HHS COMMITTEE #1
June 27, 2013
Discussion

MEMORANDUM

June 25, 2013

TO: Health and Human Services Committee

FROM: Vivian Yao, Legislative Analyst

SUBJECT: Discussion: Behavioral health workforce issues: staffing, recruitment, retention, and training

The Health and Human Services Committee will discuss workforce issues in Behavioral Health and Crisis Services (BHCS). The discussion is intended to be the first of multiple sessions that will explore staffing, recruitment, retention and training trends with social workers and other behavioral health professionals in the Department of Health and Human Services (DHHS).

The following individuals are expected to participate in the presentation and discussion:

- Uma Ahluwalia, Director, Department of Health and Human Services (DHHS)
- Raymond Crowell, Chief, Behavioral Health and Crisis Services, DHHS
- Betty Lam, Chief, Office of Community Affairs, DHHS
- Sonia Mora, Welcome Back Center, Latino Health Initiative, DHHS
- Carmen Saenz, Welcome Back Center, Latino Health Initiative, DHHS
- Brad Stewart, Vice President & Provost of the Takoma Park/Silver Spring Campus, Montgomery College
- Dr. Tony Hawkins, Dean of Instruction for the Arts, Humanities and the Social Sciences, Montgomery College
- Katie Morris, University of Maryland, Baltimore County at the Universities at Shady Grove

The Committee will receive information on: (1) key issues for current and future capacity needs; (2) the impact of the Affordable Care Act on the demand for services and behavioral health workforce; (3) efforts being made or considered by the Department to recruit and retain staff; and (4) the work experience of front line staff in BHCS. Representatives from local higher education institutions will be available to share information on behavioral health and social work education programs and recruitment efforts. The Committee will have the opportunity to discuss potential opportunities to enhance workforce retention and retention in this sector and identify needed workforce development improvements.

DHHS Behavioral Health Professionals and Social Workers

The HHS Committee members expressed interest in exploring the experience of social workers and other mental health professionals in DHHS and discussing issues related to recruitment and retention of employees. Social Worker positions are used in all of the five service areas in the Department; the Department reports that it has a total of 240 Social Worker positions in four classes that range from grade 21 to grade 25. The following chart provides information about how social workers are used across the Department. Additional programmatic information is provided at ©1-4.

	Aging & Disability Services	Behavioral Health & Crisis Services	Special Needs Housing	Children, Youth & Families	Public Health Services
Total Positions	49	3	31	149	8
Programs Using Social Workers	-Adult Svces Intake -Adult Protective Svcs -Adult Evaluation & Review Svcs -Social Svcs to Adults -Public Guardianship -Waiver for Older Adults -Home Care Services -Chore Services -Personal Care/In Home Aide -Adult Foster Care -Ombudsman Services	-Adult Behavioral Health Svcs -Child & Adolescent Mental Health Clinic	-Homeless Svcs -Housing Stabilization Svcs	-Child Welfare Srvcs (Child Protective Svcs, CPS In-Home Services, Family Preservation, Foster Care, Independent Living, Foster & Adoptive Parents Program) -Linkages to Learning	-Communicable Disease & Epidemiology

Because the nature of job responsibilities and experiences varies among different service areas and programs in DHHS, as well as the nature of recruitment, training, and retention strategies, the Committee will discuss staffing issues in Behavioral Health and Crisis Services at this meeting with the intent to discuss staffing issues for social workers in other service areas at a future meeting.

Social Worker and Mental Health Professional Roles in BHCS

DHHS reports that there are a variety of roles in BHCS that make use of master's level professionals that have been formally trained to provide mental health services. These positions include: Social Worker; Therapist, Supervisory Therapist, and Behavioral Health Associate Counselor. While master's level social workers occupy the majority of these positions, the Department also recruits from other professions including: Psychology, Counseling, Criminal Justice, and Addictions Counseling. With the exception of the Social Worker positions, the degree requirement is a masters in a Human Services related field.

Licensure or certification is an additional requirement in BHCS's hiring process. For most of the above positions, either a "graduate level" or clinical license is required. Graduate licenses are usually obtained upon completion of a master's degree program. Clinical licenses require a period of post-graduate training under the clinical supervision of a licensed professional. Clinical supervision can be obtained either on the work site or by private arrangement. BHCS provides clinical supervision for licensure in some instances. Although the Department has many licensed

clinical staff that could provide clinical supervision of unlicensed staff, most are line staff and supervision is not part of their current job description. Clinical supervision is generally provided by Supervisory Therapists or appropriately licensed program managers when available.

BHCS clinical staff also includes Psychiatrist and Psychiatric Nurse Clinical Specialist positions. The Department reports a total of 135 clinical positions that require advanced training in mental health services provision, and 33 of these positions receive multilingual pay differential.

LOCAL HIGHER EDUCATION PROGRAMS IN THE BEHAVIORAL HEALTH AND SOCIAL WORK FIELDS

Representatives from local higher education institutions including Montgomery College and University of Maryland, Baltimore County (UMBC) at the Universities at Shady Grove (USG) have been invited to participate in the meeting and will be available to present information or answer questions about the programs that they offer and how they recruit or counsel students in career options that include behavioral health and social work fields. The following chart summarizes some of the offerings at Montgomery College and the Universities at Shady Grove through the University of Maryland, Baltimore County.

Institution	Program	©
Montgomery College	Mental Health Associate A.A.S.	5-9
UMBC-USG	Social Work B.A.	10
UMBC-USG	Psychology B.A.	11-14

RECRUITMENT AND RETENTION

DHHS reports that of the 135 clinical positions in BHCS, nine are currently vacant, including six Therapist II positions and three Supervisory Therapist positions. The average time needed to fill a position in BHCS is 12 to 13 weeks. Table 1 (©15) shows clinical staffing positions in BHCS by position, grade, salary range, number of employees, and average years of experience in the County. Table 2 (©16) provides additional information on FTEs and average personnel costs for these positions.

Highlights from the tables include the following:

- There are 135 clinical positions (i.e. persons with advanced training in mental health service provision).
- Of the 135 positions, 33 receive multilingual pay differential – indicating that they are fluent in a second language and that they are required to use that language in the performance of their duties.
- BHCS currently has six vacant frontline clinical positions, and three additional vacant supervisory therapist positions. The average time it takes to fill a position in BHCS is 12 to 13 weeks.
- The lowest average years of experience in the County was shown for Behavioral Health Associate Counselors at 7.3 years and Medical Doctor III-Psychiatrist at 8.34 years. The

Therapist I position is a new category with only one employee and thus shows only 0.07 average number of years.

- The highest average years of experience was shown for Social Workers II at 25.07 years, Supervisory Therapist at 19.23 years, and Psychiatric Nurse Clinical Specialist for 17.08 years.

DHHS reports that 13% of the BHCS staff has been identified as eligible to retire in the next two years based on the Department's succession planning survey. In addition, BHCS has lost 13.25 FTEs in therapist positions due to budget reductions since 2008. Anecdotally, DHHS reports that psychiatrist and therapist positions are the hardest for BHCS to fill.

DHHS notes that OHR Compensation would need time to do a regional study to show how County salaries compare with other areas, and the Committee may want to request that OHR perform this work. DHHS believes that salaries for therapist positions are competitive. Based on a cursory review of salary ranges performed by Council staff, see table below, County salary ranges appear generally in line with other jurisdictions; however, as noted by DHHS, further research would be needed to provide a more comprehensive study of the comparability of the different positions and overall compensation packages.

Salary Comparison of Clinical Professionals

	Montgomery ©17-38	Anne Arundel ©39-40	Fairfax ©41-62	Maryland ©63-79
Psychiatrist	$114,575-191,682 Medical Doctor III-IV	$85,800-$187,280 (consultant)	$89,247-$148,745	$93,261-$192,830 Physician Clinical Staff & Specialist
Mental Health Therapist	$51,598-$89,596 Therapist I & II	$41,896-$66,880 (contractual)	$51,935-$86,558	$44,600-$71,399 Social Work Therapist
Mental Health Supervisor	$56,631-$93,944 Supervisory Therapist		$59,867-$99,778 Mental Health Supervisor/ Specialist	
Alcohol and Drug Associate Counselor	$44,900-$74,181 Behav Health Assoc. Counselor	State Merit	$45,138-$86,558 Substance Abuse Counselor I & II	$37,006-$58,719 Alcohol & Drug Assoc. Counselor
Social Worker	$51,598-$89,596 Social Worker II & III	$49,920-$54,038 (contractual)	$45,137-$95,350 Social Worker I-III	$39,366-$66,880 Social Worker I-II

To better understand behavioral health workforce challenges in the County and target strategies to address needs, the Committee may want to request additional information that specifically identifies the positions that are the most difficult to fill and retain. The Committee may be interested in requesting additional information on specific positions including the average time is takes to fill vacancies and vacancy and turnover rates.

Montgomery County Workforce Challenges

Dr. Crowell will be presenting to the Committees on workforce capacity issues and meeting the demand for services now and under the Affordable Care Act, see slides at©80-85. According to the presentation, the increase of mentally ill clients is projected to increase by 42% while clients needing addiction treatment will increase by 221%, resulting in an overall percent increase for behavioral health clients after the launch of the Affordable Care Act of 84.5%.

Dr. Crowell will also provide information about challenges in growing workforce capacity locally. Some of the challenges highlighted by DHHS include the following:

- Staffing levels will need to be addressed in County programs and in the provider community. The numbers are inadequate.
- The County is not meeting the current demand for behavioral health services: wait lists for County and provider services are often long; there has been an increase in demand for jail-based services; and there is a prevalence of behavioral health issues in the homeless population.
- The demand for services is growing faster than the County has grown the workforce with increases in waiting lists across homeless populations, increases in criminal justice populations who will be seeking services, and continuing suicide risk for persons on the waiting list.
- Shifting population demographics require greater multi-cultural/multilingual diversity in the workforce, which is not readily available or in the training pipeline.
- Recruitment and hiring take time.

National Action Plan for Behavioral Health Workforce Development

The behavioral health workforce challenges facing Montgomery County are not unique; there has been concern nationwide for a number of years about the ability of the behavioral health workforce to meet the growing demand for services. According to the Action Plan for Behavioral Health Workforce Development prepared by the Annapolis Coalition on the Behavioral Health Workforce for the Substance Abuse and Mental Health Services Administration, excerpts attached at©86-112, behavioral health workforce challenges include "difficulties in recruiting and retaining staff, the absence of career ladders for employees, marginal wages and benefits, limited access to relevant and effective training, the erosion of supervision, a vacuum with respect to future leaders, and financing systems that place enormous burdens on the workforce to meet high levels of demand with inadequate resources."

Concerns about the workforce's ability to provide quality care include the following:

- Many in the workforce are uninformed about and unengaged in health promotion and prevention activities.
- Many in the workforce lack familiarity with resilience and recovery-oriented practices and are reluctant to engage individuals and their families in collaborative relationships that involve shared decision-making about treatment options.
- It takes a long time for proven interventions to become practice with services often driven by tradition.
- The workforce lacks racial diversity of the population it serves and is often insensitive to the needs of individuals, which needs are influenced by ethnicity, culture, and language.

- The workforce is not equipped in skills or in numbers to respond to the changing needs of the American population. For example, the increase in the incidence of co-occurring mental and addictive disorders requires training and education programs to address this problem.
- There is an inadequate pipeline of new recruits to meet the complex behavioral health needs of the growing and increasingly diverse population.

The report highlights a critical shortage of individuals trained to meet the needs of children, youth and their families including a severe shortage of child and adolescent psychiatrists and practitioners trained and credentialed to treat adolescents with substance use disorders. There is also a pronounced shortfall of providers with expertise in geriatrics. The reports also asserts that only 20% of the individuals in the country who need substance use disorder treatment each year receive it – due in part to difficulties in recruiting and retaining qualified staff. The workforce lacks cultural diversity, particularly in mental health. Additional concerns were raised that recent graduates of professional training programs are unprepared for the realities of practice in real-world settings.

The report recommends seven final action goals. Council staff has provided more information about Goals 3, 4, and 5, which are more directly connected to the Committee's discussion.

Broadening the Concept of the Workforce:

Goal 1: Significantly expand the role of individuals in recovery, and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and support to others; and educate the workforce.

Goal 2: Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness.

Strengthening the Workforce:

Goal 3: Implement systematic recruitment and retention strategies at the federal, state and local levels.

--Disseminate information and evidence on effective recruitment and retention practices routinely.
--Implementation of data-driven continuous quality improvement processes by prevention or treatment organizations with interventions tailored to recruitment and retention problems.
--Expand financial incentives like stipends, tuition assistance, and loan forgiveness.
--Wages and benefits must be commensurate with education, experience, and levels of responsibility.
--Launch a comprehensive public relations campaign promoting careers in the mental health and addiction sectors.
-- Formal regional partnerships should be established between behavioral health and education systems to foster a pipeline of new recruits trained in the skills relevant to

contemporary systems of care and map out and enhance existing career ladders.
-- State and local governments should implement "grow-your-own" strategies to recruit and develop a more diverse and stable workforce.
--Address core needs of the workforce including living wages with health care benefits; opportunities to grow and advance; clarity in a job role; some autonomy and input into decisions; manageable workloads; administrative support without crushing administrative burden; basic orientation and training for assigned responsibilities; a decent and safe physical work environment; a competent and cohesive team of co-workers; the support of a supervisor; and rewords for exceptional performance.

Goal 4: Increase the relevance, effectiveness, and accessibility of training and education.
--Further development of core competencies in mental health practice.
--Development of competency-based curricula.
--Organizations that provide education and training should adopt teaching practices that have evidence of effectiveness.
--Expand use of information technology to increase access to training.
--Ensure the development of the basic competencies in the assessment and treatment of persons with substance use disorders and co-occurring mental and addictive disorders.
--Shape demand for relevant and effective training by educating prospective students about best practices in education to help them become more informed consumers as they select educational options.
--Identify and implement strategies to encourage and sustain use of newly acquired skills in practice settings to support constructive changes in practice patterns.

Goal 5: Actively foster leadership development among all segments of the workforce.
--Identify competencies necessary for leadership roles in behavioral health including developing core leadership competencies that can be adapted to different sectors of the field and competency sets for supervisors.

Structure to Support the Workforce

Goal 6: Enhance the infrastructure available to support and coordinate workforce development efforts.

Goal 7: Implement a national research and evaluation agenda on behavioral health workforce development.

The Committee may be interested in discussing the recommendations with participants, exploring whether there are opportunities to improve practices and collaboration, and identifying options that require additional resources to implement. The Committee may also be interested in exploring the possibility of having the County partner with MCPS, higher education institutions and other key stakeholders to launch a comprehensive public relations campaign to promote careers in the mental health and addiction sectors.

