

Workforce Development

“When people who recover from severe mental illnesses are asked what was helpful in their recovery, the answer is most often the people with whom they interacted, and not particular program models or system functions. Programs and systems are only as good as the people they employ.”

—William Anthony, Executive Director of the Center for Psychiatric Rehabilitation

Direct service providers are the key to effective service delivery, yet they tend to be poorly prepared for the work they are expected to do. While this is true throughout the field of behavioral health (Annapolis Coalition, 2003; WHO, 2005; Wilson, 2009), the lack of adequate preparation is especially obvious for psychiatric rehabilitation and recovery-oriented services.

The State of Training in the Field

Service providers come from a wide range of educational backgrounds, from high school equivalency to post-doctoral educational achievement (Blankertz & Robinson, 1996), but only about half of the behavioral health workforce has had any academic preparation (Leff et al., 2007). The academic pre-service programs designed to prepare the future behavioral health workforce rarely include content on psychiatric rehabilitation and mental health recovery (Farkas & Anthony, 2001), and often labor under discipline-specific curriculum requirements that obstruct efforts to modify courses and content (Farkas & Anthony, 1993). In addition, academic instruction and evaluation tend to focus on knowledge retention rather than skilled practice—providing “exposure” or “experience” rather than the development of “expertise” (Farkas & Anthony, 1993, 2001). “Exposure” represents a basic introductory level of knowledge presented and assessed, such as that delivered through an online overview course (e.g., [/develop/distance-learning](#)). An “experience” level training indicates that the participant has actually used the new knowledge in a meaningful setting, which could occur through practice assignments at an agency-based training for staff. The “expertise” level represents training that produces advanced competency in knowledge as well as skill in applying the material, such as that developed through an intensive academic program with a concurrent internship (Farkas, O’Brien & Nemec, 1988).

Service providers without academic training, and those with inadequate academic preparation, might benefit from training on the job. However, even when in-service training provides instruction in recovery and rehabilitation, it tends to be ineffective in

influencing service provider practice. As with academic instruction, in-service training too often focuses on distributing tidbits of knowledge (known as a “spray and pray” approach), rather than helping providers apply that knowledge on the job, adopt and maintain attitudes that promote recovery, and develop the skills needed to achieve the desired service outcomes.

Workforce Competencies

A competency is the ability to apply or use knowledge, skills, attitudes, and personal characteristics to successfully perform critical work tasks, specific functions, or operate in a given role or position (Ennis, 2008). Typically categorized as knowledge, skills, and attitudes, job-related competencies are often identified through an analysis of work requirements (e.g., Knapp & Knapp, 1995) and interviews with experts who achieve positive outcomes in order to determine what they do that makes them successful (Sternberg & Horvath, 1999).

The Competency Model Clearinghouse arrays work competencies in “tiers” based on the degree of generalization. The first three levels (tier one competencies) are generic and are relevant to any job. The levels in the second tier indicate industry-specific competencies, and the top tier -levels describe job-specific competencies. An interactive model of the nine tiers can be found at www.careeronestop.org/competencymodel/pyramid.aspx.

For the “industry” of recovery-oriented services, required competencies include certain attitudes and personal characteristics in service providers (Anthony, Cohen, Farkas & Gagne, 1987); foundation skills required to engage people in using services and to connect with them through trusting and supportive relationships (Lewis & Hoofnagle, 2005; Cohen, Nemec & Farkas, 2000; Russinova, 1999); as well as the knowledge and skills in psychiatric rehabilitation (e.g., Anthony, Cohen, Farkas & Gagne, 2002; Farkas, Cohen et al., 2000; Cohen, Nemec & Farkas, 2000; Cohen, M. R., Farkas, Cohen, B. F. & Unger, 1990; Cohen, M. R., Farkas & Cohen, B. F., 1986) that are needed to help people with psychiatric disabilities to:

- determine for themselves if they are ready to engage in a structured process of change
- develop their readiness if they are interested but not ready
- set personal goals relevant to where they wish to live, learn, or work in the community
- assess what skills and supports they need to achieve their goals

- learn new skills specifically related to achieving their goals
- use the skills they have and incorporate them into daily life
- link up with supports they need to achieve their goals
- engage in a hopeful, empowered relationship with another with the purpose of achieving their recovery vision

Competency-Based Training

Developing expertise calls for competency-based training and supervision, and requires a substantial time investment (Farkas & Anthony, 2001). Competency-based training and performance evaluation for developing expert performance requires that students or trainees master both knowledge and skill, and that they have the opportunity to practice integration into real-life situations through simulation in training and in the field (Stuart, Tondora & Hoge, 2004).

