Dimension Recovery Center*
- Julia Mines, M.S.W., CADC III, *Addiction Counselor Certification Board of Oregon*
- Aja Stoner, M.S., CADC III, *Addiction Counselor Certification Board of Oregon & Jackson County Health and Human Services*
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- MetroPlus Association of Addiction Peer Professionals, *review of survey questions and question writing at membership meeting of 58 peer participants*

Survey Reviewers/Editors:

- Andrea Quicksall, M.A., CADC II, *Addiction Counselor Certification Board of Oregon & Family Care*
- Cheryl Cohen, LPC, CADC I, *Healthshare, Behavioral Health Program Manager*
- Jackie Fabrick, M.A., *Oregon Health Authority*
- Reed McClintock, M.S., QMHP *Cascadia Behavioral Health Care*
- Chris Mason, *CEO Addiction Recovery Center*
- Rick Trelevan, LCSW, *Executive Director, BestCare*
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- Anthony Jordan, MPA, CADC II, CRM *Multnomah County*
- John Fitzgerald, PhD, LPC, CAS *Oregon Criminal Justice Commission*
- Jeff Marotta, Ph.D., CADC III, CGAC II, *Problem Gambling Solutions & Voices of Problem Gambling Recovery*
- David Course, M.A., LPC, CADC III, CGAC II, NCGC II, *Program Manager, Lincoln County Health & Human Services*

Section IV: Training Needs

We analyzed responses from Addiction program supervisors (*n=100*), Mental Health program supervisors (*n=50*), addiction staff (*n=710*), and mental health staff (*n=508*).

We surveyed responses from both supervisors and workers. Both presented very similar responses regarding highest priority training needs. Participants were able to choose from a list of 29 topical areas including the option of write-in responses.

Survey options and write-in response questions:

1) Medication Assisted Treatment
2) Motivational Interviewing
3) Engagement & Outreach Skills
4) SBIRT: Screening, Brief Intervention and Referral to Treatment
5) ASAM: Placement Criteria
6) DSM-5
7) Dialectical Behavior Therapy
8) Mindfulness
9) Cognitive Behavioral Therapies
10) Moral Reconation Therapy
11) Trauma informed care
12) Working with houseless populations
13) Primary care and Behavioral Health Integration
14) Documentation & Electronic Health Records
15) Working with Child Welfare clients
16) Working with Forensic/criminal justice clients
17) Co-occurring Disorders
18) Peer services
19) Laws & Regulations
20) Collaborative Assessment and Management of Suicide Risk
21) Columbia Suicide Severity Rating Scale
22) Acceptance and Commitment Therapy
23) Individual Placement and Support
24) Forensic Assertive Community Treatment,
25) Wellness Recovery Action Plan
26) Telemedicine
27) Primary care and Behavioral Health Integration
28) Other Evidence Based Practices:_____
29) Other training topics: _____

51.46% of addiction supervisors reported that most CADCs have an adequate understanding of co-occurring disorders (*fig.1*), while only 24% of mental health supervisors report that QMHAs and QMHPs have an adequate understanding of co-occurring disorders (*fig.2*).

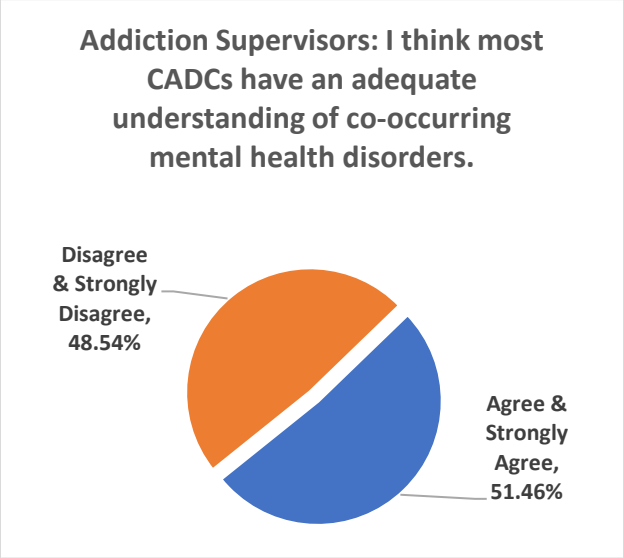

Figure 1: Percent of Addiction Supervisors who think their staff have an adequate understanding of co-occurring mental health disorders