STRATEGIES FOR ADDRESSING WORKFORCE CAPACITY AND NEEDS

Dr. Crowell will present to the Committee on efforts being made or considered by the Department to address workforce capacity and service needs. Strategies to improve staff recruitment and retention include the following:

- Changed the Department's licensure requirements for entry level therapist positions.
- Offering training opportunities to graduate level students.
- Offering supervision for licensure to new graduates.
- Offering incentives to licensed line staff to clinically supervise new hires.
- Changing clinical service models to include funded Peer Support services – both in County run services and in the provider community.
- Developing recruitment pilots through programs like the Welcome Back Center of Suburban Maryland. Welcome Back Center staff will attend the meeting and be available to describe the program and expected outcomes. See ©113-115 for more information about the Welcome Back Center.
- Fiscal support to providers to address the high cost of start-up and ongoing operations in the county.
- Selective targeting of critical and emergent needs: gaps in the children's continuum of services; growing trauma in the population.

DISCUSSION ISSUES

The Committee may be interested in exploring the following questions with participants:

Higher Education:

- What is being done locally to recruit and prepare students to go into high demand fields, e.g., child psychiatrists, therapists with diverse language capabilities, etc.?
- How do local institutions identify areas of graduate or undergraduate study to offer in fields where there is job demand? How do local institutions develop programs that convey core competencies and effective practice?
- What counseling and information is made available to students who may be interested in high demand fields? How frequently is information on workforce demand updated?
- How does UMBC-USG work with Montgomery College to articulate students into these fields of study?

DHHS

- To what extent are staffing levels of behavioral health clinical staff inadequate? How will this change with the implementation of the Affordable Care Act? What standards would the Department use to establish adequacy of staffing levels, e.g., minimum wait list, standard caseloads, etc.?
- To what extent do County policies address core needs of the behavioral health workforce? See Goal 3 above.
- What additional strategies can the Department implement to recruit and develop a more diverse and stable workforce? What strategies would be most effective in improving the

recruitment and retention of positions that are the most difficult to fill? What are the resource implications of implementing these strategies?

- What is the Department doing to actively foster leadership development in its workforce? Are there any other strategies to develop core leadership competencies?

All

- What ways can local institutions collaborate with local government to increase awareness about service needs and career and educational opportunities and grow the pipeline of new recruits to the field?

This Packet Contains: ©

DHHS—Social Worker Positions in Each Service Area

Aging and Disability Services:

Social Workers are deployed in the following programs:

Assessment and Continuing Case Management Services

The following programs employ Social Workers at the II, III and IV levels:

Adult Services Intake (ASI) is the central point of entry for Montgomery County citizens who need to access county services (Senior Care Funds, In Home Aide Service, Group Home Subsidy through the Adult Foster Care program, Senior Care Funds, Public Guardianship, and assessments through Social Services to Adults). ASI is also the unit that processes referrals for investigations of abuse, neglect, self-neglect, and financial exploitation of vulnerable adults.

Adult Protective Services law requires mandatory reporting for health practitioners, police and human service workers who find evidence of abuse or neglect. APS staff investigates maltreatment allegations, assists clients in securing needed resources, provides ongoing case management as well as community and professional education to promote the health, safety and welfare of adults age 18 and over who are at risk in the community and lack the physical or mental capacity to protect their own interests.

Adult Evaluation and Review Services provides assessment, care planning and short-term case management to the frail elderly and to adults with disabilities age 18 and older who are at risk of institutionalization. High-risk abuse and neglect clients and clients seeking access to medical assistance waiver programs to prevent institutionalization receive mandatory AERS assessments.

Note: The medical evaluations are conducted by Community Health Nurses [CHNII] and the plans of care are reviewed and approved by a Social Worker.

Social Services to Adults (SSTA), as a voluntary (i.e., non-mandated) statewide program, provides assessment, crisis intervention and voluntary care/case management to persons 18 years and older with physical and/or mental impairments. The SSTA program, which includes the Senior Care program in Montgomery County, provides case management and gap-filling resources for seniors with severe to moderate functional disabilities and defined, limited financial resources. It also provides professional social work and nursing assessments (as needed), service linkages and coordinates in-home supports for customers that seek to remain safely in the community in the least restrictive.

Public Guardianship provides surrogate decision making for adults 18 years of age and older who are adjudicated as incompetent by the Circuit Court and who have no one else willing or able to make decisions that are in their best interest for them. Services address clients' basic needs and are an intervention to remedy and/or prevent high-risk abuse, neglect or self-neglect. The **Vulnerable Elderly Initiative Program (VEPI)** works with Public Guardianship to protect vulnerable seniors. VEPI provides assessment and care planning services to adults age 18 and older living in the community who need assistance in accessing and implementing supportive services to prevent abuse, neglect or self-neglect and remain safely in the least restrictive living arrangement. These services help to ensure the provision of a client's basic needs and activities of daily living.

Waiver for Older Adults (WOA)

The MA Waiver enables eligible older adults to remain in a community setting by establishing services typically covered by Medicaid in long term care facilities, to be provided to eligible persons in their own home or in an assisted living facility. Services provided are based on individual need and are established in the individual's plan of care. The recipient must be at least 50 years of age, have a monthly income of no more than 300% of SSI level, assets of no more than $2000 or $2500 depending on eligibility category, and be determined to be in need of nursing home level of care.

Case Management is provided during regular business hours and includes the establishment of a safe plan of care, regular reviews and revisions to the plan, establishment and oversight of services. The two SW IV's in this unit approve the plans of care for the clients.

Home Care Services

An individual is eligible for Home Care Services/Personal Care Services if the individual is receiving case management and requires the service as part of a treatment plan; is unable to obtain the necessary paraprofessional services from another resource; is willing to accept Home Care; and agrees to pay any fee required according to a fee schedule. An individual is eligible for **Chore Services** if the individual is unable to obtain the necessary paraprofessional services from another resource; and is a frail senior or an individual with a disability who can provide his/her own personal care but needs assistance with chores to help the individual remain in his/her home.

The **Personal Care/In-Home Aide** program provides vital services in the home for low-income frail elderly (75%) and people with disabilities (25%). These vulnerable individuals have physical and/or mental disabilities that severely limit their ability to perform daily tasks, such as bathing, dressing, walking, feeding or toileting. The in-home support services help vulnerable individuals remain safely and cared for in the community and the services help to prevent premature institutionalization.

The Home Care **Chore Services** program provides services in the home for low-income frail elderly (52%) and people with disabilities (48%) who need help with light cleaning, vacuuming, laundry, grocery shopping, and/or meal preparation in order to remain in their own homes and in the community.

In-Home Care Services, a CHN II monitors the health related activities of the merit aides and the two SW IV's supervise and monitor client plans of care performed by the merit aides and under contract.

Assisted Living Services

Adult Foster Care (AFC). AFC provides case management and subsidized assisted living to persons with disabilities and frail seniors by providing services in family homes (usually 1-2 people) and assisted living facilities (4 and more). Montgomery County provides about $800,000 in General Funds to increase the number of placements available through State funds. Montgomery County chooses to use COMAR to regulate the placements it pays for with County General Funds.

Ombudsman Services

The **Ombudsman Services** program uses County staff and supervised volunteers to remedy problems on behalf of long-term care (Nursing Home and Assisted Living Facility) residents.

Behavioral Health and Crisis Services:

There are 3 positions in BHCS: One social worker works in Adult Behavioral Health Services and two work in Child and Adolescent Mental Health clinics (one is a family intervention specialist working with Juvenile Justice youth).

Children, Youth and Family Services: All but one of the 149 social worker positions in CYF are assigned to Child Welfare. There is one social worker in the Linkages to Learning Program. Here are CW responsibilities:

Child Protective Services--(CPS) Social Workers follow up referrals alleging child physical and sex abuse or neglect. Social Workers provide crisis intervention services to resolve problems that lead to child maltreatment.

CPS In-Home Services--Social workers provide ongoing home based intervention with families whose children can safely remain in their homes following an investigation for abuse and neglect.

Family Preservation--Social workers provide intensive, home-based, time-limited services to families in crisis. The goals are to keep children safe in their homes and to help the family resolve problems.

Foster Care--Social workers provide case management and support services to children, families and foster parents when temporary out of home placement is necessary. Interventions are focused on achieving long term stability and safety for the child in a nurturing family. Reunification is the most likely outcome after parents participate in services.

Independent Living--Social workers provide assistance and support for youth in transition from foster care to living independently. Services promote self sufficiency through mental health services academic achievement, job training and life skills classes.

Foster and Adoptive Parents Program--Social workers complete a home study with persons who want to become foster or adoptive parents. The process helps match children in need of out-of-home placement with an appropriate family. The social workers provide support and assistance to the foster families and children placed.

Public Health Services:

All 8 positions are assigned to Division of Communicable Disease and Epidemiology and work with STD and HIV clients.

Special Needs Housing:

Social Workers in Special Needs Housing work in the following areas: Homeless Services and Housing Stabilization Services. Activities include contract monitoring, assessment for family shelter, homelessness prevention; and case management to homeless, formerly homeless and at-risk customers to stabilize their housing situations.

Montgomery County, Maryland
Montgomery College

Mental Health Associate A.A.S.

Mental Health Associate A.A.S. (TP/SS)

Students who plan to major in mental health associate will be assigned the temporary major of pre-mental health associate, with POS code 560, until they are officially admitted to the mental health associate program. Students may take preparatory courses and courses that fulfill general education requirements during the waiting period. As an alternative to being assigned a temporary major, students waiting for admission to the mental health associate program may choose to major in general studies or any other open-admission program. The Office of Admissions, Records, and Registration at Takoma Park will assign a matriculated code once students are admitted to the mental health associate program.

This curriculum is designed to educate a mental health generalist who is trained for a variety of related occupations, rather than for a specific job. Students study a core of general education subjects combined with specialized courses related to a wide spectrum of human services. Part of the curriculum consists of supervised field experiences in several different kinds of agencies and institutions in the field of human services such as those in mental health, mental retardation, gerontology, drugs and alcohol rehabilitation, corrections, and school systems, and in culturally disadvantaged areas.

The mental health associate curriculum has three objectives: (1) to prepare the career student who wants a technical curriculum for immediate paid employment upon graduation, (2) to provide the transfer student with an adequate and yet flexible background so that study may be continued in the field of psychology or some allied field such as sociology or social work, and (3) to permit a student to continue with an education on a part-time basis, while being gainfully employed.

In addition to the general requirements for admission to the College, applicants will be interviewed by the coordinator of the mental health associate curriculum. Personal characteristics such as maturity, aptitude, motivation, previous experience, and evidence of ability to complete the curriculum will be considered.

In addition to the scholastic standards required of all students at the College, students in the mental health associate curriculum are expected to achieve a grade of C or better in each mental health and psychology course. Completion of all requirements for this curriculum will lead to the award of the A.A.S.

A suggested course sequence for full-time students follows; part-time students should consult an adviser.

General Education Requirements		
Foundation Courses		
	English foundation	*3*
HE 100	*Principles of Healthier Living (HLHF)*	*1*
	Mathematics foundation	*3*
	Speech Communication	*3*
Distribution Courses		
	Arts or humanities distribution	*3*
	Behavioral and social sciences distribution	*3*
	Natural sciences distribution with lab	*4*
Program Requirements		
EN 101	Techniques of Reading and Writing I *	3
MH 101	Introduction to Mental Health I	3
MH 102	Introduction to Mental Health II	3

MH 112	Group Dynamic I	3
MH 200	Practicum / Fieldwork †	12
MH 208	Activities Therapies	3
MH 213	Group Dynamics II	3
PY 102	General Psychology	3
PY 221	Introduction to Abnormal Psychology	3
	PY Elective	3
	Elective	1
		Total credit hours 60

* EN 101 if needed for EN 109/109 or general elective

† Students must complete two practicum experiences to complete this course of study, each of which is worth 6 credits. Register for MH 200 to gain credit for each fieldwork.

Program Outcomes for the Mental Health A.A.S. Degree

Upon completion of this program a student will be able to:

- Demonstrate an understanding of the history of the mental health movement as it relates to human service professionals.
- Demonstrate an understanding of the current trends in the delivery of human services.
- Demonstrate an understanding of the characteristics of the effective human service professionals.
- Apply interview and related skills to demonstrate that they can communicate effectively in verbal and written language.
- Synthesize skills and knowledge learned in class.
- Apply skills learned through agency paper assignment and be able to communicate effectively in verbal and written language.
- Demonstrate an understanding of group dynamics theory.
- Demonstrate an understanding of the role of art and creativity in expressive arts therapies.
- Apply non-verbal communication skills to fieldwork.
- Demonstrate an understanding of leadership skills and the application of current group methods.
- Apply skills learned from fieldwork assignment and to communicate effectively through verbal and written language.

Refer to course description pages to identify courses with prerequisites.
Courses in italics meet General Education requirements.

Montgomery College
Montgomery County, MD

240-567-5000

Montgomery College endless possibilities — Montgomery County, Maryland

HELP

ARTD-Arts BSSD-Behav. & Social Sci. HUMD-Humanities NSLD-Nat. Sci. with Lab NSND-Nat. Sci. NO lab [M] - Multicultural
CE -- Credit by Exam available (...only) -- offered only on indicated campus(es) G - Germantown R - Rockville TP - Takoma Park

Course	Course Title	Semester Hours	Subject

MH 101 INTRO MENTAL HEALTH I 3 semester hours MH-Mental Health

Course Description: First of two related courses (with MH 102). An introduction for beginning mental health students in their training toward becoming responsible, aware agents-for-change in their communities. MH 101 covers history, concepts, roles, and institutions of the mental health field. Emphasis on the role of the mental health associate and development of a conceptual frame of reference. Exploration by the beginning student of area facilities. (TP only) PREREQUISITE: Consent of department. Assessment levels: EN 101/101A, MA 100, RD 120. Three hours each week.

MH 102 INTRO MENTAL HEALTH II 3 semester hours MH-Mental Health

Course Description: Second of two related courses (with MH 101, which must be taken first). An introduction for beginning mental health students in their training toward becoming responsible, aware agents-for-change in their communities. MH 102 provides skill training in the use and the application of the tools of mental health workers, such as interviewing, behavior modification, diagnostic and evaluative methods, research, community mental health approaches, and other skills as the need arises. A continual discussion of professional ethics and responsibilities is maintained throughout the course. (TP only) PREREQUISITES: MH 101 and consent of department. Three hours each week.

MH 112 GROUP DYNAMICS I 3 semester hours MH-Mental Health

Course Description: First of two related courses (with MH 213). These two courses are to be taken consecutively in order to provide a continuous one-year experience. Focus is on helping students to realize their potential for growth more fully and to increase their ability to work with others in a variety of situations. Experiential learning is directed toward the development of self-insight and awareness of impact upon others through a variety of techniques. Lectures, discussion, and reading materials are directed to an understanding of group processes, including factors of cohesion, leadership, conflict, individual roles, communication systems, tasks, and problem solving. (TP only) PREREQUISITES: PY 102 (or concurrent enrollment) and consent of department. Two hours lecture, two hours laboratory each week.