Training alone does not guarantee the use of a new skill in actual practice. Supervision is needed to assess performance and to prompt improvement, along with agency policies and procedures that support and reward the delivery of effective rehabilitation and recovery-oriented services. A report by the Boston-based Technical Assistance Collaborative (Hyde, Falls, Morris & Schoenwald, 2003) recommends supervision as a means for providing feedback, but also suggests that supervisors need training—both generic training in supervision and specific training on how to support the use of the new intervention or approach being adopted. Supervision or mentoring needs to include a structure for feedback and opportunities for re-training as needed.

Effective Training Strategies

Skills-teaching methods used in psychiatric rehabilitation service delivery (Cohen, Danley & Nemec, 1985) are equally effective in teaching professional competencies, although the content focus is different. For example, techniques used to support the generalization of acquired skills are relevant to faculty desiring to change student behavior in the field, not simply in the classroom.

Any educational program that aims to create changes in practice would do well to follow a train-practice-train format (Nemec, 2006), where trainees learn new knowledge and skills, then apply their new learning on the job, and finally return to a training session—with the same trainer—to discuss successes and struggles. This approach works equally well in an academic program with an internship or practicum; in a

continuing education program, such as the Certificate Program in Psychiatric Vocational Rehabilitation (see the September 2000 and June 2005 Recovery & Rehabilitation newsletters); and in an agency-based in-service program. "Our training curricula always build in applied practice with supervision and feedback," says Marianne Farkas, Director of Training, Dissemination & Technical Assistance (TDTA) at the Center for Psychiatric Rehabilitation (CPR), "and we pioneered the use of a standardized checklist for trainee self-evaluation. This gives the learner the chance to accurately self-assess and then set personal goals for improvement." Setting personal learning goals increases motivation for further training, and helps build lifelong learners.

Tailoring in-service training content and process to meet local needs increases the chance that service providers will adopt the new practices being taught. In designing in-service training for particular agencies around the world, the Training, Dissemination & Technical Assistance Division (TDTA) of the Center for Psychiatric Rehabilitation first assesses the specific job roles and functions that support the intended mission and outcomes of an organization. Technical assistance may be provided to better align job roles and intended outcomes. Training and existing curricula are then designed to promote specific competencies that match these job functions. Further consultation is often necessary—either in advance or concurrent with training—to ensure that agency policy and procedures promote, rather than create obstacles for, practitioners' use of the new skills (Anthony, Cohen & Farkas, 1987; Farkas and Anthony, 2001). Lastly, all TDTA competency-building in-service training programs include follow-up supervised practice in order to embed the use of the skills in the ongoing routine of the organization. Follow-up training after practice provides an opportunity to re-teach as needed and to address trainee needs, questions, and concerns (Nemec, 2006), which, along with targeted supervision after the training is complete, results in the greatest success for changing practice (Corrigan, Steiner, McCracken, Blazer & Barr, 2001). TDTA/CPR includes trainers and consultants with—and without—lived experience on its project teams to ensure projects stay focused on advancing recovery. Projects have been conducted in areas as diverse as North America (U.S., Canada), the Pacific Rim (e.g., New Zealand, Australia), Asia (Singapore), the European Union (e.g., Denmark, Belgium, Italy, and the Netherlands), and the Middle East (e.g., Israel).

