Greater Bay Area Mental Health and Education Workforce Collaborative

California Institute For Mental Health

MENTAL HEALTH COMPETENCIES PROJECT

January 2014

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The California Institute for Mental Health is a non-profit public interest corporation established for the purpose of promoting wellness and positive mental health and substance use disorder outcomes through improvements in California’s Health System. CiMH is dedicated to a vision of “a community and mental health services system which provides recovery and full social integration for persons with psychiatric disabilities; sustains and supports families and children; and promotes mental health wellness.”

The Greater Bay Area Mental Health & Education Workforce Collaborative (the Collaborative) represents many different counties, agencies, organizations, and institutions, all committed to expanding the Greater Bay Area’s public mental health workforce. The Collaborative is a project of the California Institute for Mental Health (CiMH) in partnership with the Greater Bay Area County Mental Health Directors, Alameda County Behavioral Health Care Services and the Office of Statewide Health Planning & Development (OSHPD). Funding is provided through the Mental Health Services Act (MHSA – Prop 63) and the Zellerbach Family Foundation. The Collaborative’s website can be found at www.mentalhealthworkforce.org.

The mission of the Zellerbach Family Foundation is to be a catalyst for constructive social change by initiating and investing in efforts that strengthen families and communities.
Acknowledgements

First and foremost, we would like to express our appreciation to the Zellerbach Family Foundation for their vision and funding of this project. We would also like to especially thank Kimberly Mayer, MSSW, whose advice, counsel and guidance on this project has been invaluable.
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In the San Francisco Bay region of California, the Greater Bay Area Mental Health and Education Workforce Collaborative (hereinafter referred to as the Collaborative) has been a leader in workforce development programming since the early 2000s. Highlighted in the 2004 California Mental Health Services Act (MHSA) as a model for regional partnership, the Collaborative has continued to enrich the regional training and workforce development structure to meet the challenges of a transforming mental health and behavioral health system. The Collaborative’s website can be found at www.mentalhealthworkforce.org.

One of the Collaborative’s overarching goals from its work plan is to “increase human resources/civil service responsiveness to – and operational support of – public mental health employment needs.” In 2009 the Zellerbach Family Foundation funded several projects for the Collaborative, including a mental health and human resources directors forum. This day-long event, titled, *Building Our Partnership to Recruit, Hire and Retain a Diverse Workforce Including Consumers and Family Members*, was a facilitated meeting to share information, human resources strategies, job classifications, and practical tips. In 2010 the Collaborative identified mental health competencies as one of its priorities. In keeping with this commitment, the Collaborative sought and received funding from the Zellerbach Family Foundation to begin the process of exploring regional workforce competency development targeted toward the public mental health and behavioral health workforce across the Collaborative’s region of 12 counties and one metropolitan city. A consultant was hired in 2010 to develop the product.

The public mental health system is composed of many classifications and a broad variety of staff members. Counties vary greatly in their job titles and descriptions. Regardless of the staff members’ licensure, degree, or classification, basic competencies are required to meet the needs of individuals seeking mental health services in the public sector. Whether it is the county-run system or community-based organizations serving these individuals, the same competencies are necessary.

The goal of this particular project is to focus on a singular process that can be applied to the public mental health workforce. This process can be used to define the essential values and knowledge needed that make up competencies, as well as the hard skills (learned and applied) and soft skills (interpersonal or people skills) required to perform duties and tasks in the public mental health system.

By focusing on a singular “umbrella” process, both public mental health and educational institutions that train their staff should be better prepared to develop curricula for future workers. Persons entering the public mental health workforce...
should have a clearer understanding of the competencies that are required of them along with the knowledge, skills, and abilities that they must possess to be successful.

It is important to acknowledge similar work that is occurring in various regions in California. In Southern California, the Southern Counties Regional Partnership (SCRP) is working with Loma Linda University to develop a set of core competencies for both professional clinical staff and paraprofessional staff members through the Southern Counties Regional Partnership Core Competency Project. They are focusing on specific knowledge, skills and abilities tied to particular competencies. This project differs in that the Collaborative has been seeking an umbrella, or macro model, that can be easily compatible with other models. The Central Regional Partnership also did some exploration on this topic by seeking a more generic template that is not specific to job classification. This model can be tailored to any size system – county-run or community-based – and can be adapted to fit local human resource needs. It will be the work of each organization to overlay the model onto its existing system and fill in the specifics to develop custom models to fit unique individual needs.
Our Process and Literature Review

Once the Collaborative decided that mental health competencies should be an area of focus, and the project was launched, several concurrent activities ensued.