MH 200 FIELD WORK MENTAL HEALTH 6 semester hours MH-Mental Health

Course Description: Provides a continuous fieldwork experience in mental health and other human services. Students are assigned to a community human services facility. Their participation is supervised by the instructor and appropriate personnel at the facility. The seminar on campus provides an opportunity for the students to discuss concepts of working in a helping relationship; to verbalize and to learn to handle their feelings about the work experience; and to continue the study and applications of human services worker skills,

such as case study methods, testing procedures, interviewing, behavior modification, communication problems, group activities, counseling, and staff relations. In the second semester, training will continue as in the first semester, but with increasing responsibility. Students will be working at a more sophisticated level, using more independent judgment and discrimination. Practice, using group process skills both as leader and group member in various client and staff relations, will be added to fieldwork. Each student will be expected to find an area of special interest and to gain some expertise in it through more practice and experience. (TP only) (CE) PREREQUISITES: MH 101 and MH 112. Two-hour seminar each week, 200 hours fieldwork each semester. Course may not be repeated more than two times.

HELP

ARTD-Arts BSSD-Behav. & Social Sci. HUMD-Humanities NSLD-Nat. Sci. with Lab NSND-Nat. Sci. NO lab [M] - Multicultural
CE -- Credit by Exam available (...only) -- offered only on indicated campus(es) G - Germantown R - Rockville TP - Takoma Park

Course	Course Title	Semester Hours	Subject
MH 208	ACTIVITY THERAPIES	3 semester hours	MH-Mental Health

Course Description: Laboratory study and experience of a survey of treatment approaches used in various activity therapies selected from art, music, dance, occupational and recreational therapies, and storytelling. Experience with methods of nonverbal communication. (TP only) PREREQUISITES: PY 102 and consent of department. Three hours each week.

MH 213	GROUP DYNAMICS II	3 semester hours	MH-Mental Health

Course Description: Second of two related courses (with MH 112, which must be taken first). These two courses are to be taken consecutively in order to provide a continuous one-year experience. Focus is on helping students to realize their potential for growth more fully and to increase their ability to work with others in a variety of situations. Experiential learning is directed toward the development of self-insight and awareness of impact upon others through a variety of techniques. Lectures, discussion, and reading materials are directed to an understanding of group process, including factors of cohesion, leadership, conflict, individual roles, communication systems, tasks, and problem solving. (TP only) PREREQUISITE: MH 112. Two hours lecture, two hours laboratory each week.

Try a new search.

DEPARTMENT OF SOCIAL SCIENCES

MY MC LOGIN Montgomery College opens possibilities

A Word about Transferring

In order to accept credits earned from this program, four-year institutions require the students to have earned the Associate of Applied Science (A.A.S.) degree. The Mental Health Associate Program has been designed to ensure a seamless transfer of all 60 credits to the University of Maryland, Baltimore County (UMBC), which has a well-regarded social work program. Students transferring to UMBC can complete their social work degree at UMBC Shady Grove Campus. In addition, many students transfer to Bowie State, Catholic University, Hood College, and the University of Maryland College Park.

For Undergraduate Program:
The UMBC at Shady Grove, Department of Social Work
http://www.umbc.edu/shadygrove
The Social Work Program at UMBC is part of the University of Maryland's Department of Social Work. The School offers undergraduate social work program.

The University of Maryland BC
School of Social Work - http://www.umbc.edu/socialwork/
The Baccalaureate Social Work Program at UMBC is part of the University of Maryland's School of Social Work. The School offers a continuum of social work degree programs - - baccalaureate, masters, and doctorate.

Major in Social Work at The Catholic University of America:
http://ncsss.cua.edu/
Social work is an exciting profession for undergraduates who want to work with people. Social work majors at the undergraduate level are eligible for licensure as social workers in many localities.

School of Professional Studies at Bowie State University
http://www.bowiestate.edu/academics/departments/social/
The academic programs empower students to become leaders by providing the foundations of essential theory and practice that prepares them for beginning roles in various service-oriented professions.

Social Work at Hood College:
http://hood.edu/academics/sociology-and-social-work/index.html
The Hood College Social Work major is accredited by the Council on Social Work Education. This accreditation gives graduates the opportunity to apply for advanced standing at many graduate schools of social work, which allows students to earn a master's degree in Social Work (M.S.W.) with one additional year of graduate study.

The UNIVERSITIES at Shady Grove

Published on *The Universities at Shady Grove* (http://shadygrove.umd.edu)

Social Work (B.A.)

Program Information

UMBC's B.A. degree in Social Work prepares students for generalist social work practice with individuals, families, groups and communities at the beginning level. Students learn a range of skills and helping techniques that will enable them to intervene effectively in addressing social problems.

The program is fully accredited by the Council on Social Work Education, a national organization founded to promote and improve the quality of education in social work. Based on this accreditation, students are assured that the quality of education at UMBC meets national standards and prepares them for employment at the bachelor's level, for graduate study and for meeting the various state licensing and employment requirements for social work practice. Graduates qualify to take the state examination to become licensed social work associates in the State of Maryland.

Graduates of the UMBC program are successful in the job market, as well as in graduate school. Alumni are employed in various human-service positions with federal, state and local governments, as well as with nonprofit agencies, corporations, health care organizations and hospitals.

The undergraduate social work major at UMBC is affiliated with the University of Maryland School of Social Work. As such, students completing the social work major at UMBC with an overall GPA of 3.0 or better in their final 60 credits may be eligible for consideration for advanced standing in the master's degree program in the School of Social Work.

Completion of the accredited program at UMBC also qualifies graduates for consideration for admission to all accredited master's degree social work programs in the United States. Social work builds on and is integrated with a liberal arts base that includes knowledge in the humanities and the social, behavioral and biological sciences. The course of study in social work at UMBC includes social work practice methods, social welfare policy and services, human behavior and the social environment, statistics and social research, and participation in direct services through an intensive field-work experience in a community based social service department or agency.

For more information, please contact Program Director Katherine (Katie) Morris, LCSW-C at 301-738-6312 or kath@umbc.edu.

The UNIVERSITIES at Shady Grove

Published on *The Universities at Shady Grove* (http://shadygrove.umd.edu)

Psychology (B.A.)

Program Information

The Bachelor of Arts in Psychology is an exciting discipline, and at UMBC @ Shady Grove, students can share and participate in that excitement!

The UMBC's Psychology department provides an exceptional opportunity for students to see how basic laboratory research can be translated into treatments, interventions, and policies that improve the quality of life. Interested undergraduates learn from professionals in the field and have the opportunity to participate in research projects and internships. In recent years, students have participated in studies that look at the ways in which people make judgments on qualifications of people in the service industry based on the ethnicity of their names, how people approach or avoid their goals and the ways in which it relates to their fear of failure, and also the ways in which messages in the media can influence pre-adolescents.

The UMBC Psychology program offers concentrations in various areas for students to do in-depth exploration. The USG campus fully supports the following concentrations:

- Developmental Psychology
- Human Services Psychology

Students choose to major in psychology for many different reasons. Some students see the psychology major as the first step towards a career as a psychologist and plan to continue their studies in graduate school. Other students choose psychology because it fits into their more immediate occupational plans; majoring in psychology is a good way to start a career in social work as well as many other social service and public sector professions. Psychology is also often a first step toward careers in advertising, business, civil service, personnel/human relations, public relations or any other field that includes extensive work with people.

Many psychology majors go on to law or medical school. Finally, many students major in psychology just because it is interesting and fun. (If you ask your instructors, you are likely to find most of them started in psychology because they simply enjoy psychology!)

The Universities at Shady Grove
9630 Gudelsky Drive

(11)

Domain Areas and Additional Information for the Psychology B.A.

This page is for your information – it does not need to be printed or brought to the advising session.

In addition to the CORE (PSYC 100, 331, & 332) and Upper Area requirements (at least one 300 and at least one 400-level course)[2] Psychology BA Majors must take at least one course from each of the 6 areas; Minors must take at least one course from 5 of the 6 areas in addition to Introductory Psychology:

No more than three courses at the 200-level may be used towards the major or minor

Learning and Cognition (L&C)	**Social, Personality, and Abnormal (SP&A)**
PSYC 210 Learning	**PSYC 285** Abnormal *(MC: PY221, FCC: PS206))*
PSYC 316 Language and Thought	**PSYC 340** Social *(MC: PY211, FCC: PS202*
PSYC 317 Cognitive Psychology	**PSYC 380** Personality *(MC: PY204)*
PSYC 360 Motivation	**PSYC 382** Child and Adolescent Psychopathology
Biological Bases of Behavior (BBB)	**Developmental (DEV)**
PSYC 335 Physiological Psychology	**PSYC 200** Child Developmental Psyc *(MC: PY215)*
PSYC 370 Sensation & Perception	**PSYC 304** Adolescent Psyc *(MC: PY216)*
PSYC 375 Neuroanatomy	**PSYC 305** The Exceptional Child
PSYC 390 Neuropsychopharmacology	**PSYC 307** Psychology of Aging
	PSYC 365 Children with Disabilities
Culture, Diversity & Context (CD&C)	**Applied (AP)**
PSYC 230 Psychology and Culture	**PSYC 308** Child Maltreatment
PSYC 330 Child Development and Culture	**PSYC 320** Psychological Assessment
PSYC 356 The Psychology of Sex and Gender	**PSYC 324** Introduction to Interviewing Techniques
PSYC 357 Psychology of Women *(MC: PY207)*	**PSYC 342** Aggression and Anti-Social Behavior
PSYC 387 Community Psychology	**PSYC 345** Introduction to Clinical Psychology and Psychotherapy
	PSYC 346 Industrial/Organizational Psychology
	PSYC 385 Health Psychology

General UMBC Notes:

- UMBC requires 120 credits for graduation; the final 30 credits may not be transferred from an outside institution.
- Students may transfer a maximum of 60 credits from a two-year school to UMBC and a maximum of 90 credits from a four-year school.
- Once enrolled in a degree program at UMBC, courses listed in ARTSYS may no longer apply. Students will need to check with their advisors and complete a Verification of Transferability (VoT) form in order to ensure proper transfer of coursework. To access the form, go to http://www.umbc.edu/registrar/Pages/forms.html. IMPORTANT: If you are ***within the last 30 credits*** when you take the course, make sure to check off the checkbox for "Residency Waiver" in the form to ensure that the course will transfer properly. You can submit the form through the RT Help ticketing system, which you can access through the "Help" dropdown within your myUMBC account.

Psychology Program Notes:

- Psychology majors at UMBC must complete at least 18 credits in Psychology at UMBC; Psychology minors must complete at least 9 credits in Psychology at UMBC.
- Psychology majors are urged to take PSYC 331 and PSYC 332 (in sequence) in the junior year; PSYC 332 is a prerequisite for 400-level Psychology electives.
- No grade lower than a "C" in any course will be counted toward the required 36 total credits for the Psychology major.
- Math Recommendation – While students who transfer from MC may use MA 110 to fulfill the Gen Ed Math requirements, MA116 (Statistics) is the recommended course to fulfill both the Gen Ed requirement and to prepare the student for the required PSYC 331-332 Experimental Methods sequence.

[2] ***Exclusions***: *for 300-level courses: PSYC 306, 397, 398, 399, and for 400-level courses: PSYC 490, 498, 499*

PRE-ADVISING WORKSHEET for UMBC@USG PSYCHOLOGY BA STUDENTS

NAME: _____, **Appointment Date:** _____, **Appointment Time:** _____

Please complete the following worksheet by logging onto myUMBC and viewing your DegreeAudit.
For support in using Degree Audit go to: http://registrar.umbc.edu/services/degree-audit/

1. General Info (GPA and Credits). For the following, please provide:

Total Number of **Academic Credits** (*(including current semester)*: ____ (out of 120 required)

Number of **Upper-Level Credits** *(including current semester)*: _____ (out of 45 required)

Number of Credits from institutions **not yet transferred** (including "in progress" credits): ____

Are you at **risk** of receiving a grade of D, F, or W in any course this semester (Y/N)? ____

What is your **current GPA** (out of 4.0): ____

When is your **anticipated graduation date**? ____

If you plan to graduate next semester, **have you applied** (Y/N)? _____

Have you completed both PE classes (Y/N)? ____ Indicate if you are eligible for waiver: ____

2. General Education Requirements. Have you satisfied all of these? Check all requirements that have been MET:

Check off which set of Gen Eds you follow, as indicated in your DegreeAudit: ☐ GEPs ☐ GFRs

☑	Requirement[1]	Notes
☐	**ENGL [Required for USG Program]**	
☐	AH (need 3 from at least 2 disciplines -- can complete at USG)	
☐	SS (need 3 from at least 2 disciplines -- can complete at USG)	
☐	**M** (Statistics is recommended for PSYC degree)	
☐	**BPS non-lab**	
☐	**BPS with Lab**	
☐	C (can complete at USG)	
☐	**L(201)**	
☐	WI Course (required for GEP Students only)	____

Do you have any questions about your Gen Ed courses and how they are being applied? If so, state:

3. Major Requirements for the Psychology B.A. Have you satisfied all of these? Check all requirements that have been MET:

☑	Major Requirement	Notes
☐	CORE: PSYC 100 [Required for entry into USG Program]	
☐	CORE: PSYC 331	
☐	CORE: PSYC 332	
☐	DOMAIN: Learning & Cognition (L&C): PSYC 210, 316, 317, 360	
☐	DOMAIN: Social, Personality, & Abnormal (SP&A) PSYC 285, 340, 380, 382	
☐	DOMAIN: Biological Bases of Behavior (BBB): PSYC 335, 370, 375, 390	
☐	DOMAIN: Developmental (DEV): PSYC 200, 304, 305, 307, 365	
☐	DOMAIN: Culture, Diversity & Context (CD&C): PSYC 230, 330, 356, 357, 387	
☐	DOMAIN: Applied Psychology (AP): PSYC 308, 320, 324, 342, 345, 346, 385	
☐	Additional 300-level PSYC: _____ (Can be a domain course if domain *met*)	
☐	Capstone 400-level PSYC: _____ *(To be taken after PSYC 332)*	

Do you have any questions about your Major courses and how they are being applied? If so, state:

[1] Gen Ed courses listed in **boldface** are not offered at the USG campus.

4. Schedule. What courses do you plan on registering for next semester? *(Review UMBC@USG's Schedule of Classes prior to your advising session)*

☑	Course	Institution	Credits	Comments
☐				
☐				
☐				
☐				
☐				
☐				
Alternative courses if one or more of the above are filled OR for Summer or Winter courses)				
☐				
☐				
☐				

TOTAL: ____ ***FT = 12 credits***

Are you interested in Course Sharing? For information and links to the schedule see the USG website.

Do you have any questions or concerns about your schedule? If so, state:

5. Additional questions to bring to your advising session.

Do you have questions about Internships or Research opportunities?

Do you have questions about graduation?

What are your post-baccalaureate plans (plans after graduation)?

Do you have questions about Graduate or Professional School?

Do you have any other questions?