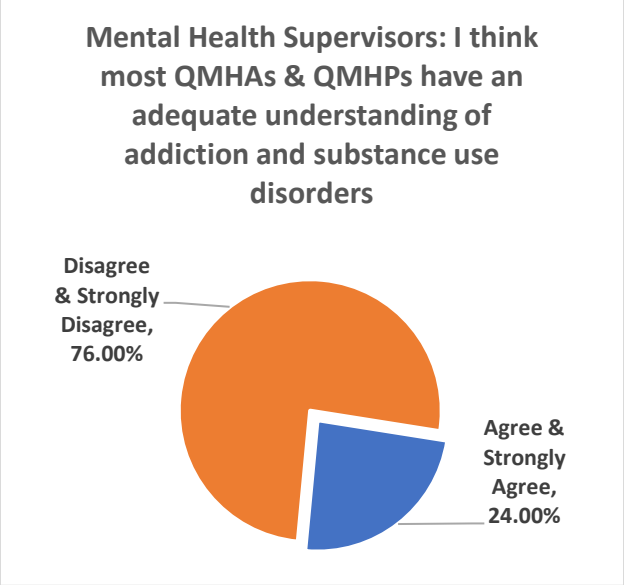

Figure 2: Percent of Mental Health Supervisors who think their staff have an adequate understanding of addiction and SUDs

Both CADCs and Addiction Supervisors were asked to rate the "Top Three" training needs of CADC's from a list of 29+ topical areas. Stunningly, both CADCs and Supervisors ranked the same identical top five training needs for CADCs (*fig.3 and fig.4*).

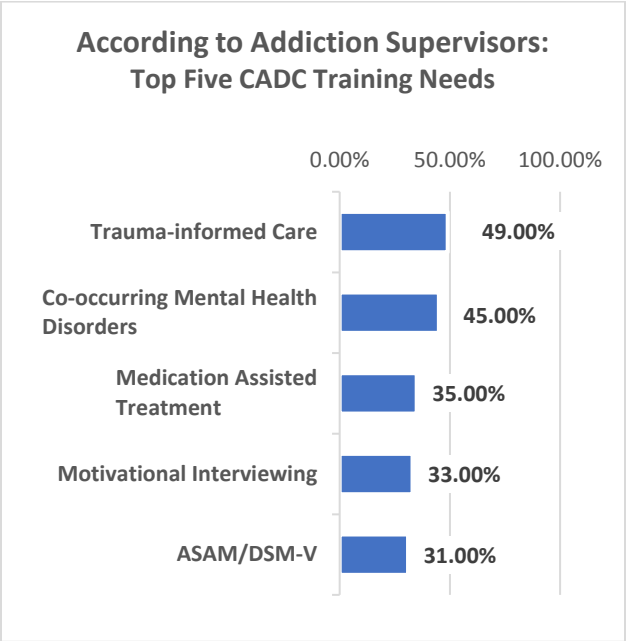

Figure 3: Percent of Addiction Supervisors identifying top training needs for CADCs