We set about to unearth as many definitions of “competencies” as we could find, and here are but a few:

- Competencies are groups of skills, behaviors, or knowledge that are identified as performance standards for a particular job. Competencies are applied to a particular job rather than an individual employee (North Carolina, DHHS).

- Competencies are identified behaviors, knowledge, skills and abilities that directly and positively impact the success of employees and organizations. Competencies can be objectively measured, enhanced, and improved through coaching and learning opportunities (State of Virginia, DHHS).

- A competency is the capability to apply or use a set of related knowledge, skills, and abilities required to successfully perform “critical work functions” or tasks in a defined work setting. Not to be confused with competence, a competency describes a behavior, but does not attempt to describe a level of performance (U.S. Department of Labor).

- Competencies often serve as the basis for skill standards that specify the level of knowledge, skills, and abilities required for success in the workplace, as well as potential measurement criteria for assessing competency attainment (U.S. Department of Labor).

We also reviewed most of the Greater Bay Area Counties’ Mental Health Services Act Workforce, Education and Training (WET) plans. A review of the counties’ mental health human resources information included job descriptions and classifications in the various counties, and the minimum qualifications required for each. We also looked at the DACUM (Developing a Curriculum) process, which is a nationally recognized standard for highlighting specific hard and soft skills necessary for a particular job function.

Other activities included participating as a representative of the California Mental Health Director’s Association and working with the California Social Work Education Center (CalSWEC) to develop knowledge, skills, and abilities related to competencies for graduate-level social work students concentrating in the field of mental health. The Collaborative performed a review of existing guild or professional associations, as well as the California Business and Professions Code standards for each discipline.

We conducted a review of other states that have been forerunners in the competency race, including North Carolina, Virginia, Alaska, Minnesota, Maine,
Table 1: Selected association competencies

<table>
<thead>
<tr>
<th>Association</th>
<th>Website/Resource Link</th>
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<tbody>
<tr>
<td>Marriage and Family Therapy</td>
<td><a href="http://www.aamft.org/imis15/Documents/MFT_Core_Competencies.pdf">www.aamft.org/imis15/Documents/MFT_Core_Competencies.pdf</a></td>
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<td><a href="http://www.cswe.org/Accreditation/EPASImplementation.aspx">www.cswe.org/Accreditation/EPASImplementation.aspx</a></td>
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<td><a href="http://calswec.berkeley.edu">http://calswec.berkeley.edu</a></td>
</tr>
<tr>
<td>Social Work</td>
<td><a href="http://counseling.org">http://counseling.org</a></td>
</tr>
<tr>
<td>Licensed Professional Clinical Counselors</td>
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<tr>
<td>Registered Nurses</td>
<td><a href="http://www.nursingworld.org">www.nursingworld.org</a></td>
</tr>
<tr>
<td>Psychiatric-Mental Health Nurse Practitioners</td>
<td><a href="http://www.aacn.nche.edu/">www.aacn.nche.edu/</a></td>
</tr>
<tr>
<td>Nurse Practitioner Primary Care Competencies</td>
<td><a href="http://www.aacn.nche.edu/education-resources/npcompetencies.pdf">www.aacn.nche.edu/education-resources/npcompetencies.pdf</a></td>
</tr>
<tr>
<td>Practical and Vocational Nurses</td>
<td><a href="http://napnes.org">http://napnes.org</a></td>
</tr>
<tr>
<td>Psychiatric Technicians</td>
<td><a href="http://www.psychtechs.org">www.psychtechs.org</a></td>
</tr>
<tr>
<td>Psychologists</td>
<td><a href="http://www.apa.org/graduate/competency.aspx">www.apa.org/graduate/competency.aspx</a></td>
</tr>
<tr>
<td>Public Health Professions</td>
<td><a href="http://www.phf.org">www.phf.org</a></td>
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Iowa, Ohio, and Vermont. We also consulted with and reviewed materials from the Annapolis Coalition, which has been working on behavioral health workforce issues for more than a decade.