6. At your advising session. What do you need to do next?

Notes based on our advising session (please write down what you need to do):

***Signature** (to complete at advising appointment): I met with my advisor and understand what we discussed in this advising session. I also understand that I am ultimately responsible for checking my online transcripts (from the UMBC web site, http://my.umbc.edu) and verifying that all of my information is correct to the best of my knowledge.*

→Signature of Student: _____ Date: ___/___/___

Table 1: Behavioral Health and Crisis Services
Clinical Staffing as of 6/13

	Grade	Grade Range	# of Emps	Average Years of Experience
Medical Doctor III - Psychiatrist	H3	$114,575 - $174,256	7	8.34
Medical Doctor IV - Psychiatrist	H4	$126,003 - $191,682	1	12.02
Social Worker II	23	$51,598 - $85,463	1	25.07
Social Worker III	24	$54,054 - $89,596	2	14.01
Supervisory Therapist	25	$56,631 - $93,944	12	19.23
Therapist I	23	$51,598 - $85,463	1	0.07
Therapist II	24	$54,054 - $89,596	94	13.59
Psychiatric Nurse Clinical Specialist	25	$56,631 - $93,944	2	17.08
Behav Health Assoc Cnslr	20	$44,900 - $74,181	15	7.30
			135	**13.15**

Social Worker IV	Class is not used in BH&CS
Supervisory Therapist (3)	Vacant
Therapist II (6) Positions	Vacant

135 Staff in place in these jobs with 33 staff with Multilingual Differentials
Average time to fill a position in BHCS 12-13 weeks

15

Table 2: HHS State of MH Profession (FTE) from Budget

	BHCS FY13 CC Approved				Other Service Areas FY13 CC Approved			
Job Title	**FTE**	**Avg Salary**	**Avg Fringe**	**Total PC$**	**FTE**	**Avg Salary**	**Avg Fringe**	**Total PC$**
Nurse Manager	1.00	78,729	25,850	104,579	8.49	92,848	28,185	121,033
Psych Nurse Clin Spec	2.00	91,513	30,554	122,067	-			-
Community Health Nurse II	2.50	85,871	29,964	115,835	148.80	83,257	28,359	111,616
Laboratory Scientist	1.00	87,792	30,934	118,726	-			-
Laboratory Assistant	1.00	41,332	11,748	53,080	-			-
Supervisory Therapist	15.00	93,315	40,071	133,386	-			-
Therapist II	**86.80**	**82,314**	**31,512**	**113,826**	0.50	65,492	39,180	104,672
Therapist II (Grouped)	**2.40**	**56,633**	**3,722**	**60,355**	-			-
Behav Health Assoc Cnslr	16.50	61,811	23,907	85,718	0.50	44,900	15,730	60,630
Social Worker III	**4.00**	**93,361**	**41,911**	**135,272**	105.10	82,861	25,030	107,891
Social Worker II	**1.00**	**90,366**	**38,678**	**129,044**	91.60	61,947	18,804	80,751
Social Worker IV	-			-	31.50	92,573	28,279	120,852
Med Doc III Physician	-			-	2.00	165,443	34,031	199,474
Med Doc III Psychiatrist	**4.00**	**172,410**	**36,766**	**209,176**	-			-
Med Doc IV Physician	-			-	1.70	180,852	57,820	238,672
Med Doc IV Psychiatrist	1.00	174,185	47,931	222,116	-			-

MONTGOMERY COUNTY GOVERNMENT Code No. 2004
ROCKVILLE, MARYLAND
(See Minimum Qualifications Below)

CLASS SPECIFICATION
MEDICAL DOCTOR
PHYSICIAN

DEFINITION OF CLASS:

This is full performance level clinical staff work providing medical treatment services to patients in a major community health program. Employees in this classification are responsible for providing direct and consultative medical care to patients, and for implementing the medical component of a community health program. Contacts are with the general public for the purpose of providing medical services and consultation; and with physicians and other health or mental health care providers at various hospitals and specialty clinics, school officials, Protective Services, court and community representatives to provide consultation, to discuss clients' medical problems and agree on courses of action, and to plan and coordinate the delivery of community health medical services. Direct patient care services, which are provided on demand and on an on-going basis, require conducting physical examinations and the lengthy, detailed questioning of patients in order to determine the nature of care required.

Work is performed under the administrative direction of a Section/Division Chief and the professional guidance/clinical oversight of the County Health Officer, or his/her designee. Mastery of and competency in one or more of the specialized fields of medicine is required. A Physician is medically responsible for all aspects of his/her patient's medical treatment program. Guidelines are of limited use, and the employee must consider a broad range of medical factors and issues. Decisions regarding what needs to be done require extensive examination and analysis to determine the nature and scope of patients' problems. The work involves isolating and defining unknown conditions and resolving critical problems, and impacts the well-being of substantial numbers of patients. Performance of this work occasionally involves some unpleasantness resulting from exposure to blood and other body fluids when conducting physical examinations, drawing blood, and giving injections. A Physician is exposed to some risk due to contact with blood-borne pathogens such as hepatitis and HIV, and other contagious diseases. This work involves some standing, bending and occasional lifting of up to fifty pounds in caring for patients. Work may involve evening hours, shift and/or weekend work.

EXAMPLES OF DUTIES: (Illustrative Only)

Provides a broad spectrum of direct clinical and evaluation services to individuals and families in clinics, schools, and elsewhere in the community as needed to implement community health programs for all ages.
Maintains appropriate patient records, data, test results and statistics; posts appropriate results and notations in patient charts; and prepares reports.
Maintains medical care quality standards.
Provides medical consultation to Area Health Center staff of various other disciplines, school health teams and faculty members of assigned public schools, and personnel of other agencies.
Refers patients as required for further medical diagnosis, treatment,
and/or extended follow up by other providers; acts as medical liaison between the agency and other providers regarding individual case management.

Attends Juvenile/Criminal Court hearings and testifies as an expert witness.
Implements the medical component of a community health program and provides medical input into planning health services in an assigned area.
Provides counseling and health education to groups and individuals.
Provides data to document medical problems encountered, in order to evaluate medical services rendered; and participates in the analysis of these data.
Provides consultation to Nurse Practitioners under a defined contractual relationship as required by the State, and defined by the Department of Health and Mental Hygiene.
Directs or participates in staff meetings and conferences.
Participates as medical member in interdisciplinary case conference and management for individual patients, serving as Team Leader or Team Medical Director providing leadership and consultation to a team of health professionals.
Participates in special studies, projects, and other related activities.
Attends professional meetings and Continuing Medical Education courses required to maintain licensure.
Contributes to and participates in agency in service training.
Performs other related duties as required.

MINIMUM QUALIFICATIONS:

Physician I (Grade H1 - Class Code 112004)
Experience: Completion of one (1) year post graduate work(PGY1).
Education: Graduation from an accredited medical school with a degree of Doctor of Medicine, or from an accredited school of osteopathic medicine with a degree of Doctor of Osteopathy; and successful completion of PGY 1.
Equivalency: None

Physician II-Not Board Certified (Grade H2 - Class Code 122004)
Experience: Completion of three (3) years post graduate work (PGY 3) that is recognized by the American Board of Medical Specialties.
Education: Graduation from an accredited medical school with a degree of Doctor of Medicine, or from an accredited school of osteopathic medicine with a degree of Doctor of Osteopathy.
Equivalency: None
Certification: None

Physician III* - Board Certified Grade H3 - Class Code 132004)
Experience: Completion of three (3) years post graduate work (PGY 3) that is recognized by the American Board of Medical Specialties.
Education: Graduation from an accredited medical school with a degree of Doctor of Medicine, or from an accredited school of osteopathic medicine with a degree of Doctor of Osteopathy.
Equivalency: None
Certification: Certification by the American Board of Medical Specialties in an appropriate field of study.

Physician IV - Board Certified in a Subspecialty Area (Grade H4 - Class Code 142004)
Experience: Completion of five (5) years post graduate work (PGY5).
Education: Graduation from an accredited medical school with a degree of Doctor of Medicine, or from an accredited school of osteopathic medicine with a degree of Doctor of Osteopathy
Equivalency: None Certification: Certification by the American Board of Medical Specialties in a subspecialty.

(18)

Knowledge, Skills and Abilities:
Thorough knowledge of the principles, practices, methods and techniques of the appropriate medical specialty.
Thorough knowledge of the principles and practices of preventive medicine.
Thorough knowledge of current developments in the public health field.
Thorough knowledge of selected pharmaceuticals, their desired effects, side effects, and complications which may arise from their use.
Thorough knowledge of the roles, responsibilities, and inter relationships of the various disciplines that provide health care and related services.
Thorough knowledge of and ability to enforce applicable laws, regulations, practices, and procedures governing health care and related services.
Knowledge of the principles and practices of health care administration.
Ability to plan, organize and implement the medical component of a community health program.
Ability to effectively interview, examine, and assess patient condition.
Ability to distinguish between different shades of skin color in order to assess patient wellness, i.e. cyanosis, pallor, jaundice, and color of lesions.
Ability to establish and maintain effective and cooperative working relationships with members of the community health care staff, with the staff of private and public agencies, and with individuals concerned with the provision of health care services.
Ability to communicate clearly and effectively, both orally and in writing.
Ability to attend meetings or perform other assignments at locations outside the office.

LICENSE:
At time of appointment, possession of a valid license to practice medicine issued by the Maryland State Board of Medical Examiners; and Federal and State licenses to prescribe drugs, from the Drug Enforcement Agency and State of Maryland Department of Health and Mental Hygiene Division of Drug Control, respectively.

PROBATIONARY PERIOD:
Individuals appointed to this class will be required to serve a probationary period of twelve (12) months, during which time performance will be carefully evaluated. Continuation in this class will be contingent upon successful completion of the probationary period.

MEDICAL PROTOCOL: Limited Core Exam.

*Budget Level

Class Established: November 1965
Revised: April 1969
May 1976
October 1985
May 1990
July 1990
February 1994 (M)
July 2003(M)
December 2005
July 2006
April 2013

Formerly titled: Physician II

MONTGOMERY COUNTY GOVERNMENT Code No. 2755
ROCKVILLE, MARYLAND Grade 23

CLASS SPECIFICATION

THERAPIST I

DEFINITION OF CLASS:

This is entry level professional clinical counseling involving the application of counseling principles and methods in the diagnosis, prevention, psychotherapeutic treatment, and amelioration of psychological problems, emotional conditions, substance use disorders or mental conditions of individuals, families and/or groups. Contacts are with clients served, their families, County Government health care professionals and other public and private treatment providers and health care agency representatives for the purpose of providing/coordinating direct treatment services, consultation, referral, exchanging information and resolving problems. The public service and assistance involves intensive interaction with clients during counseling therapy.

An employee in this class provides psychotherapeutic counseling to assist the client in improving functioning, obtaining symptom relief, preventing psychosocial dysfunction or changing personality. The employee receives close supervision from a licensed therapist, receiving progressively more complex case assignments as the on-the-job training progresses. The employee's work is reviewed through records, conferences and observations. Available guidelines include professional psychotherapy and counseling principles, methods, and theories; diagnostic and evaluative standards of practice; Federal, State and County laws and regulations; and established departmental policies and procedures. Available guidelines are not directly applicable to all situations, and the employee must exercise judgment in interpreting the guides. Work involves identification of issues and conditions (e.g., history, symptoms, behavior, etc.) in each case; assessment of those issues and conditions (e.g., type and level of clinical/mental health needs, personal risk/public safety threat, case management needs, eligibility determination, etc.) and selection of a course of action from many alternatives (e.g., therapeutic approach, intervention and treatment; referral to public/private sector for mental health, medical or social services; report to enforcement authorities, etc.) The employee's work has an effect on the well-being of clients and their families, the accomplishment of program objectives and the general safety and productivity of the community. Work is primarily sedentary, is performed in a variety of clinical settings (e.g., crisis center, mental health center, health clinic, residential shelter, detention center) and/or home settings; and involves occasional exposure to some risk as a result of aggressive and unpredictable behavior from clients. Work may involve evening/weekend/holiday or rotating shift work.

EXAMPLES OF DUTIES: (Illustrative Only)

Under the supervision of a licensed mental health care professional, the employee provides crisis intervention therapy and direct psychotherapy and clinical counseling. Conducts comprehensive clinical assessment, mental status and diagnostic evaluation and recommends treatment plan and placement. Develops therapeutic case management services to clients who have varying presenting problems (e.g., serious mental illness; substance abuse use or relapse; emotional or mental conditions) Collects data and maintains records documenting and tracking clients' progress; documents clinical assessments, mental status evaluations, and treatment plans; prepares and maintains client files; prepares appropriate reports.
Collaborates closely with supervisor and other mental health/medical professionals and recommends diagnoses. Develop and recommends client treatment and/or care plans; makes appropriate

referrals/placements and follows up to ensure clinical appropriateness of placements.
Coordinates referrals and provides appropriate linkage for clients to community services; works closely with representatives of other agencies (private and public) involved in cases to ensure clinical coordination of services and continuity of care among various treatment/provider agencies. .
Attends case consultation staff meetings; provides recommendations regarding appropriate treatment interventions.
Performs related duties as required.

MINIMUM QUALIFICATIONS:
Experience: None.
Education: Graduation from an accredited college or university with a Master's degree in Psychology, Counseling, Social Work or a related field appropriate to the area of specialization required by the position.
Equivalency: No equivalency.
Knowledge, Skills and Abilities:
Knowledge of philosophies, practices, policies and outcomes of the most generally accepted scientifically supported models of treatment, recovery, prevention and continuing care for psychological, emotional, mental, addiction and/or substance-related disorders and conditions.
Knowledge of the established diagnostic criteria, treatment modalities and placement criteria within the continuum of care for psychological, emotional, mental, addictions and/or substance related disorders and conditions.
Knowledge of models and theories applicable to psychological, emotional, mental, addiction and/or substance disorders and conditions.
Knowledge of medical and pharmacological resources in the treatment of psychological, emotional, mental, addiction and/or substance disorders and conditions. Ability to learn the Federal, State and County policies and procedures governing the delivery of treatment services.
Ability to learn helping strategies, support systems and available community resources for referral and placement and how to tailor these mechanisms to the client.
Ability to learn to provide treatment services appropriate to the personal and cultural identity of the client.
Ability to learn to apply research findings and outcome data to improve clinical practice.
Ability to develop supportive and therapeutic relationships with clients.
Ability to learn to apply crises management skills to client crises.
Ability to learn to make constructive therapeutic responses when the client's behavior is inconsistent with stated recovery goals.
Ability to learn to work cooperatively with other professionals and agencies. Ability to learn to prepare complete client records and reports.
Ability to communicate clearly and effectively.
Ability to attend meetings and perform other assignments at locations outside the office.

LICENSE:
Employees in this class have a mandatory licensure requirement, as cited in COMAR which contains regulations governing the practice of clinical counseling/psychotherapy. One of the following licenses, issued by the State of Maryland, must be held by the employee:
Licensed Graduate Social Worker (LGSW)
Licensed Graduate Professional Counselor (LGPC)
Licensed Graduate Marriage and Family Therapist (LGMFT)

PROBATIONARY PERIOD:
Individuals appointed or promoted to this class will be required to serve a probationary period of six months, during which time performance will be carefully evaluated. Continuation in this class will be contingent upon successful completion of the probationary period.