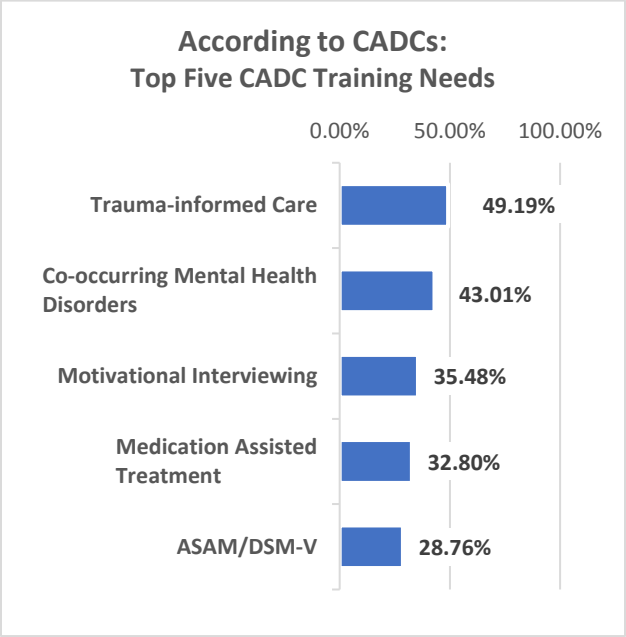

Figure 4: Percent of CADCs identifying top training needs for CADCs

Mental Health Supervisors were asked to rate the "Top Three" training needs of QMHAs & QMHPs from a list of 29+ topical areas (*fig.5*)

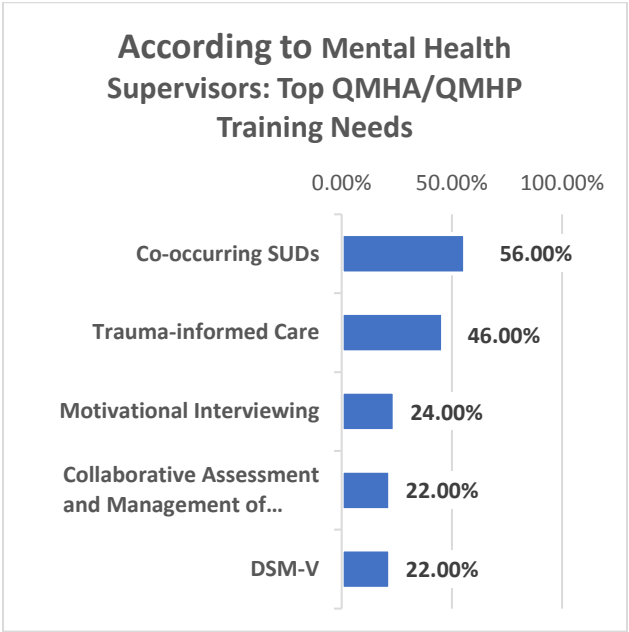

Figure 5: Percent of Mental Health Supervisors identifying top training needs of QMHAs & QMHPs

QMHPs were asked to rate the "Top Three" training needs of QMHPs from a list of 29+ topical areas (*fig.6*)

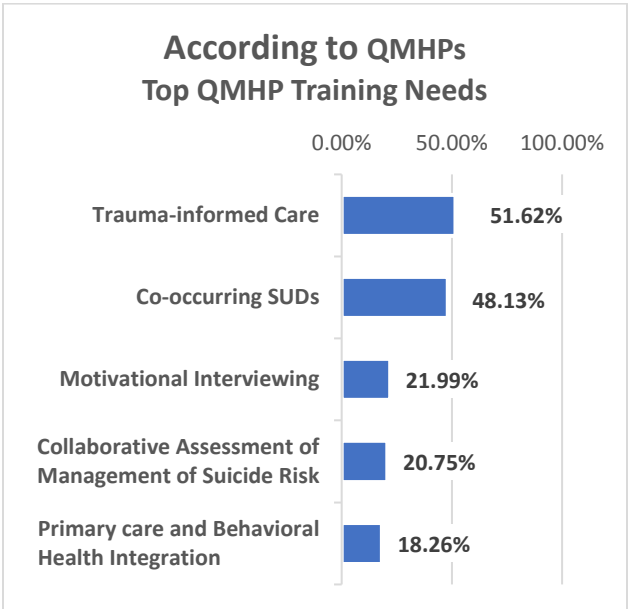

Figure 6: Percent of QMHPs identifying top training needs of QMHPs

QMHAs were asked to rate the "Top Three" training needs of QMHAs from a list of 29+ topical areas. Three items tied for 4th place in rank order: Cognitive Behavioral Therapy (22.0%), Working with Houseless Populations (22.0%), and Working with Criminal Justice Involved Clients (22.0%) (*fig.7*)