Given the imminent implementation of the Affordable Care Act (ACA or Health Care Reform), which includes behavioral health services as a component, we reviewed many documents on primary health and behavioral health care integration. The effect of the ACA and the move toward integrated care relative to system transformation in mental health and behavioral health is expected to be significant. Competencies needed in an integrated system are expected to include (but not limited to) what is currently available in the workforce skill sets, as well as the possibility of expansion of competencies that are at the very least cross-disciplinarily compatible. Although this issue has not been explored in great measure in this project, baseline data related to health and human services occupations’ job classifications was noted in data collection as a reference for future research.

We thoroughly reviewed two preeminent federal models: 1) A Provider’s Guide on How to Use

We also reviewed work done by the International Initiative for Mental Health Leadership, titled, Leadership Training Programs and Competencies for Mental Health, Health, Public Administration, and Business in Seven Countries.

Lastly, we examined competencies and evidence-based practices for subpopulations, including early childhood and family, children and youth, transition-aged youth, adults with serious mental illness, and older adults.

This process was very complex and labor-intensive because so many competency models exist – not only in this country, but in the world. It was difficult to sort through all of the details of the various models. We found ourselves drilling down further and further into the weeds, until we could no longer see the singular path that we had envisioned. After much discussion with the project manager, we were able to refocus our energies on selecting a comprehensive model that would be applicable to any size or type of behavioral health provider organization.

All of the above-referenced material in this process review is available as an appendix to this document.

### Table 2: Selected competency development websites

<table>
<thead>
<tr>
<th>Competency Model Clearinghouse (United States Department of Labor)</th>
<th><a href="http://www.careeronestop.org/CompetencyModel/">http://www.careeronestop.org/CompetencyModel/</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Occupational Classifications (United States Department of Labor)</td>
<td><a href="http://www.bls.gov/SOC/">http://www.bls.gov/SOC/</a></td>
</tr>
<tr>
<td>United States Department of Health and Human Services</td>
<td><a href="http://hhsu.learning.hhs.gov/competencies/">http://hhsu.learning.hhs.gov/competencies/</a></td>
</tr>
<tr>
<td>O*NET (Occupational Information Database)</td>
<td><a href="http://www.onetonline.org/">http://www.onetonline.org/</a></td>
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During the previous discussions, we kept returning to a model that was not developed specifically for behavioral health care workforce competencies; that being the U.S. Department of Labor’s building block model, titled, *Technical Assistance Guide for Developing and Using Competency Models – One Solution for the Workforce Development System*, published in January 2012.

Building block modeling in competency development has existed for some time. In 2005, the U.S. Department of Labor, in conjunction with the state of Minnesota, hired consultants to develop a building block competency model guide for public workforce investment. This guide was updated in 2012.

The U.S Department of Labor, housed in the Employment and Training Administration, initially provided technical assistance and frameworks for competency models targeted toward business and industry, workforce investment boards, one-stop career centers, economic developers, educators and training providers, and professional organizations. These frameworks included what are called “building blocks” for competency modeling, which consisted of seven separate identified tiers. These included, in order of complexity: personal effectiveness competencies, academic competencies, workplace competencies, industry-wide technical competencies, industry/sector technical competencies, occupation-specific competencies, and management competencies. Two of the four previously mentioned definitions of competencies were developed by the U.S. Department of Labor in their endeavor here.

The tiered approach provides creative suggestions from very basic to more specialized, and industry-specific levels of competency expectations that are designed to inform competency model development within any industry. In the rapidly transforming mental health industry, this tiered approach allows for competency development to be targeted at job-specific activities, skills, and knowledge. This allows for the discussion not to be isolated in professional guilds, wherein competencies are largely based on academic performance in degree programs, and thereafter in the capacity to attain state licensure. Instead, this model broadens the discussion to investigating system-wide competencies that can be both general and specific.

Because California has used multiple types and so many levels of analyses in competency development, this block model strategy can allow for unification of all efforts; a way to pull all of the various strings together, so to speak. This will not negate the process of any prior or concurrent competency development work.

The following page is the Building Blocks Competency Model by the U.S. Department of Labor, used with their permission.
Figure 1: Building Blocks Competency Model of the USDL's Technical Assistance Guide for Developing and Using Competency Models – One Solution for the Workforce Development System, January 2012 (Figure 3 in source document).
The Building Block model can be divided into three major sections. Tiers 1 through 3 on the bottom of figure 1 form the foundation competencies that are necessary for entry and success in most jobs in any workplace. These competencies represent the “soft skills” that most employers require. Tiers 4 and 5 in the middle of the block show cross cutting, industry-wide technical competencies that are needed to create career ladders within an industry. This model can support the development of an agile workforce that can move across industry subsectors. The upper tier is used to describe the knowledge, skills and abilities that are specific to a particular occupation within an industry, as well as management and administrative skills.