MEDICAL PROTOCOL: Core Exam.

Class Established: January 1988
Revised: May 1996(M)
June 2001
June 2003(M)
January 2013

MONTGOMERY COUNTY GOVERNMENT Code No. 2754
ROCKVILLE, MARYLAND Grade 24

CLASS SPECIFICATION

THERAPIST II

DEFINITION OF CLASS:

This is full performance level professional clinical counseling involving the application of counseling principles and methods in the diagnosis, prevention, psychotherapeutic treatment, and amelioration of psychological problems, emotional conditions, substance use disorders or mental conditions of individuals, families and/or groups. Contacts are with clients served, their families, County Government health care professionals, other public and private treatment providers and health care agency representatives, attorneys, law enforcement agents, public school staff and/or hospital staff for the purpose of providing/coordinating direct treatment services, consultation, referral, exchanging information and resolving problems. Public service and assistance includes intensive interaction with clients during counseling therapy.

An employee in this class serves as therapist and case manager, performing a comprehensive variety of professional treatment services (e.g., preliminary diagnosis, evaluation and/or referral; crisis intervention; and/or clinical case management and service coordination) for the purpose of assisting the client in improving functioning, obtaining symptom relief, preventing psychosocial dysfunction or changing personality. Assignments are carried out independently and subject to clinical review through records, conferences and observations. The employee performs work in accordance with professional psychotherapy and counseling principles, methods and theories; diagnostic and evaluative standards of practice, i.e., Diagnostic and Statistical Manual of Mental Disorders; Federal, State and County laws and regulations; and established departmental policies and procedures. Available guidelines are not directly applicable to all situations, and the employee must exercise judgment in interpreting the guides to the specific problems and disorders presented by a client. Work is complicated by the need to identify and clinically assess, from an array of possibilities, the severity of a client's mental health and/or addiction condition; identify and develop a plan to mitigate numerous other problems and circumstances (i.e., legal, medical, homelessness, joblessness, limited referral resources, cultural/language barriers, dysfunctional relationships, lack of support network); determine safety risk of client to self and others; and, initiate appropriate level of intervention and/or treatment. The employee must be creative in matching clients, who may be resistant or hostile, to appropriate referring agencies. This class is distinguished from the next lower class by the wide variety of difficult and complex work assignments. An employee in this class is expected to be assigned a large proportion of difficult cases which require assessment of unusual circumstances, variations in approach and analysis of conflicting or incomplete data. The employee's work has an effect on the well being of clients and an impact on the success of the therapeutic program. Work, which is primarily sedentary, is performed in a variety of clinical settings (crisis intervention operations room, residential shelter, mental health center, health clinic, and detention center) and/or home settings; and involves occasional exposure to some risk as a result of aggressive and unpredictable behavior from clients. Work may involve evening/weekend/holiday or rotating shift work.

EXAMPLES OF DUTIES: (Illustrative Only)

Provides crisis intervention therapy, direct psychotherapy and clinical counseling, comprehensive clinical assessment, mental status and diagnostic evaluation, treatment planning and placement and

therapeutic case management services to diverse caseload of clients who have varying presenting problems (e.g., serious mental illness; substance abuse use or relapse; emotional or behavioral crisis including AIDS, cancer or other life threatening conditions; and victims of domestic violence, sexual assault or other crimes).
Collects data and maintains records documenting and tracking clients' progress; documents clinical assessments, mental status evaluations, and treatment plans; prepares and maintains client files; prepares appropriate reports.
Collaborates with other mental health/medical professionals to establish diagnoses, develop and implement client treatment and/or care plans; makes appropriate referrals/placements and follows up on to ensure clinical appropriateness of placements.
Coordinates referrals and provides appropriate linkage for clients to a wide range of community services to address multiply problems (e.g., financial, employment, medical, shelter, education, legal/courts, etc.); works closely with representatives of other agencies (private and public) involved in cases to ensure clinical coordination of services and continuity of care among various treatment/provider agencies.
Attends case consultation staff meetings; provides input regarding appropriate treatment interventions.
Conducts and contributes to orientation and in service training for new professional employees, students/interns and volunteers; provides guidance and assistance to paraprofessional staff and volunteers who perform crisis intervention services.
Serves on task forces and/or committees to address needs of mental health clients and make proposals for better service to this population in the County.
Appears in court as an expert witness, provides depositions, and prepares court reports.
Speaks before community, civic, and other public groups concerning available programs and services.
Performs related duties as required.

MINIMUM QUALIFICATIONS:
Experience: Two (2) years clinical experience post graduate licensure.
Education: Graduation from an accredited college or university with a Master's degree in Psychology, Counseling, Social Work or a related field appropriate to the area of specialization required by the position.
Equivalency: No equivalency
Knowledge, Skills and Abilities:
Knowledge of and ability to apply philosophies, practices, policies and outcomes of the most generally accepted scientifically supported models of treatment, recovery, prevention and continuing care for psychological, emotional, mental, addiction and/or substance-related disorders and conditions.
Knowledge of the established diagnostic criteria, treatment modalities and placement criteria within the continuum of care for psychological, emotional, mental, addictions and/or substance related disorders and conditions.
Knowledge of and ability to assess and treat psychopathology, emotional and mental disorders, personality disorders, and/or alcohol and drug disorders and the accompanying clinical dynamics appropriate to the program assignments.
Knowledge of models and theories applicable to psychological, emotional, mental, addiction and/or substance disorders and conditions.
Knowledge of medical and pharmacological resources in the treatment of psychological, emotional, mental, addiction and/or substance disorders and conditions.
Knowledge of methods of measuring treatment outcomes.
Knowledge of Federal, State and local policies and procedures governing the delivery of treatment

services, ethics, confidentiality and clinical responsibility.
Skill in tailoring helping strategies, support systems and available community resources for referral and placement to the clients' needs.
Skill in providing treatment services appropriate to the personal and cultural identity of the client.
Skill in adapting clinical practice to the range of treatment settings and modalities.
Skill in applying crisis management skills to client crises.
Ability to apply research findings and outcome data to improve clinical practice.
Ability to establish and maintain a therapeutic relationship with clients.
Ability to identify and utilize the role of family, social networks, self-help groups and community systems in the treatment and recovery process.
Ability to make constructive therapeutic responses when the client's behavior is inconsistent with stated recovery goals.
Ability to work cooperatively with other professionals and agencies.
Ability to develop therapeutic relationships with clients, some of whom may by hostile, angry, aggressive and potentially violent.
Ability to establish and maintain effective working relationships with, and to provide consultation and feedback to, a range of professional and paraprofessional staff, students and volunteers, and with representatives of public and private agencies in planning and coordinating client treatment.
Ability to prepare complete client records and reports.
Ability to communicate clearly and effectively.
Ability to attend meetings and perform other assignments at locations outside the office.

LICENSE:
Employees in this class have a mandatory licensure requirement, as cited in COMAR which contains regulations governing the practice of clinical counseling/psychotherapy. One of the following licenses, issued by the State of Maryland, must be held and maintained by the employee:
Licensed Clinical Professional Counselor (LCPC)
Licensed Clinical Marriage and Family Therapy (LCMFT)
Licensed Clinical Alcohol Drug Counselor (LCADC)
Licensed Certified Social Worker/Clinical (LCSW-C)
Certification as Advanced Practice Registered Nurse/Psychiatric Mental Health (APRN-PMH)
Licensed Psychologist

PROBATIONARY PERIOD:
Individuals appointed or promoted to this class will be required to serve a probationary period of six months, during which time performance will be carefully evaluated. Continuation in this class will be contingent upon successful completion of the probationary period.

MEDICAL PROTOCOL: Core Exam.

Class Established: September 1976
Revised: March 1981
January 1988
May 1996(M)
June 2001
June 2003(M)
January 2013

MONTGOMERY COUNTY GOVERNMENT Code No. 2753
ROCKVILLE, MARYLAND Grade 25

CLASS SPECIFICATION

SUPERVISORYTHERAPIST

DEFINITION OF CLASS:

This is first-level supervision and program management over professional clinical counseling work, providing direction to a group of professional therapist in the implementation of clinical aspects of a specific service. Contacts are with staff, department managers, County Government and community agency representatives, clients served and their families, for the purpose of exchanging information, making referrals, planning-coordinating program work and services, and resolving operational problems. This class of work may entail some interaction with clients but it is incidental to the primary focus of the supervisor/program management work performed.

An employee in this class provides administrative and clinical supervision to professional therapists and related staff in the day-to-day management of therapeutic program activities. Work is performed under the general direction of a higher level administrator. The employee alone, or in consultation with the supervisor, develops the deadlines, projects and work to be done. An employee in this class has the authority and responsibility for making recommendations and decisions in the areas of procedures, implementation of policy and the daily operations of assigned staff, to include regular participation in a variety of personnel matters. Guidelines governing the work include professional psychotherapy and counseling principles, methods and theories; diagnostic and evaluative standards of practice, i.e., Diagnostic and Statistical Manual of Mental Disorders; Federal, State and County laws and regulations; and established departmental policies and procedures. The employee has considerable latitude for independent judgment and action. Major deviations from existing policy require approval of higher level administrators. The complexity of the work is reflected in the varied and wide range of duties performed and the number of issues, factors, circumstances and alternatives that must be considered when making a decision. The employee impacts the therapeutic program supervised by providing direct input to higher level management in such areas as staffing needs assessments, planning the implementation of new or modified service delivery mechanisms, coordination of service delivery with other services, program effectiveness assessments, and development of budget projections. Work is primarily sedentary, is performed in a variety of clinical settings (e.g., crisis center, mental health center, health clinic, detention center); and involves occasional exposure to some risk as a result of aggressive and unpredictable behavior from clients in the workplace. Work may involve evening/weekend/holiday or rotating shift work.

EXAMPLES OF DUTIES: (Illustrative Only)

Supervises day-to-day program operations; plans, assigns, reviews and evaluates the work of professional therapists and other subordinate staff within the assigned program area.
Provides clinical expertise to staff regarding difficult case resolution and operational problems within the delivery system.
Develops and implements program activities and services, including training and educational activities.

Assures consistent application of and compliance with Federal, State and County regulations, policies and procedures.
Establishes and maintains liaison with other departments and governmental and private agencies to resolve systemic problems and to develop and coordinate client services.
Evaluates program service areas; analyzes program data; submits activity reports; provides input/projections for budget submissions; recommends ways and means for improving service delivery and cost effectiveness.
Develops, interprets and monitors quality assurance standards; plans, recommends and executes quality initiatives related to mental health standards.
Serves on intra-interagency committees and task forces; develops and presents program-specific perspective related to mental health treatment and services.
Provides direct psychotherapy and clinical counseling as necessary to meet program needs and/or provide clinical training.
Speaks before community, civic, and other public groups concerning available programs and services.
Performs related duties as required.

MINIMUM QUALIFICATIONS:

Experience: Considerable (3 years) post licensure professional clinical counseling experience.
Education: Graduation from an accredited college or university with a Master's degree in Psychology, Counseling, Social Work or a related field appropriate to the area of specialization required by the position.
Equivalency: An equivalent combination of education and experience may be substituted.
Knowledge, Skills and Abilities:
Knowledge of and ability to apply philosophies, practices, policies and outcomes of the most generally accepted scientifically supported models of treatment, recovery, prevention and continuing care for psychological, emotional, mental, addiction and/or substance-related disorders and conditions.

Knowledge of the established diagnostic criteria, treatment modalities and placement criteria within the continuum of care for psychological, emotional, mental, addiction and/or substance-related disorders and conditions.
Knowledge of and ability to assess and treat psychopathology, emotional and mental disorders, personality disorders and/or alcohol and drug disorders and the accompanying clinical dynamics appropriate to the program assignment.
Knowledge of models and theories applicable to psychological, emotional, mental, addiction and/or substance disorders and conditions.
Knowledge of medical and pharmacological resources in the treatment of psychological, emotional, mental, addiction and/or substance disorders and conditions.
Knowledge of methods of measuring treatment outcomes.
Knowledge of Federal, State and local policies and procedures governing the delivery of treatment services, ethics, confidentiality and clinical responsibility.
Knowledge of clinical supervisory methods and techniques.
Considerable knowledge of the techniques associated with, and the ability to lead case consultation meetings which include case review, video taped and/or live supervision of client therapy sessions.
Ability to conduct performance evaluations and implement personnel procedures.
Ability to develop and maintain effective working relationships with subordinates, co-workers, public and private sector organizations, community groups and the general public; to provide effective consultation and feedback to a range of professional and paraprofessional staff, students and

volunteers, and representatives of public and private agencies in planning and coordinating client treatment.
Ability to provide clinical supervision, guidance and assistance to professional and paraprofessional counselors and volunteers.
Ability to prepare complete client records and narrative and statistical reports.
Ability to communicate clearly and effectively.
Ability to attend meetings or perform other assignments at locations outside the office.

LICENSE:
Employees in this class have a mandatory licensure requirement, as cited in COMAR which contains regulations governing the practice of clinical counseling/psychotherapy. One of the following licenses, issued by the State of Maryland, must be held and maintained by the employee:
Licensed Clinical Professional Counselor (LCPC)
Licensed Clinical Marriage and Family Therapy (LCMFT)
Licensed Clinical Alcohol Drug Counselor (LCADC)
Licensed Certified Social Worker/Clinical (LCSW-C)
Certification as Advanced Practice Registered Nurse/Psychiatric Mental Health (APRN-PMH)
Licensed Psychologist

PROBATIONARY PERIOD:

Individuals appointed to a position in this class will be required to serve a probationary period of twelve months and, if promoted to a position in this class, will be required to serve a probationary period of six months. Performance will be carefully evaluated during the probationary period. Continuation in this class will be contingent upon successful completion of the probationary period.

MEDICAL GROUP: Core Exam with Drug/Alcohol Screen

Class Established: September 1976
Revised: March 1981
January 1988
May 1996(M)
June 2001
June 2003(M)
July, 2008

Formerly Titled: Therapist III
Medical Protocol Revised (7/08) to include "Drug/Alcohol" screen

MONTGOMERY COUNTY GOVERNMENT Code No. 2760
R0CKVILLE, MARYLAND Grade 20

CLASS SPECIFICATION

BEHAVIORAL HEALTH ASSOCIATE COUNSELOR- Alcohol/Drug

DEFINITION OF CLASS:
This is full performance professional level work providing substance abuse assessment, short-term alcohol and drug counseling, case management services to clients with substance use disorders, and/or crisis intervention services to clients in a community crisis center, shelter, or other health/social service setting. Personal contacts are with a variety of health, mental health, social service providers and staff and legal system representatives in order to exchange information and make referrals related to clients' treatment needs, track progress, and resolve problems. The work requires detailed questioning when interviewing clients to obtain factual and sensitive information and determine crisis situation, general nature and priority of assistance needed, and appropriate level of substance abuse treatment.