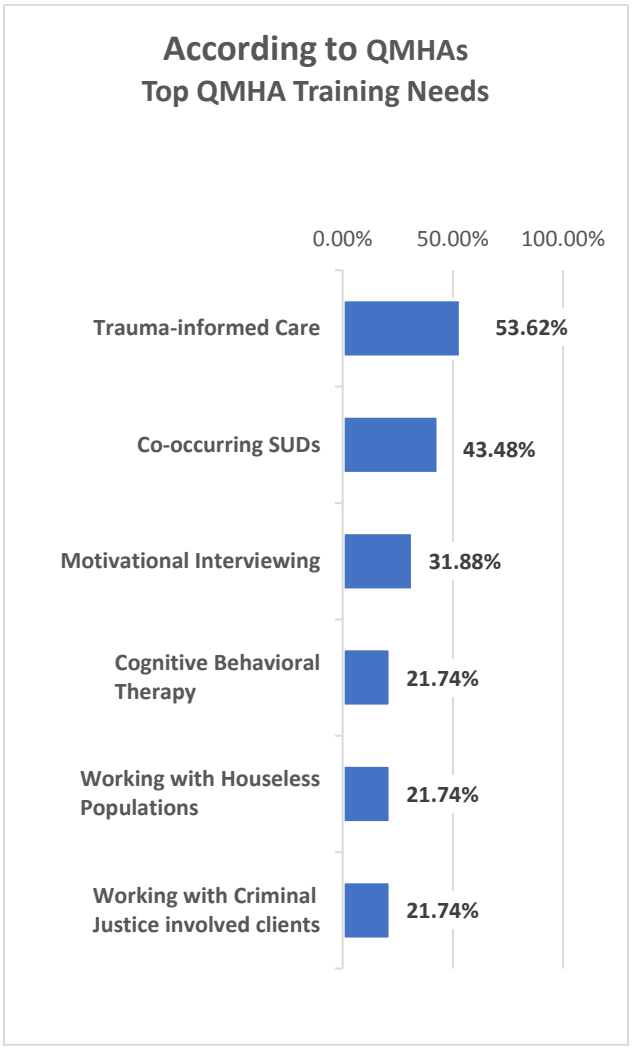

Figure 7: Percent of QMHAs identifying top training needs of QMHAs

Addiction Supervisors were asked to rate the "Top Three" training needs of Addiction Peers from a list of 29+ topical areas (*fig.8*)

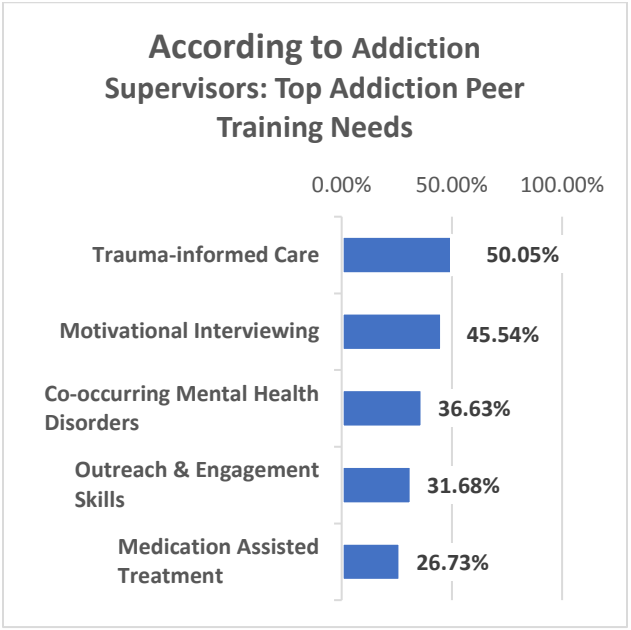

Figure 8: Percent of Addiction Supervisors identifying top training needs of Addiction Peers

Mental Health Supervisors were asked to rate the "Top Three" training needs of Mental Health Peers from a list of 29+ topical areas (*fig.9*)