In Tier 1, motives and traits, as well as interpersonal and self-management styles are present. These include competencies such as interpersonal skills, integrity, professionalism, initiative, dependability and reliability, and willingness to learn. These competencies are basic to maintaining a positive work environment that is efficient, effective, and enhances interpersonal relationships in teamwork as well as the ability to work independently.

Tier 2 of the model contains critical competencies primarily learned in academic settings, as well as cognitive functions and thinking styles. These may be discipline-specific, and/or relate to community college, baccalaureate, or graduate programs.

Tier 3 includes workplace competencies. These competency domains represent those skills and abilities that allow individuals to function in an organizational setting. Chief among this skill set are teamwork, adaptability, customer focus, planning and organizing, creative thinking, problem solving and decision making, using computers, accessing and updating computer files, keyboard and word processing, scheduling and coordinating, checking, examining and recording.

Tier 4 includes industry-wide technical competencies. These represent the knowledge, skills and abilities needed in all occupations within an industry. In mental health systems these might include general knowledge of mental health symptoms and interventions, risk factors, comfort level in working with specific consumer populations, and ability to work independently in an ever-changing system.

Tier 5 includes industry-specific technical competencies. These represent knowledge, skills and abilities and other characteristics needed by all occupations within an industry segment. It is recommended that industry leader and partner associations specify and define these competencies. Differentiation between this Tier and Tier 4 may be in the specifics of the particular population (e.g., children, transition-aged youth, adults, and older adults) and/or a specific program type that requires certain competencies to work in the setting (e.g., inpatient, emergency/crisis, residential treatment).

The right half of Tier 6 includes occupation-specific knowledge areas. The Department of Labor’s Occupational Information Network may provide some suggestions related to specific aspects of occupations that are critical. Beyond this, the
categorization relates to a specific knowledge base that is over and above that which is required in the industry as a whole. This may include specialized training (e.g., psychiatric medication), and industry-specific, rather than occupational-specific needs.

Occupational-specific technical competencies are included. It is recommended that these be defined by partners and stakeholders. Examples may be knowledge of Medi-Cal billing, housing resources, and supported educational resources.

Occupation-specific requirements are also included. This level includes requirements such as certification, licensure, and specialized educational degrees, or physical training requirements. These skills would be critical in profession-specific, license-eligible/acquired workforce groups. Arguably this group, especially if licensed, may have both plusses and minuses to offer an industry. For example, the industry itself may have certain needs that may be incompatible with licensed personnel, whose work product may be tempered by licensing restrictions and scope of work parameters.

The left half of Tier 6 includes management competencies. These are specific to supervisory and managerial occupations. Specific competencies include staffing, informing, delegating, networking, monitoring work, entrepreneurship, supporting others, motivating and inspiring, developing and mentoring, strategic planning/action, preparing and evaluating budgets, clarifying roles and objectives, managing team conflict and team building, developing an organizational vision, and monitoring and controlling resources.

As we mentioned previously, one of the key components that kept our focus on this Building Block model was that it can be overlaid onto any size or complexity of organization. In the case of public mental health entities, it matters not if the organization is that of a very large county system of care or a much smaller community-based non-profit organization.

For example, there are certain overarching principles and values that every public mental health service delivery system should embrace in the current era. These are the underlying tenets and beliefs of the culture of how best to serve those individuals seeking mental health services from the public sector. A brief discussion of a few of these follows.

For the last two decades, the belief in recovery from mental illness has laid a new path in practice with adults in the public mental health system. Although this is a concept that is well accepted now, until recently interventions with this population focused upon lifelong care and maintenance of functioning through medication. The thought of adults with serious psychiatric conditions actually improving significantly, finding employment and independent housing was a radical (and some thought, dangerous) idea.

Similarly, the resiliency of children and youth was much underestimated for decades. Many of
Figure 2. Descriptions of targeted elements within each tier.
them who entered the mental health system with certain diagnoses were destined towards long-term maintenance care, instead of encouraged to achieve and thrive.