An employee in this class is responsible for assisting clients who may be substance abuse dependent to obtain addiction treatment services by providing initial screening and assessment, counseling, crisis intervention as needed, referral to drug testing, addiction treatment and mental health or other health/social services. The work involves the provision of ongoing client casework, short-term counseling, referral to other services (e.g., food, shelter, child care), and tracking of clients' compliance with program requirements and progress towards stability and self-sufficiency. The employee works under the supervision of a licensed Professional Clinical Counselor, Social Worker, or supervisor of equivalent credentials (approved by the Maryland State Board of Professional Counselors and Therapists to supervise alcohol and drug counseling). The employee independently carries out day-to-day work and handles most problems that arise; however, the supervisor regularly reviews and discusses case files with the employee and is available to provide guidance in difficult or unprecedented cases. The work is performed in accordance with established State and local codes, regulations, policies, and practices and accepted professional standards and operating procedures. Judgment and resourcefulness are applied in the application of available guidelines and policies to the identification and assessment of substance abuse dependence and development and/or implementation of treatment plans. The work is made complex by the sensitivity, severity and multiple number of problems presented by the clients (e.g., substance abuse and dependence, domestic violence, sexual assault, chronic mental illness, criminal behavior, homelessness, suicide ideation, etc.) which must be assessed and prioritized by the employee in order to provide counseling, crisis intervention, and referral to substance abuse treatment and other services, as necessary. The purpose of the work is to provide clients access to addiction treatment, counseling, case management and other services in order to improve their stability and self-sufficiency. Work is generally performed in an office environment and requires ordinary physical effort associated with sitting at a desk, walking, standing, and/or driving an automobile. Visits to clients' homes have the potential for confrontation with unpredictable or aggressive individuals and appropriate measures or practices must be taken to deal with such conditions.

EXAMPLES OF DUTIES: (Illustrative Only)
Provides short term counseling and/or crisis intervention, as necessary to assist individuals through the client-counselor relationship to define goals and make decisions relating to substance abuse; plan

a course of action reflecting the needs, interests and abilities of the individual relating to substance abuse; and use informational and community substance abuse resources relating to personal, social, emotional, educational, and vocational development and adjustment.

Provides screening, comprehensive assessment of substance abuse and dependency, and referral for drug testing and substance abuse treatment and/or mental health counseling, and follow-up.

Maintains client case load and monitors compliance with substance abuse treatment and other requirements or recommendations.

Participates as a team member in the case management of clients' needs and services by providing clients' status and service/assistance needs information; collaborates with other staff to implement clients' treatment plans.

Coordinates referrals and provides appropriate linkage for clients to community services; works with other health care agency representatives to ensure coordination of services, outreach, and advocacy.

Collects data and maintains necessary case work files and records to document client progress for review with senior program staff; prepares appropriate reports and statistics for local and state agencies.

Confers with public and private sector agencies, both orally and in writing, to facilitate client's progress or in the capacity of referring individuals for services and assistance.

Performs related duties as required.

MINIMUM QUALIFICATIONS:
Experience: None beyond that required to obtain, in the State of Maryland certification as Certified Supervised Counselor, Alcohol/Drug (CSC-AD); or, Certified Associate Counselor, Alcohol/Drug (CAC-AD).
Education: None beyond that required to obtain, in the State of Maryland, certification as Certified Supervised Counselor, Alcohol/Drug (CSC-AD); or, Certified Associate Counselor, Alcohol/Drug (CAC-AD).
Equivalency: None.

Knowledge, Skills and Abilities:
Knowledge of, and the ability to apply, the theories and principles of human behavior and personality development and the principles, practices and techniques used in short term counseling.
Knowledge of intrapersonal and interpersonal substance abuse problems.
Knowledge of current social, economic, cultural, and health issues affecting individuals and their families.
Knowledge of the functions and resources of public and private agencies available for referral.
Ability to establish and maintain effective working relationships with clients and representatives of public and private referral agencies.
Ability to identify health, social service, and mental hygiene resources and appropriately link individuals to these resources.
Ability to interview clients and ascertain facts relevant to follow-up assessments by licensed mental health professionals.
Ability to work effectively with individuals who have social, economic, emotional, behavioral, or mental health problems.

Ability to communicate effectively both orally and in writing.
Ability to maintain records and prepare reports.
Ability to attend meetings or perform other assignments at locations outside the office, if necessary.

LICENSE:

Certification, in the State of Maryland as a Certified Supervised Counselor, Alcohol/Drug (CSC-AD); or, Certified Associate Counselor, Alcohol/Drug (CAC-AD).

PROBATIONARY PERIOD:

Individuals appointed or promoted to this class will be required to serve a probationary period of six months, during which time performance will be carefully evaluated. Continuation in this class will be contingent upon successful completion of the probationary period.

MEDICAL PROTOCOL: Core Exam - Drug Alcohol Screen

Class Established: May, 2005

MONTGOMERY COUNTY GOVERNMENT Code No. 2807

ROCKVILLE, MARYLAND Grade 23

CLASS SPECIFICATION

SOCIAL WORKER II

DEFINITION OF CLASS:

This is professional social work at the full performance level. Employees provide a wide range of social work services in a residential facility, local health clinic, school, or local social services environment. Personal contacts are with individuals both in and outside the County Government for the purposes of providing professional advice, discussing unusual case situations, or for coordinating systems of service delivery with other units or agencies. Employees in this class provide direct professional assistance or care to clients involving intense interaction and counseling therapy.

Social workers may function on an interdisciplinary team and perform therapeutic activities which require knowledge and skill in a wide range of social work principles and methods. Social workers also coordinate a social support system to promote satisfactory adjustment in the community. In a clinic or local health program, social workers are responsible for social work planning and treatment including individual, family and group intervention, long range therapeutic counseling or other support services to assist clients and to help them in obtaining a more satisfactory social, economic, emotional or physical adjustment. Employees in this class plan and carry out the successive steps required to accomplish objectives, in accordance with Agency policies, professional training and/or accepted practices in the field. Guidelines for the work, such as State/County Codes, program regulations, and professional manuals are available but do not cover unusual aspects of the work. The work is usually supervised by a higher level social worker who evaluates case records and provides guidance or advice for unusual or difficult problems through periodic conferences. The work consists of duties involving a variety of processes and methods including client casework, community intervention, family therapy, and/or group counseling. The work involves treating a variety of psychosocial problems, crises, and situations in accordance with established criteria. The work of this class is generally performed in an office environment but may require occasional visits to clients' homes to render social work services. There are no unusual physical demands associated with this work.

EXAMPLES OF DUTIES:

Obtains pertinent data from clients, members of their families and others to assess socioeconomic, emotional or health problems.

Identifies and recommends appropriate resources to minimize problems and develops, with the client, a plan of action for services and follow-up;

Provides counseling to clients and members of their families to aid them in achieving a more satisfactory social functioning.

Provides preventive, protective or supportive services to individuals or groups threatened by situations detrimental to their well being or that of the community.

Participates in conferences concerning treatment plans for individuals.

Participates in discussions of policies and procedures relating to eligibility and coordination of community services.

Works in close cooperation with staff in other social, health, education and related agencies to meet the needs of clients.

Interprets the social service program to applicants, clients and other professional staff.

Composes reports and recommendations for courts and other agencies regarding individual cases.

Performs related duties as required.

MINIMUM QUALIFICATIONS:

Education: Possession of a master's degree in social work from an accredited college or university that meets the criteria of a graduate social work program accredited by the Council on Social Work Education.

Experience: One year experience rendering social work services.

License: Candidates must be licensed by the Maryland State Board of Social Work Examiners prior to appointment.

Notes:

1. Pertinent volunteer and/or part-time experience is acceptable.

2. Field work placement while attending a school of social work will not be considered as qualifying experience.

3. Qualifying work experience must have been obtained subsequent to receipt of the bachelor's degree.

4. These requirements are established by the Social Services Administration by authority provided in Section 1 of Article 88A of the Annotated Code of Maryland, and the Personnel Office does not have authority to accept substitution or equivalents.

Knowledge, Skills, and Abilities:

Some knowledge (at a graduate professional level) of social work principles and methods; of current social, economic and health problems and resources; of individual, family and group behavior; of ways of working effectively with adults and children who have social, emotional, economic and health problems; of normal and abnormal behavior; of methods of assessing clients' strengths, weaknesses and resources; and of methods of enhancing and developing problem solving capabilities of clients.

Knowledge of health and welfare resources; of medical terminology; of social work research; and of client advocacy.

Ability to work effectively with people and aid them in the constructive use of their capabilities in adjusting to their specific problems; to establish and maintain effective working relationships with other staff, the general public and outside agencies or institutions; to express ideas clearly and concisely, orally and in writing; to analyze case information and to make sound decisions on the basis of that information; to treat personal information discretely and confidentially; and to organize and manage a caseload.

LICENSE:

Possession of a valid motor vehicle operator's license when required for job-related duties.

PROBATIONARY PERIOD:

Individuals appointed or promoted to this class will be required to serve a probationary period of six months, during which time performance will be carefully evaluated. Continuation in this class will be contingent upon successful completion of the probationary period.

MEDICAL PROTOCOL: Limited Core*

* Preplacement Drug/Alcohol Screen

Date Adopted: March 9, 1963

Date Revised: June 21, 1965

Corrected: February 1984

Date Revised: July 1, 1965

Date Adopted by Montgomery County: December 1988

Date Revised: June 1995 (M)

NOTE:

This class specification is largely based on the State of Maryland class descriptions in order to ensure comparability between State and County social worker positions, and to ensure that minimum qualifications mandated by State law are met. Modifications have been made to reflect language used in the County's job evaluation system.

MONTGOMERY COUNTY GOVERNMENT Code No. 2806
ROCKVILLE, MARYLAND Grade 24

CLASS SPECIFICATION

SOCIAL WORKER III

DEFINITION OF CLASS:

This is professional social work at the proficient (clinical specialist) level. Employees are generally assigned the more difficult cases which require the application of highly developed casework or group work techniques. Employees provide a wide range of social work services in a residential facility, local health clinic, school, clients' homes, or social services environment. Personal contacts are with individuals in and outside the County Government for the purpose of providing professional advice, conducting clinical assessments, discussing unusual case situations, and/or coordinating systems of service delivery with other units or agencies. Employees in this class provide direct professional assistance or care to clients involving intensive interaction and may include counseling therapy.

The work of this class is multidisciplinary and requires knowledge of a wide range of social work principles and methods. The employee may render direct services in a particular area of social work or may be responsible for implementing, developing and directing a small unit or program. The work is performed in accordance with the objectives, responsibilities, and policies of the agency, but the employee is expected to exercise considerable initiative and independent judgment in discharging the assigned duties, and to require advice and help only on the most unusual or difficult cases. Employees in this class apply professional social work theory and methods for the treatment and prevention of psychosocial dysfunction, disability, or impairment, including emotional and mental disorders of individuals and families. The employee plans and carries out the successive steps of assignments and handles problems in accordance with policies, training, and/or accepted practices in the field. Guidelines, such as County Codes, program regulations, and professional manuals, are available but are not completely applicable to all aspects of the work and do not cover unusual situations. The work is cross-disciplinary and consists of varied duties and processes. Employees are required to make decisions in such areas as needs assessment, treatment, and evaluation. The work involves treating a variety of psychosocial problems, crises, and situations in accordance with established criteria. The work of this class may be performed in an office environment or in clients' homes. There are no unusual physical demands associated with this work.
An employee in this class works under the professional supervision of a higher level social worker. In the absence of direct social work supervision, the employee reports to an administrator and receives professional direction from the agency's headquarters staff. Assignments may involve the supervision of subordinate social services staff positions. Work effectiveness is ascertained through consultation, group conferences, and review of written communications and case reports.

EXAMPLES OF DUTIES: (Illustrative Only)

Works in close cooperation with other agency staff, and staff of other agencies to coordinate services and meet the needs of the clients.
Provides advanced and specialized clinical social work and casework, or group work services to clients and families of clients.
Conducts clinical assessments, formulates a diagnostic impression, and provides treatment services,

including psychotherapy, for mental and emotional disorders.
Consults with other social workers and other professional personnel in order to provide the best possible treatment program for clients.
Interprets the social service program to professional staff members and works with them in effecting the most efficient and integrated service.
Participates in staff conferences concerning treatment plans for individuals.
Participates in discussions of policies and procedures relating to eligibility and coordination of community services.
Reviews and analyzes case records.
Interprets the program to other staff and community organizations through conferences and group talks.
Prepares reports and maintains case records.
May be responsible for supervision of staff.
May assist in preparing and advocating a program budget.
May represent the department or center on boards or task forces, or act as a liaison with other agencies.
May plan and present continuing education presentations.
Performs related duties as required.

MINIMUM QUALIFICATIONS:

Education: Possession of a master's degree in social work from an accredited college or university that meets the criteria of graduate social work program accredited by the Council on Social Work Education.
Experience: Three years experience rendering social work services.
License: Candidates for clinical specialist positions must be licensed by the Maryland State Board of Social Work Examiners prior to appointment as Certified Social Worker-Clinical (LCSW-C).

NOTES:
1. Pertinent volunteer and/or part-time experience is acceptable.
2. Field work placement while attending a school of social work will not be considered as qualifying experience.
3. Qualifying work experience must have been obtained subsequent to receipt of the bachelor's degree.
4. One complete year of graduate social work education beyond the master's degree in an accredited college or university may be substituted for one year of experience. Applicants must submit a statement from the college/university that the advanced course work constitutes one full year toward the completion of work required for a doctoral degree.
5. A doctoral degree in social work from an accredited college or university may be substituted for two years of experience.
6. These requirements are established by the Social Services Administration by authority provided in Section 1 of Article 88A of the Annotated Code of Maryland and the Personnel Office does not have authority to accept substitutions or equivalents.

Knowledge, Skills, and Abilities:
Considerable knowledge of clinical social work principles and methods.
Considerable knowledge of individual and group behavior; of ways of working effectively with adults and children who have social, emotional, mental disorders, and health problems; of the function and organization of community health and social services programs and other resources on local, State and Federal levels; of recent developments, current literature and sources of information in social

work; of medical terminology; of the social implications of various diseases, disabilities, and work; of current social, economic and health problems and resources; and of the administrative procedures and educational techniques used in social work.
Knowledge of guidelines provided in the current edition of the Diagnostic and Statistical Manual.
Ability to plan and review the work of subordinate staff; to instruct lower level staff in clinical social work and casework techniques; to supervise and teach students in social work; to understand the effect of environmental factors and to apply this understanding to individual cases for social adjustment and rehabilitation; to maintain effective working relationships with supervisors, associates, clients, families of clients, and staff of other social, welfare, health, civic and religious organizations; to express ideas clearly and concisely, orally and in writing; to analyze case information and to reach sound decisions on the basis of such information; and to act as a consultant in the assigned area of service.
Ability to attend meetings and perform work assignments at locations outside the office.

LICENSE:

Possession of a valid motor vehicle operator's license when required for job-related duties.

