

THEME

Workforce and Training

RECOMMENDATION 8:

Assure a workforce that possess skills, values, and attributes consistent with the vision of a recovery- and resilience-oriented system.

Strategy 8.1: Create, within the defined budget, flexibility to authorize and reallocate positions in order to respond to the needs of individuals receiving mental health services.

Strategy 8.2: Recruit and develop a workforce that possesses competencies that support and sustain the vision for the system.

Strategy 8.3: View personal experience with mental illness as a preferred qualification in recruiting applicants for positions.

Strategy 8.4: Assure training opportunities for persons interested in offering peer support.

Strategy 8.5: Demonstrate high expectations for efficiency and accountability through clear performance and productivity standards.

Strategy 8.6: Promote person-first language that is consistent with a recovery- and resilience-oriented system of care.

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The Substance Abuse and Mental Health Services Administration (SAMHSA) commissioned the Annapolis Coalition to develop a national strategic plan on behavioral health workforce development. Strategic goals in this national plan focus on broadening the concept of the workforce, strengthening the workforce, and instituting structures to support it.¹ As the Fairfax-Falls Church mental health system shifts to a transformed culture focused on recovery and resilience, new and different workforce skills and competencies are required. This shift will necessitate a transformed approach to recruiting, developing, and evaluating the behavioral healthcare workforce.

We fully expect that as the system is transformed, changes will occur in how positions are used and how staff members are deployed. As public entities in Virginia and across the nation are finding, the path to transformation requires changes to the mix of care coordination, peer support, psychiatric, and psychotherapeutic resources.

Strategy 8.1: Create, within the defined budget, flexibility to authorize and reallocate positions in order to respond to the needs of individuals receiving mental health services.

Currently, the Board of Supervisors exercises legislative control over an agency's appropriated funds and allocated number of positions. Adjustments to either require board action. The

design elements of this system transformation require increased emphasis on care coordination (case management) and peer support. To accomplish this transformation, the agency needs flexibility in the workforce planning process to create and reallocate positions as necessary to meet the changing needs of individuals receiving mental health services. For example, if an assessment determines that two peer support positions would achieve greater results than one mental health therapist position, individuals served would benefit by system flexibility to make that change as long as CSB manages within its overall funding allocation.

Strategy 8.2: Recruit and develop a workforce that possesses competencies that support and sustain the vision for the system.

Competency identification, development, and assessment are receiving increased attention in all areas of health care, including behavioral health. "This trend is driven by the compelling notion that, for a field to advance, there must be more precision in specifying the optimal attitudes, knowledge, and skills of the workforce."² Once competencies unique to a recovery- and resilience-oriented system "have been identified, the objective is to build them into the workforce [through ongoing competency-based education/training] and to demonstrate, using various assessment strategies, that the competencies have been acquired by individual providers."³

STAFF MEMBERS WHO HAVE EXPERIENCED MENTAL ILLNESS WILL BE TREATED AS AN ASSET TO THE ORGANIZATION. BY SHARING THEIR STORY, THEY ARE HELPING TO REDUCE THE STIGMA SURROUNDING MENTAL ILLNESS.

As a specific example, linguistic competency – the communication of information in a manner that is easily understood by diverse audiences including the deaf population as well as persons of limited English proficiency, low literacy skills, and/or linguistic disabilities – is becoming an essential skill for providers in today’s behavioral healthcare workforce.⁴ Recognizing the diversity of cultures in the Fairfax-Falls Church area, we were pleased to note that all stakeholder groups represented in the survey gave a 65% or greater positive rating (i.e., “Almost Always/Always” and “Often”) to the item “Staff treat me with respect regarding my cultural background” (Appendix C: Survey Summary, p. 20). The challenge of this system, as previously noted in this report, appears to be in attracting bilingual staff to serve an increasingly multicultural population.

The Commission encourages the CSB to build into the recruitment and development processes a continuous assessment of identified workforce competencies and ongoing development to update thinking, skills, and practices.