Another fundamental tenet of practice with those in the public mental health system is that of cultural competency and work with diverse populations. In the National Association of Social Workers’ document from 2001, NASW Standards for Cultural Competence in Social Work Practice, it was stated that “Cultural competence refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities, and protects and preserves the dignity of each.” It is accepted that in order to be successful working with those who enter the public system, mental health professionals must be learned in many cultures’ beliefs and value systems. The capacity to speak multiple languages is a prized ability.

A third widely accepted concept in the public mental health sector now is the understanding that the whole person and all of the conditions that may be affecting the health and mental health of an individual should be taken into consideration. There was a time not so long ago when the public mental health system failed to focus on the medical and health conditions that might be affecting the individual. Similarly, the ability to focus on co-occurring drug and/or alcohol problems was lacking.

These are just three core beliefs or principles that staff members must have in order to work in any capacity in the public mental health system. They apply to every job classification, whether management, clinical staff, consumer and family support staff, or clerical/administrative support staff. These underlying values lead to expectations that personnel will be skilled in work activities that emanate from these perspectives. They are overlaid on every classification of every tier in the Building Block model and stand as a few of the core competencies of successfully working in the public mental health sector.

So let us now look at how these core competencies can be transposed onto the USDL Building Block model. Since recovery and resiliency have been accepted concepts and have been in practice in some counties in California for two decades now, we can easily see how they fit into this model.

In the first Tier of Personal Effectiveness Competencies, we could add under Interpersonal Skills the expectation that all staff behave towards consumers and family members in such a manner that fosters the belief that individuals do recover from mental health conditions. This can be observed in the respectful and encouraging manner in which staff interact with those who come for service, whether that individual staff member is administrative support, clinical staff, or management.
Tier 1: Personal Effectiveness Competencies

In Tier 2 of Academic Competencies, which include Communication, Critical and Analytic Thinking, and Active Learning skills, recovery and resiliency should be implemented as an active part of these processes. An example would be observing staff specifically addressing the issue of recovery with consumers and family members in their communication with them. Another observable behavior would be to incorporate steps towards recovery into the partnership planning process (formerly, treatment planning).

Tier 2: Academic Competencies

The same applies to Tier 3, especially in the areas of Customer Focus, Creative Thinking, and Problem Solving and Decision Making. For example, does staff encourage the consumer in making decisions for themselves towards increasing independence in their recovery, and encourage responsible and independent problem-solving?

Tier 3: Workplace Competencies
In Tiers 4 and 5, recovery and resiliency practice skill sets become more specific. For example, in Tier 4 the expectation that these are industry-wide technical competencies that guide the workforce’s specific practice is present. So regardless of population, program, or job classification, it would be expected that all staff should be able to demonstrate through their practice behavior the underlying principle that the consumer will recover, if the interactive process includes specific interventions and supports.

**Tier 4: Industry-Wide Technical Competencies**

In Tier 5, even more specificity occurs. Staff members who are employed and working with certain populations and programs should be able to apply recovery principles and practices within those target groups. For example, if an individual works in a residential treatment program with adolescents, recovery and resiliency practices would be tailored in a different manner than with adults receiving outpatient and/or case management services.

**Tier 5: Industry-Sector Technical Competencies**

Tier 6 includes Management Competencies and other Occupation-Specific Requirements, which might include licensure and other knowledge-based skills, such as the psychiatric medical staff’s ability to prescribe and monitor medication. In that case, that staff’s capacity to work with consumers around medication issues in a manner that promotes education, choice, and self-monitoring and reporting can be observed.
Likewise, management and administration in the organization can demonstrate this principle through planning future programs and reorganizing current programs so that they operate predominately with recovery and resiliency goals and direction.

In addition, let us consider a second example and one that may be more difficult to predict. We previously discussed three accepted core principles in the public mental health system, including the treatment of co-occurring conditions. These can include mental health, drug and alcohol, and physical health problems. In a changing care environment as we head toward full implementation of Health Care Reform, we must look to new models of care delivery. These have been proposed in numerous structures, most notably the Four Quadrant Clinical Integration model, which describes levels of integration in terms of primary care complexity and risk and Mental Health/Substance Use complexity and risk.

Let us examine just one of these models of integrating mental health staff into a primary care system. It is widely acknowledged that behavioral health and primary care have vastly different cultures. The language and terms used, the approach to care, and treatment philosophies can be worlds apart. Primary care staff members live in a fast-paced environment, compared to staff in the public mental health system. This can be frustrating for mental health staff, who are accustomed to taking time for engagement and more in-depth assessment.