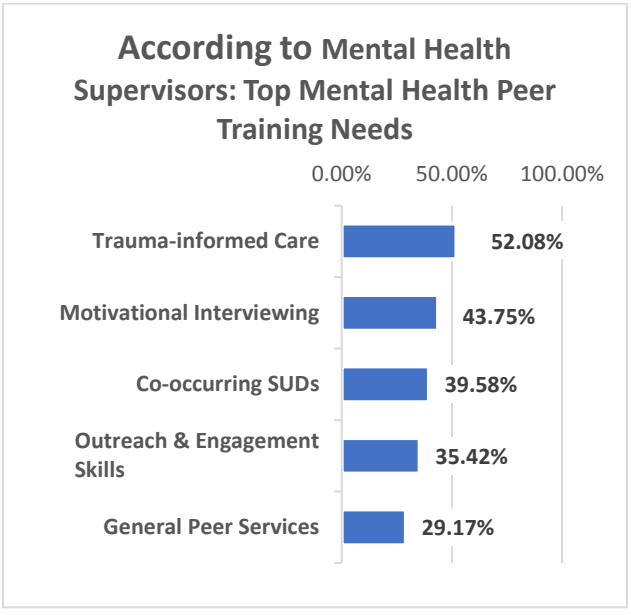

Figure 9: Percent of Mental Health Supervisors identifying top training needs of Mental Health Peers

Summary

We surveyed responses from both supervisors and workers. Participants were able to choose from a list of 29 topical areas including the option of write-in responses. Both supervisors and workers presented very similar responses regarding highest priority training needs.

A greater percentage of mental health supervisors (76%) reported a deficiency in co-occurring disorder competency of mental health staff compared to the percentage of addiction supervisors (48%) reporting a deficiency in the addiction workforce's co-occurring disorder competency.

Top Five Areas of Needed Training

These aggregated topical areas were the most reported training needs for behavioral health workers, by both supervisors and workers. Up to 56% of various behavioral health staff endorsed these topical areas as the highest priority training needs:

1) **Trauma Informed Care**
2) **Motivational Interviewing**
3) **Co-occurring Disorders**
4) **Medication Assisted Treatment**
5) **DSM-V/ASAM**

Discussion

Nearly 100 stakeholders participated in the design, authoring, implementation and interpretation of this survey. A variety of stakeholders made the following observations regarding survey findings.

Trauma Informed Care: Stakeholders report that staff need greater training regarding trauma informed care as it relates to "systems" vs. therapeutic interventions with clients. There is a lack of educational content regarding, agency practices and policies that are trauma informed. Moreover, there is growing confusion regarding scope of practice limitations of various workers (Peers, CADCs and QMHAs, etc.) regarding trauma informed interventions. Peers, CADCs, and QMHAs have been given training, sometimes required or mandated training regarding trauma work which is often beyond their scope of practice. There is a lack of clarity regarding trauma informed practices and interventions that should be implemented by various worker types (Peers, CADCs, QMHAs, and QMHPs).

Motivational Interviewing: Stakeholders report their concerns regarding staff fidelity to the practice of Motivational Interviewing and the need for more ongoing skill-based training with staff.

Co-occurring Disorders: Stakeholders report a significant deficit in knowledge regarding substance use disorders among mental health workers.

Medication Assisted Treatment: Our previous survey, Oregon Behavioral Health Survey Part I Medication Assisted Treatment, reveals that many behavioral health workers (90%+) report positive beliefs regarding the efficacy of MAT, however there are some fundamental misunderstandings regarding the procedures and best practices within MAT clinics. For example, many workers are unware that short term use of MAT for the purposes of withdrawal management produce poor outcomes and high rates of relapse compared to longer lengths of stay in medication assisted treatment.

DSM-V/ASAM: Stakeholders report an ongoing deficit regarding DSM-V and ASAM staff competencies.

Other training areas of interest reported by greater than 20% of supervisors and workers included:

- Outreach & Engagement Skills
- Peer Services
- Collaborative Assessment and Management of Suicide Risk

- Working with Forensic/criminal justice clients
- Working with houseless populations
- Cognitive Behavioral Therapies