PROBATIONARY PERIOD:

Individuals appointed or promoted to this class will be required to serve a probationary period of six months, during which time performance will be carefully evaluated. Continuation in this class will be contingent upon successful completion of the probationary period.

MEDICAL PROTOCOL: Limited Core*

* Pre-placement Drug/Alcohol Screen

Date Adopted: June 28, 1955
Date Revised: March 4, 1963
Date Revised: November 24, 1970
Date Revised: July 4, 1973
Corrected: February 1984
Date Revised: July 1, 1986
Date Adopted by Montgomery County: December 1988
Date Revised: June 1995 (M)
Date Revised: December 2004

NOTE: This class specification is largely based on the State of Maryland class description in order to ensure comparability between State and County social worker positions, and to ensure that minimum qualifications mandated by State law are met. Modifications have been made to reflect language used in the County's job evaluation system.

Anne Arundel County Employee Listing

Employee Status Code (A/T/L/D/N) exactly matches A and Bureau Code begins with BHS

Title	Employee Type	Salary Range
Alcohol and Drug Associate Counselor Lead	State Merit	$38,594 - $61,427
Alcohol and Drug Associate Counselor	State Merit	$36,280 - $57,567
Alcohol and Drug Supervised Counselor	State Merit	$32,091 - $50,563
Addictions Counselor	County Contractual	$39,998 - $54,995
Addictions Specialist	County Merit	$40,976 - $64,759
Alcohol and Other Drug Abuse Prevention Specialist	County Contractual	$41,600 - $45,760
Alcohol and Other Drug Abuse Prevention Supervisor	State Merit	$38,594 - $61,427
Care Coordinator	County Contractual	$32,733 - $51,575
Community Health Outreach Worker	County Contractual	$22,448 - $36,928
Community Health Nurse	County Contractual	$23,400 - $59,092
Community Health Nurse II	State Merit	$41,074 - $65,568
Community Health Nurse Supervisor	State Merit	$43.725 - $69,999
Clinical Program Supervisor	County Contractual	$60,569 - $75,005
Coordinator Special Programs (I - IV)	County Contractual	$32,091 - $61,427
Court Assessor	County Contractual	$56,160.00
Crisis Intervention Counsellor	County Merit	$40,976 - $64,759
Deputy Director, Public Health Programs	County Merit	$62,365 - $103,536
Director, Public Health Programs	County Merit	$67,159 - $111,498
Human Services Specialist	County Merit	$43,062 - $68,039
Human Services Supervisor	County Merit	$49,932 - $82,900
Medical Director	Consultant	$145,600 - $291,200
Mental Health Therapist	County Contractual	$41,896 - $66,880
Mental Health Professional Counselor	State Merit	$41,074 - $65,568
Nurse Practitioner	County Contractual	$33,280 - $39,738
Physician	Consultant	$80,285 - $146,643
Program Administrator, Health Service (I - III)	County Contractual	$41,074 - $74,725
Program Specialist I	County Merit	$43,062 - $68,759
Psychiatrist	Consultant	$85,800 - $137,280
Senior Management Associate (aka Program Manager)	County Merit	$63,710 - $88,628
Social Worker	County Contractual	$49,920 - $54,038
Social Worker Advanced Health Services	State Merit	$43,725 - $69,999
Social Worker II Health Services	State Merit	$41,074 - $65,568
Special Program Mgr II	County Merit	$40,984 - $64,759

Anne Arundel County Employee Listing

Employee Status Code (A/T/L/D/N) exactly matches A and Bureau Code begins with BHS

Title	Employee Type	Salary Range
Strengthening Fam Facilit	Consultant	$10,400 - $20,800
Substance Abuse Prev Spec	County Contractual	$37,006 - $58,023
TCA Assessor	County Contractual	$37,006 - $58,023

(47)

CLASS SPECIFICATION
County of Fairfax, Virginia

CLASS CODE: 3618 **TITLE:** PSYCHIATRIST **GRADE:** S-35

DEFINITION:
This is advanced professional medical and supervisory work in the field of psychiatry. An employee in this class performs medical psychiatric diagnosis and treatment with a minimum of supervision. The incumbent is independently responsible for prescribing medication and certifying to the provision of therapeutic treatment based on evaluation of patient's condition and progress. Unusually difficult cases are assigned to the incumbent, who is also a consultant for other therapists at the Center. May act as a specialist in a sub-area of psychiatry such as child psychiatry. May be designated as chief psychiatrist to coordinate the work of staff psychiatrists.

ILLUSTRATIVE DUTIES:
(Any one position may not include all of the duties listed, nor do the examples cover all of the duties which may be performed.)

Conducts drug maintenance clinic for after care and borderline but ambulatory population to maintain them outside a hospital. Prescribes treatment plan and psychotropic medication based on medication evaluation.
Supports other therapists in emergency psychiatric evaluations.
Evaluates exceptionally difficult cases. Recommends disposition.
Responds to requests for assistance in crisis intervention situations as part of a combined staff approach.
Provides consulting support for therapists in several disciplines and varied aspects of the mental hygiene program.
Provides individual, couple, and family therapy both short and long term.
Coordinates psychiatry training.
Participates in group therapy (with a co-therapist) for adolescents and children. Counsels parents of children and adolescents in treatment on an individual and family basis.
Leads or participates in administrative, programmatic, and clinical meetings.
Acts as chief of an important component of the total program involving a small staff.
Evaluates patients for social services, courts, social security, and programs such as vocational rehabilitation, and home-bound teachers.

REQUIRED KNOWLEDGE, SKILLS, AND ABILITIES:
Extensive knowledge of modern psychiatric theory and practice.
Thorough knowledge of causes, treatment, and prevention of mental illness.
Considerable knowledge of available community resources useful in the treatment and prevention of emotional maladjustments.
Considerable knowledge of the clinical use of educational and psychological tests and techniques.

Ability to establish and maintain effective and cooperative relations with professional, administrative, and other persons working in related fields, such as local welfare and public health departments, schools, courts, law enforcement hospitals and other institutions.
Ability to plan and execute work effectively.
Ability to supervise the work of Mental Health Therapists.

EMPLOYMENT STANDARDS:
Doctor of Medicine degree.
Completion of approved residency training in psychiatry.
Any combination of education, training, and experience giving evidence of competence in meeting the Requirements of Work above and certification as a Child Psychiatrist if essential for the existing vacancy.

CERTIFICATES AND LICENSES REQUIRED:
Possession of a license to practice medicine in the State of Virginia.
Contingent upon area of assignment, some positions within this class will require a National Provider Identifier.

REVISED: January 2, 2007

1071O

CLASS SPECIFICATION
County of Fairfax, Virginia

CLASS CODE: 3654 **TITLE:** MENTAL HEALTH THERAPIST **GRADE:** S-23

DEFINITION:
Under clinical and administrative supervision, serves as a primary therapist and case manager, performing a comprehensive variety of professional treatment services; and performs related work as required.

DISTINGUISHING CHARACTERSTICS OF THE CLASS:
The Mental Health Therapist differs from the Mental Health Counselor in that the Mental Health Therapist serves as a primary therapist and case manager with an assigned caseload, whereas the Mental Health Counselor serves as a secondary therapist, performing a limited variety of professional treatment services.

The Mental Health Therapist differs from the MH/MR/ADS Senior Clinician in that the Mental Health Therapist performs a variety of professional treatment services under clinical supervision, whereas the MH/MR/ADS Senior Clinician performs autonomously in providing an array of professional treatment services.

ILLUSTRATIVE DUTIES:
Makes preliminary or provisional diagnoses using Diagnostic and Statistical Manual of Mental Disorders;
Maintains a diverse caseload of clients with a variety of mental illnesses;
Develops and recommends therapeutic treatment plans to a more senior therapist, with consideration given to the nature and severity of the mental health problem, family and job-related circumstances, legal complications, individual and family histories, physical condition, and other pertinent factors;
Implements therapeutic treatment plan under clinical supervision;
Conducts independent intakes and assessments for review by a more senior therapist;
Provides individual, group, and family treatment under direction of a more senior therapist;
Collaborates with service professionals as participant of the Interdisciplinary Team (IDT);
Shares information and discusses prevention and treatment methods and techniques in conjunction with peers and other professionals;
Adapts and modifies treatment interventions and approaches for review by a more senior therapist;
Links clients with appropriate community resources;
Conducts prevention education activities;
Maintains all appropriate client records according to governing standards, ensuring that records of clients on their caseload are complete, accurate and comprehensive;
Advocates on behalf of clients regarding rights and needed services;
Develops cooperative relationships with community groups and agencies;
Monitors the impact of psychotropic medication on client's functioning and mental status;
Provides crisis stabilization and crisis management under direction of a more senior therapist;
Provides ongoing risk assessments for dangerousness to self and others under the direction of a more senior therapist.

REQUIRED KNOWLEDGE, SKILLS, AND ABILITIES:
Knowledge of the principles, theories, and methods of the psychological and social development of the individual;
Knowledge of major schools of treatment of emotionally and socially disturbed individuals;
Considerable knowledge of psychiatric, psychological, and/or sociological terminology and concepts;
Considerable knowledge of intake procedures, social history development and interviewing techniques;
Knowledge of existing referral agencies and community resources;
Ability to diagnostically interpret data obtained from psychological test results, social histories, and interviews;
Ability to formulate diagnoses;
Ability to perform mental health assessments and apply treatment approaches/modalities;
Ability to manage a caseload;
Ability to establish rapport and maintain effective relationships with clients;
Ability to maintain effective working relationships with co-workers, public and private organizations, community groups, and the general public;
Ability to successfully perform as a team member;
Ability to communicate effectively, both orally and in writing;
Ability to maintain records and prepare reports.

EMPLOYMENT STANDARDS:
Graduation from an accredited college with at least a bachelor's degree in social work, psychology, sociology, counseling, nursing (or, for certain positions providing services to children and adolescents, a Bachelor's degree in special education) PLUS two years of clinical experience OR graduation from an accredited college or university with a master's degree in social work, psychology, sociology or counseling PLUS one year of clinical experience. Clinical experience means providing direct clinical services to individuals with mental illness and includes supervised internships, practicums, and field experience. Additional education may not substitute for clinical experience.

CERTIFICATES AND LICENSES REQUIRED:
MANDT Certifications within six (6) months of appointment and annually thereafter, for positions in CSB residential services;
First Aid and CPR certification, within 90 days of appointment and maintained throughout CSB employment, for positions in residential programs;
Medication Administration Assistance Certification within 90 days of appointment, for positions in residential programs.

NECESSARY SPECIAL REQUIREMENTS:
Criminal background record check;
TB screening upon hire and annually thereafter;
Contingent upon area of assignment, some positions within this class:

- Must be eligible to provide services that can be reimbursed by Medicaid in accordance with the Virginia Department of Medical Assistance Services' requirements;
- Must meet the requirements to be a provider of Case Management Services as set forth by the Virginia Department of Medical Assistance Services;

- Require a valid Motor Vehicle Driver's license with fewer than six demerit points (or equivalent in another state) at time of appointment and maintained throughout employment with CSB;
- Require a Hepatitis C screening upon hire and annually thereafter;
- Require a National Provider Identifier.

REVISED:	February 17, 2011
REVISED:	January 2, 2007
REGRADED:	July 8, 2006
REVISED:	July 18, 2000
REVISED:	June 26, 2000
ESTABLISHED:	May 23, 2000

CLASS SPECIFICATION
County of Fairfax, Virginia

CLASS CODE: 3653
TITLE: MENTAL HEALTH SUPERVISOR/SPECIALIST
GRADE: S-26

DEFINITION:
Under general clinical and administrative direction, serves as a first-level supervisor, providing direction to a group of professional therapists in the implementation of a specific service or in a residential setting; OR coordinates an agency-wide support function with clinical orientation; OR serves as a therapist assigned to Emergency Services or the Mobile Crisis Unit; and performs related work as required.

DISTINGUISHING CHARACTERSTICS OF THE CLASS:
The Mental Health Supervisor/Specialist differs from the MH/MR/ADS Senior Clinician in that the Mental Health Supervisor/Specialist functions as a first-level supervisor over a group of professional therapists, which may include facility management, or as a certified therapist assigned to Emergency Services or the Mobile Crisis Unit, whereas the MH/MR/ADS Senior Clinician functions as a licensed/certified primary therapist in a designated area which requires a broad range of clinical expertise.

The Mental Health Supervisor/Specialist differs from the Mental Health Manager in that the Mental Health Supervisor/Specialist functions as a first-level supervisor over a group of professional therapists, which may include facility management, or as a certified therapist assigned to Emergency Services or the Mobile Crisis Unit, whereas the Mental Health Manager is responsible for administering a direct service program within a major service area, or an agency-wide support function with clinical orientation.

ILLUSTRATIVE DUTIES:
Provides staff supervision for all clinical aspects of the program;
Plans, assigns, and reviews work of team members;
Interviews and selects candidates for various positions;
Performs complex evaluations and makes independent diagnoses using Diagnostic and Statistical Manual of Mental Disorders;
Provides individual, family and group treatment;
Maintains a caseload of diverse, complex, and high-risk clients;
Develops treatment plans and adapts treatment interventions and approaches;
Provides assessment and treatment services to clients presenting a wide variety of emotional, social, and mental disorders over a range of severity;
Consults with professionals on a variety of problems including delivery of needed services for clinically complex cases;
Provides liaison to community agencies to facilitate communication and service provision for clients requiring multiple services;
Evaluates clients whose lives may be in substantial and imminent danger or who may pose an imminent, substantial risk to the lives and safety of others;

Recommends and coordinates Emergency Custody Orders;
Responds to high-risk hostage/barricade situations;
Responds to public safety personnel who have been exposed to psychologically traumatic events in the course of duty;
Develops and implements program activities and services, including training and educational activities;
Under direction, develops and implements a specialized program which is designed to maximize the effectiveness and efficiency of service provision;
Supervises day-to-day program operations;
Promotes awareness of program services through presentations;
Develops and monitors program's policies and procedures;
Facilitates voluntary or involuntary hospitalization of high-risk clients;
Ensures that program is in compliance with applicable federal, state, and local policies, regulations, and statutes;
Mediates and facilitates inter-and intra-program issues needing a systems perspective;
Plans, recommends, and executes quality initiatives related to mental health standards;
Monitors and analyzes the impact of psychotropic medication on client's functioning and mental status;
Provides risk assessments for dangerousness to self and others;
Provides crisis stabilization and crisis management;
Ensures that facility is maintained and in good operating condition.