The Building Block Competency model may be used as a lens to discern what skill sets mental health staff would need in order to be successful in delivering behavioral health services in a primary care setting.
Tiers 1 through 3 represent the foundation of personal effectiveness, academic and workplace competencies. Mental Health staff would have to be able to demonstrate the ability to function in the faster-paced primary care environment. As noted in the Integrated Behavioral Health Project Tool Kit of Primary Care/County Mental Health Collaboration (a document published in 2013, with funding from the California Mental Health Services Authority), staff should be able to exhibit skills such as flexibility to deal with noise, interruptions, and scheduling changes. The ability to give brief, targeted interventions is necessary. Shorter-term sessions of less than 30 minutes and shorter-term treatment of less than eight visits is the norm. Functioning well with a predominantly medical team of which mental health workers are not the staff in charge of care is necessary. Focusing on behaviors as markers is the rule. The ability to communicate quickly, often in hallway consultations and “on the fly” interactions, is a requirement.

Tiers 4 through 6 represent the industry-wide, industry sector, and occupation-specific competencies and requirements. Behavioral health staff in primary care settings would have to demonstrate specific knowledge, skills, and abilities. Some of these are listed below (based in part on Integrated Behavioral Health Care, A Guide to Effective Intervention, O’Donohue, 2006):

- Proficiency in the identification and treatment of mental disorders.
- Ability to think in terms of population management, assisting a large clientele in the most efficient way possible, using approaches such as stepped care and group therapy.
- Knowledge of evidence-based behavioral assessments and interventions relevant to medical conditions (e.g., disease management, lifestyle changes).
- Ability to make quick, accurate clinical assessments.
- Care management skills and knowledge of local resources.
- Skill in targeted, brief therapy, group intervention, and stepped care.
- Knowledge of at least basic physiology, psychopharmacology, and medical terminology.
- Ability to document services according to primary care requirements, as well as usefulness to the medical provider and the quality improvement process.
- Skill in consultation and liaison.

In addition, the management competencies required to oversee a truly integrated behavioral health service within a primary care setting have not begun to be clearly defined or articulated. Given the two very differing historical cultures and the potential personalities involved, it will take a very patient, persevering individual to move this model forward.
This area of integrated primary care and behavioral health is slowly beginning to receive attention from training institutions. Many current staff of the public mental health system may not want to transition to an integrated model within a medical setting. It may take a new generation of individuals who have been trained with skill sets on both sides of the aisle, so to speak.

One such training example has been implemented at the University of Massachusetts Medical School, whose Department of Family Medicine and Community Health instituted a Certificate Program in Primary Care Behavioral Health in 2007. It is particularly targeted to prepare behavioral health professionals for the Patient-Centered Medical Home model. It is also open to the primary care medical providers from their worksite to encourage team-based preparation. The program is a 36-hour didactic and interactive training, which can be accomplished on site or through distance learning. To view the curricula, visit the website at http://www.umassmed.edu/cipc/pcbhoverview.aspx.


Let us now examine how the Building Block model can be applied to a specific public mental health job classification. Many counties have created a position within their system that is for consumers or ex-consumers of mental health services. These are known by a few different names, including peer counselor, peer provider, peer specialist, and peer support worker. Some counties use a more generic title of community support worker, or mental health worker. Some counties use these classifications to hire family members of consumers to help support and navigate other family members in and through the county system. We would like to thank the counties of Contra Costa, Santa Clara, and Napa, which contributed their classifications for this endeavor.

Remembering that the foundation competencies of Tiers 1 through 3 are related to personal effectiveness, academic and workplace competencies, typical expectations of this job classification would be similar to others in the organization, which are to follow oral and written instructions; work harmoniously with clients and co-workers; work under supervision; write reports and maintain records; complete necessary paperwork in a timely manner; attend and participate in staff meetings as a team member; attend and participate in interagency meetings; behave from a customer service orientation; have basic computer skills; adhere to standard office practices and work schedules; communicate effectively; and maintain confidentiality and ethical standards.