A list of best practices in psychiatric rehabilitation education has been developed by the Consortium of Psychiatric Rehabilitation Educators (see the July 2004 Recovery & Rehabilitation newsletter), and includes these additional recommendations:

- Include people with firsthand experience living with a psychiatric disability in all phases of the process of training curriculum design, delivery, and evaluation
- Base training on practice guidelines and manuals, where these exist

- Use interactive methods designed to elicit, reflect, and assess learner perspectives
- Model psychiatric rehabilitation practice by showing respect to the learners and to people with psychiatric disabilities by connecting with the learners and eliciting/reflecting their ideas and experiences, by collaborative and inclusive methods of instructional design and delivery, and by demonstrating hope and optimism for recovery for all people with psychiatric disabilities
- Focus on values, attitudes, beliefs, and feelings (the affective domain) as well as practice competencies
- Use open-ended assignments that promote creativity, including presenting novel situations, problem-based learning activities, and challenges that require critical thinking and creative solutions

Credentials for Quality Assurance

If completion of an academic degree program does not guarantee relevant knowledge and skill, then some other forms of credential are needed to indicate competence. The “tug-of-war” between delivering effective services and doing so at the lowest possible cost requires a supply of competent professionals, and creates a market for provider certification that offers some sort of quality guarantee (Van Houtte, 2009).

According to the National Organization for Competency Assurance (NOCA), certification programs involve a voluntary assessment using defined standards for measuring knowledge and skill competencies. An individual who passes a certain threshold of competence is granted a time-limited credential. Often, a combination of academic training and work experience is required for certification, and continuing education is needed for renewal.

However “certificates” are not the same as certification. A “curriculum-based certificate” (NOCA, 2006) requires completion of a series of courses, and graduates receive a transcript indicating grades for each of the courses in the curriculum. Another format for a certificate program is a relatively short, non-degree-granting training course in specified knowledge and skills, with a completion certificate indicating full attendance or, in some instances, successful achievement of a minimum level of performance based on a standardized assessment. Licensing differs from certification, as it is based on requirements established by state governments, although a certification sometimes meets the requirements for a license. Both certification and licensure require evidence of knowledge and experience. While certification and licensure aid in the recruitment and selection of qualified workers, holding a certification or licensure does not necessarily

mean that a person will be successful on the job, and does not guarantee professional behavior at all times (Nemec & Legere, 2008).

In psychiatric rehabilitation, the Certified Psychiatric Rehabilitation Practitioner (CPRP) program is a national exam-based certification program designed to identify and recognize practitioners with demonstrated knowledge and competencies in psychiatric rehabilitation (Gill, 2005). Although now formally recognized in 15 states in the U.S., the CPRP remains unknown to many of the academic faculty now training future mental health service providers.

Another approach, one that complements the certification of practitioners, is the certification of trainers. The Boston University Center for Psychiatric Rehabilitation has initiated a new performance-based certification for trainers and program consultants in psychiatric rehabilitation. This program was launched in September 2009 with a first-phase training for colleagues from around the U.S. who have already been trained in the Center's technology and approaches to rehabilitation and recovery. Additional training will be required for certification, which will then identify trainers qualified to conduct training and consultation in the work of the Center.

Communities of Practice

A supplement or alternative to training involves building a "community of practice" (Wenger, McDermott & Snyder, 2003), which organizes a group focused on improving practice in some particular area. A community of practice builds its group identity through its shared focus, and often works to build knowledge as well as share it. Individuals who join a community of practice do not have to be experts in the focus area, but do need to commit to learning and sharing knowledge and expertise.

Just such a community of practice is in development by the Boston University Center for Psychiatric Rehabilitation. The Online Community for Recovery Resources will allow users to share resources, as well as connect to discuss resources through an online forum. Users will be able to post questions and topics of discussion, search the site, create accounts, and contact each other through profile pages. The technological platform has been established and will be launched as part of the Repository for Recovery Services on the Center's website (cpr.bu.edu). The related listserv for Providers of Recovery-Oriented Rehabilitation will create an opportunity for psychiatric rehabilitation providers to explore and resolve issues through discussion and networking.

Summary

Defining required competencies facilitates recruitment, selection, training design, and performance evaluation. Because high quality training builds capacity through developing the exact knowledge and skills required and enhancing staff motivation to learn, an investment in effective workforce development pays big dividends.

Resources and References

Certificate Program in Psychiatric Vocational Rehabilitation: cpr.bu.edu/develop/vocrehab

Training and Consultation at the Center for Psychiatric Rehabilitation: cpr.bu.edu/develop

The Essential Guide to Psychiatric Rehabilitation Practice: [/store/books/essential-guide-psychiatric-rehabilitation-practice](http://store/books/essential-guide-psychiatric-rehabilitation-practice)

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