Strategy 8.3: View personal experience with mental illness as a preferred qualification in recruiting applicants for positions.

Some mental health systems hire peers to fill existing positions. The terminology “personal experience preferred” or “lived experience preferred” in position advertisements sets the tone that personal experience with mental illness is viewed as an asset, not a deficit. Furthermore, viewing a person’s lived experience with mental disability as an additional qualification during the hiring

process sets an organizational precedent that reduces stigma.

In addition to viewing personal experience with mental illness as an asset in the recruitment of applicants, the Commission believes that staff members who have experienced mental illness should feel safe identifying their disability and find comfort in the knowledge that they will be treated as an asset to the organization because of their personal experience. Individuals who choose to self-disclose their history of mental illness are expected in, and evidence of, a recovery- and resilience-oriented system. In a transformed system, staff will understand the purpose and importance of being open about their own lived experience and will recognize that, by sharing their story, they are helping to reduce the stigma surrounding mental illness and providing invaluable support to other individuals.

Strategy 8.4: Assure training opportunities for persons interested in offering peer support.

The use of peers in the provision of mental health services has many benefits but requires support systems in order to be as successful and purposeful as possible. These support systems include the proper training and quality supervision of peers, an atmosphere that is friendly and accepting toward individuals receiving services, and opportunities for discussion among peer and non-peer providers.⁵ The Commission strongly believes in the use of peers in the recovery process but acknowledges that some of these supports are lacking in the Fairfax-Falls Church area. One challenge is that peer training programs are not available locally, making it time-

intensive and expensive for peers to get the training they need.

As the Fairfax-Falls Church mental health system expands its utilization of peers, more training opportunities will be needed. Programs such as the Peer-to-Peer education course offered by the National Alliance on Mental Illness (NAMI) could be brought to local colleges so that willing peers can get the training they need.⁶ As the Northern Virginia Regional Recovery plan also recognized the need for local training opportunities, it is possible that more training options will become available in the years to come.⁷ The Commission also would encourage the county to consider establishing a local institute to provide training, ongoing education, and a continual support network for peers serving in the community.

Strategy 8.5: Demonstrate high expectations for efficiency and accountability through clear performance and productivity standards.

Productivity can be encouraged by building productivity measures into the county's pay-for-performance system. These productivity measures would serve as incentives and would be established through benchmarking other system standards and having conversations with staff and individuals receiving mental health services. These standards would be periodically re-evaluated to assure that they are reasonable but challenging. Advances in technology that impact the work would also affect these standards.

Strategy 8.6: Promote person-first language that is consistent with a recovery- and resilience-oriented system of care.

“Creation of a recovery-oriented system of care requires behavioral health-care practitioners to alter the way they look at persons with mental illness and addiction, their own roles in facilitating recovery from these conditions, and the language they use in referring to individuals they serve.”⁸

“‘Person first’ language is used to acknowledge that the diagnosis is not as important as the person’s individuality and humanity, e.g., ‘a person diagnosed with schizophrenia’ versus ‘a schizophrenic.’”⁹ Person-first language recognizes that the person to whom one is referring is firstly a multidimensional human being like everyone else, and secondarily has a disability with which he or she is dealing. Employing person-first language does not mean that a person’s diagnosis is hidden or seen as irrelevant; however, it also is not the sole focus of any description about that person.¹⁰ The intentional use of person-first language helps to promote an environment in which people with mental illness are valued, motivated to gain hope for the future, and reach their goals.

“‘PERSON FIRST’ LANGUAGE IS USED TO ACKNOWLEDGE THAT THE DIAGNOSIS IS NOT AS IMPORTANT AS THE PERSON’S INDIVIDUALITY AND HUMANITY, E.G., ‘A PERSON DIAGNOSED WITH SCHIZOPHRENIA’ VERSUS ‘A SCHIZOPHRENIC’.”