Tier 4 involves industry-wide technical competencies, or those knowledge, skills and
abilities needed in order to work in a public mental health organization. For these classifications, skills might include knowledge of community resources that are available, including crisis intervention; outreach and engagement methods; principles of recovery and resiliency; strength-based approaches; group and individual peer support; cultural issues and factors in service delivery; advocacy for the client; ability to work in a wellness/recovery/support model; providing transportation when needed; and recognition of symptoms signaling the need to refer clients for more intensive care.

Tier 5 includes industry-specific technical competencies, or those knowledge, skills and abilities needed in order to work in a segment or subset of the public mental health organization. In this case, specificity regarding the particular program or population that the consumer or family member is assigned to is important.

For example, a consumer provider assigned to work with the adult population would need to demonstrate certain skills, such as assisting in reviewing the clients’ functional assessment and determine clients’ needs with clinical staff; teaching daily living activities, such as budgeting, cooking, shopping and self-advocacy; participating in group and individual wellness recovery action planning (WRAP); providing housing counseling; providing support to residents in their homes; assisting in acquiring and maintaining public benefits (SSI, TANF, GA); providing assistance during outings; and linking clients with community resources for adults.

A family member working with adults in the mental health system would need to demonstrate other behaviors, such as welcoming families of consumers into the organization; acting as the family voice in consulting with staff; addressing concerns and questions of family members; leading groups for families; and acting as a navigator or guide for the family members in issues regarding the mental health system, housing and community resources, and financial benefits.

Family members who are assigned to work in a children’s mental health program would require similar, but somewhat different skills. They would need to participate in Wraparound meetings with staff and understand that model of service to families; participate in interagency meetings, which are frequently necessary for troubled youth; work with the parent(s) or guardian(s) around their functioning and daily living skills; lead groups for the parents; act as a navigator for the parents regarding accessing care, housing, or financial assistance (Medi-Cal, Healthy Families etc.); and work with youth in residential placement and their families.

Tier 6 involves supervisory and management competencies, and those competencies that are very occupation-specific. For these purposes, some counties promote consumer or family member providers to a supervisory or management level. Other competencies are then involved, such as arranging daily work schedules; organizing meetings, trainings, educational events, and
presentations; training of new consumer or family staff; supervision of staff and knowledge of the organization’s personnel policies and procedures; attending supervisor or manager-level meetings to communicate needs of consumers and also of their staff; attending meetings with administration to participate in program planning and decision-making, representing the consumer or family perspective; and becoming an active member in the quality improvement process and system change activities.
To date, the U.S. Department of Labor’s Employment and Training Administration (ETA) has completed 21 industry competency models. Unfortunately, behavioral health, mental health and/or substance abuse fields are not among them. The closest industry model from this list is the health services field. All existing models can be found at the Competency Model Clearinghouse (CMC) at http://www.careeronestop.org/CompetencyModel.

The site also includes two interactive tools. The Build a Competency Model and the Career Ladder/Lattice tools are designed to be utilized with the 21 existing industries on the website.

So how can we utilize this model if the public mental health sector has not been developed yet in the U.S.D.A.’s national industry standards? As discussed previously, any organization can tailor the model to their own culture’s principles, goals, and priorities.

This would be in the form of a very hands-on, practical process. The first portion would involve a relatively small group of leaders from within the organization. These individuals would not (and should not) necessarily be the top administrators and managers in the organization.

There are various forms of leadership within any organizational structure, and they occur at all levels. Examples might be clinical staff, and consumer and family support staff, as well as administrative and clerical support staff, who are the perceived leaders among their ranks.

This initial workgroup cannot be too large, as it is rare that a group of more than eight persons can produce a finished product efficiently. Of course, the top administrator of the organization would set the tone and mission for the group. They would use the six-tiered Building Block model and apply it, step-by-step to the agreed-upon values and principles of their organization, which would be broken down into observable and reportable behaviors at every level. The document would be vetted, both internally (staff within the organization at all levels) and externally, with stakeholder groups (consumer and family-member organizations, and advisory bodies).

Once adopted, this document could have further usefulness from a human resources/personnel perspective. It could be used as a tool to enhance the specificity of job descriptions. It could also be factored into performance expectations and evaluations.

However, one of the best things for organizational change would be to use it as a training tool for staff. Both incoming and existing staff throughout the organization could be trained to specific behaviors that reflect its values and principles.


Association for Prevention Teaching and Research and the Center for Health Policy, Columbia University School of Nursing. (2004). Competency-to-curriculum toolkit: Developing curricula for public health workers.