REQUIRED KNOWLEDGE, SKILLS, AND ABILITIES:
Extensive knowledge of the principles, theories, and methods of the psychological and social development of the individual;
Thorough knowledge of intake procedures, social history development, and interviewing techniques;
Thorough knowledge of major schools of treatment of emotionally and socially disturbed individuals;
Knowledge of psychiatric, psychological, and/or sociological terminology and concepts;
Knowledge of clinical supervisory methods and techniques;
Knowledge of federal, state, and county laws regarding Emergency Custody Orders, Temporary Detention Orders, and involuntary commitment;
Ability to conduct mental health assessments and apply treatment approaches/modalities;
Ability to formulate diagnoses;
Ability to diagnostically interpret data obtained from psychological test results, social histories, and interviews;
Ability to prepare, produce, and conduct program presentations;
Ability to develop, implement, manage, and evaluate programs;
Ability to supervise and train service professionals;
Ability to conduct performance evaluations and implement personnel procedures;
Ability to function independently in high-stress situations;
Ability to develop and maintain effective working relationships with subordinates, co-workers, public and private sector organizations, community groups, and the general public;

Ability to successfully perform as a team leader/member;
Ability to communicate effectively, both orally and in writing.

EMPLOYMENT STANDARDS:

For those positions serving as Mental Health Supervisors:
Graduation from an accredited college with at least a bachelor's degree in social work, psychology, sociology, counseling or nursing (or, for certain positions providing services to children and adolescents, a Bachelor's degree in special education) PLUS four years of clinical experience OR a master's degree in social work, psychology, sociology, counseling or nursing (or, for certain positions providing services to children and adolescents, a Master's degree in special education) PLUS three years of clinical experience OR a doctoral degree in psychology, social work, counseling or nursing plus one year of clinical experience. Clinical experience means providing direct clinical services to individuals with mental illness and includes supervised internships, practicums, and field experience.

For those positions serving as Mental Health Specialists:
Graduation from an accredited college with at least a master's degree in social work, psychology, counseling, or nursing PLUS three years of clinical experience OR a doctoral degree in psychology, social, counseling or nursing plus one year of clinical experience and be eligible to be licensed to practice in the Commonwealth of Virginia in one of the following: Licensed Clinical Social Worker, Licensed Professional Counselor, Clinical Psychologist, Licensed Marriage and Family Therapist, or Clinical Nurse Specialist.

CERTIFICATES AND LICENSES REQUIRED:
MANDT Certifications within six (6) months of appointment and annually thereafter, for positions in CSB residential services;
First Aid and CPR certification within 90 days of appointment and maintained throughout CSB employment, for positions in residential programs;
Medication Administration Assistance Certification within 90 days of appointment, for positions in residential programs.

NECESSARY SPECIAL REQUIREMENTS:
Criminal background record check;
TB screening upon hire and annually thereafter;
Contingent upon area of assignment, some positions within this class:

- Must be eligible to provide services that can be reimbursed by Medicaid in accordance with the Virginia Department of Medical Assistance Services' requirements;
- Must meet the requirements to be a provider of Case Management Services as set forth by the Virginia Department of Medical Assistance Services;
- Must be currently licensed to practice in the Commonwealth of Virginia in one of the following: Licensed Clinical Social Worker, Licensed Professional Counselor, Clinical Psychologist, Licensed Marriage and Family Therapist, or Clinical Nurse Specialist;
- Within six (6) months of appointment, certification in
    - Hostage-Barricade Negotiation Techniques

  - Critical Incident Stress Debriefing,
  - Preadmission Screenings and Involuntary Detentions
- Require a valid Motor Vehicle Driver's license with fewer than six demerit points (or equivalent in another state) at time of appointment and maintained throughout employment with CSB;
- Require a Hepatitis C screening upon hire and annually thereafter;
- Require a National Provider Identifier.

REVISED:	February 17, 2011
REVISED:	January 2, 2007
REGRADED:	July 8, 2006
REISSUED W/O CHANGE:	July 18, 2000
REVISED:	June 26, 2000
ESTABLISHED:	May 23, 2000

CLASS SPECIFICATION
County of Fairfax, Virginia

CLASS CODE: 3644 **TITLE:** SUBSTANCE ABUSE COUNSELOR I **GRADE:** S-20

DEFINITION:
Under close clinical and administrative supervision, serves as a secondary counselor and performs a limited variety of professional treatment services involving the exercise of independent judgment; may serve as the sole counselor on a night or weekend shift independently performing a limited variety of professional treatment services; and performs related work as required.

DISTINGUISHING CHARACTERSTICS OF THE CLASS:
The Substance Abuse Counselor I differs from the Assistant Residential Counselor in that the Substance Abuse Counselor I serves as a secondary counselor, performing a limited variety of professional treatment services, whereas the Assistant Residential Counselor performs paraprofessional educative and administrative duties.

The Substance Abuse Counselor I differs from the Substance Abuse Counselor II in that the Substance Abuse Counselor I serves as a secondary counselor, performing a limited variety of professional treatment services, whereas the Substance Abuse Counselor II serves as a primary counselor with clinical responsibility for a caseload of clients.

ILLUSTRATIVE DUTIES:
Interviews prospective clients to assess service needs, determine factual history and explain the Substance Abuse Program;
Prepares draft treatment plans for review, with consideration given to the nature and severity of the problem, family and job-related pressures or complications, individual and family histories, physical condition, and other pertinent factors;
Provides program coverage and supervises program activities as designated;
Provides information or referral services for individuals, families, and other concerned persons;
Shares information and discusses prevention and treatment methods and techniques in conjunction with peers and other professionals;
Advocates for clients in the community;
Co-leads counseling groups for clients with alcohol and/or drug-related problems;
Provides individual/group counseling in support of the treatment plan;
Counsels and provides services to clients' family members in support of the family treatment plan;
Teaches substance abuse education classes for clients, their families, and other concerned persons;
Assists clients in developing and practicing living and empowerment skills;
Provides intervention in crisis situations;
Provides reassurance and encouragement to clients who make phone or personal contact during crisis or emergency situations;
Maintains all appropriate client records according to governing standards.

REQUIRED KNOWLEDGE, SKILLS, AND ABILITIES:
Knowledge of alcohol and/or drug addiction and the physiological and psychological effects;
Knowledge of various substance abuse prevention and treatment methods/techniques;
Knowledge of intake procedures, social history development and interviewing techniques;
Knowledge of existing referral agencies and community resources;
Ability to assist with initial screening of the severity of a client's substance abuse problem;
Ability to recognize external behavioral symptoms of substance abusers who may concurrently exhibit signs of mental illness;
Ability to establish rapport and maintain effective relationships with clients;
Ability to develop and maintain effective working relationships with co-workers and the general public;
Ability to communicate effectively, both orally and in writing;
Ability to maintain records and prepare reports.

EMPLOYMENT STANDARDS:
Any combination of education, experience, and training equivalent to the following:
Graduation from an accredited four-year college or university with a bachelor's degree in psychology, social work, or a related field.

CERTIFICATES AND LICENSES REQUIRED:
Valid Motor Vehicle Driver's license with fewer than six demerit points (or the equivalent in another State) at time of appointment and maintained throughout employment with CSB, for positions in residential programs;
First Aid and CPR Certification within 90 days of appointment and maintained throughout employment with CSB, for positions in residential programs;
Medication Administration Assistance Certification within 90 days of appointment, for positions in residential programs.

NECESSARY SPECIAL REQUIREMENTS:
Criminal background record check;
TB screening upon hire and annually thereafter.
Contingent upon area of assignment, some positions within this class will require a National Provider Identifier.

REVISED: January 2, 2007
REGRADED: July 8, 2006
REVISED: July 18, 2000
REVISED: June 26, 2000
REVISED: January 11, 1995
APPROVED: January 26, 1981

CLASS SPECIFICATION
County of Fairfax, Virginia

CLASS CODE: 3643 **TITLE:** SUBSTANCE ABUSE COUNSELOR II **GRADE:** S-23

DEFINITION:
Under clinical and administrative supervision, serves as a primary counselor, performing a comprehensive variety of professional treatment services involving the exercise of independent judgment; OR performs a direct service function with agency-wide impact; and performs related work as required.

DISTINGUISHING CHARACTERSTICS OF THE CLASS:
The Substance Abuse Counselor II differs from the Substance Abuse Counselor I in that the Substance Abuse Counselor II serves as a primary counselor, with clinical responsibility for a caseload of clients, whereas the Substance Abuse Counselor I serves as a secondary counselor.

The Substance Abuse Counselor II differs from the Substance Abuse Counselor III in that the Substance Abuse Counselor II serves as a primary counselor, whereas the Substance Abuse Counselor III serves as a first-level supervisor over a group of counselors.

ILLUSTRATIVE DUTIES:
Maintains all appropriate client records according to governing standards, ensuring that records of clients on their caseload are complete, accurate and comprehensive;
Interviews and provides a full diagnostic intake on prospective clients to assess needs, determine factual history and explain the Substance Abuse Program;
Establishes a treatment plan with consideration given to the nature and severity of the addiction problem, family and job-related circumstances, legal complications, individual and family histories, physical condition, and other pertinent factors;
Leads counseling sessions for clients with alcohol and/or drug-related problems;
Provides therapeutic family counseling with clients' family members which is designed to address and alleviate the problems documented in the treatment plan;
Provides crisis stabilization and crisis management;
Advocates for clients in the community;
Provides information or referral services for individuals, families and other concerned persons;
Shares information and discusses prevention and treatment methods and techniques in conjunction with peers and other professionals;
Prepares and administers educational curricula for substance abuse education classes;
Testifies in court to explain client's treatment and assess progress or recovery.

REQUIRED KNOWLEDGE, SKILLS, AND ABILITIES:
Knowledge of alcohol and/or drug addiction and the physiological and psychological effects;
Knowledge of various substance abuse prevention and treatment methods/techniques;
Knowledge of complete and diagnostic intake procedures, social history development and interviewing techniques;
Knowledge of existing referral agencies and community resources;

Ability to evaluate the severity of a client's substance abuse problem and implement counseling efforts to treat the abuse;
Ability to manage a caseload;
Ability to establish rapport and maintain effective relationships with clients;
Ability to maintain effective working relationships with co-workers, public and private organizations, community groups, and the general public;
Ability to successfully perform as a team member;
Ability to communicate effectively, both orally and in writing;
Ability to maintain records and prepare reports.

EMPLOYMENT STANDARDS:
Any combination of education, experience, and training equivalent to the following:
Graduation from an accredited college or university with a master's degree in psychology, social work, or a related field.

CERTIFICATES AND LICENSES REQUIRED:
Valid Motor Vehicle Driver's license with fewer than six demerit points (or equivalent in another state) at time of appointment and maintained throughout employment with CSB, for positions in residential programs;
First Aid and CPR Certification within 90 days of appointment and maintained throughout employment with CSB, for positions in residential programs;
Medication Administration Assistance Certification within 90 days of appointment, for positions in residential programs.

NECESSARY SPECIAL REQUIREMENTS:
Criminal background record check;
TB screening upon hire and annually thereafter.
Contingent upon area of assignment, some positions within this class will require a National Provider Identifier.

REVISED:	January 2, 2007
REGRADED:	July 8, 2006
REVISED:	June 26, 2000
REVISED:	January 11, 1995
APPROVED:	January 26, 1981

CLASS SPECIFICATION
County of Fairfax, Virginia

CLASS CODE: 3258 **TITLE:** SOCIAL SERVICES SPECIALST I **GRADE:** S-20

DEFINITION:
Under close supervision, performs entry-level social work assessment of social, health, emotional, and economic needs of clients in order to implement a plan of service; makes appropriate referrals; provides consultation; tracks the progress of clients through their plans; **OR** performs a specific aspect of the full range of professional casework services; and performs related work as required.

DISTINGUISHING CHARACTERISTICS OF THE CLASS:
Positions in the Social Services Specialist I job class are distinguished from positions in the Human Service Worker class series in that Human Service Workers determine eligibility for services while Social Services Specialist Is assess clients' needs and develops service plans. Social Services Specialist Is differ from positions in the Social Services Specialist II job class in that Social Services Specialist Is are either entry level Social Services Specialist **OR** perform a specific aspect of the full range of professional casework services while the Social Services Specialist IIs work more independently to perform the full range of social work services.

ILLUSTRATIVE DUTIES:
Interviews the client and family members to gather data on their social, health, emotional and economic problems.
Conducts comprehensive client assessments and prepares and implements service plans. Works with clients to develop a plan of service to meet social, health, emotional and economic needs. With the clients, formulates objectives and identifies actions to resolve the clients' problems.
Conducts home visits to families for the purpose of monitoring, counseling and supervision.
Assists applicants and service recipients with identifying and utilizing available resources and refers clients to other public and private agencies and services.
Assesses and authorizes purchase of social services to qualifying clients that will help to meet their social, health, emotional and economic needs.
Recruits, develops, trains, and monitors individual service providers such as contract service providers and volunteers.
Uses automated technology and hard copy files to maintain and update case data, notes, documents, records, contacts and summaries of information.

REQUIRED KNOWLEDGE, SKILLS, AND ABILITIES:
Knowledge of the principles and practices of social work.
Knowledge of current social service problems and methods/approaches to address issues.
Knowledge of regulations and guidelines relating to the assigned area of social service specialization.
Ability to analyze case information and to reach sound decisions on the basis of such information.
Ability to communicate clearly and concisely, both orally and in writing.

Ability to use automated technology to establish and maintain case records.
Ability to maintain professional ethics and confidentiality of client information.
Ability to establish and maintain effective working relationships with a variety of individuals.
Ability to schedule and manage workload sufficiently to meet deadlines.

EMPLOYMENT STANDARDS:
Graduation from an accredited four-year college or university with a bachelor's degree.

CERTIFICATES AND LICENSES REQUIRED:
Not applicable.

NECESSARY SPECIAL REQUIREMENTS:
New County employees must satisfactorily complete a criminal background check and a check of the Child Protective Services Registry.

Driver's license or ability to efficiently access other means of transportation in order to visit clients in their homes and to meet with community service providers.

Some positions may require oral and written bilingual competency in English and a second language.

RETITLED: July 1, 2013
REVISED: June 17, 2005

CLASS SPECIFICATION
County of Fairfax, Virginia

CLASS CODE: 3256 **TITLE:** SOCIAL SERVICES SPECIALIST II **GRADE:** S-23

DEFINITION:
Under general supervision, works independently to perform the full range of journey level professional social casework services on a variety of social work cases; performs clinical assessment of social, health, emotional, and economic needs of clients in order to implement a plan of service; makes appropriate referrals; provides consultation; tracks the progress of client through their service plans; and performs related work as required.

DISTINGUISHING CHARACTERISTICS OF THE CLASS:
This is the full performance level for social services specialists. The Social Services Specialist II is distinguished from the Social Services Specialist III in that the Social Services Specialist III performs complex social casework services, and/or assists the unit supervisor with providing guidance and training to staff, and/or serves as policy expert in a specialized area, and/or oversees and coordinates a program or project while the Social Services II works independently to perform the full range of journey level professional social casework services. The Social Services Specialist II and the Social Services Specialist I perform very similar duties, however, the Social Services Specialist I class is reserved for the social services specialist who is either less experienced or performs a specific aspect of the full range of social work services.

ILLUSTRATIVE DUTIES:
Conducts comprehensive clinical assessments and prepares and implements service plans. Works with clients to develop a plan of service to meet social, health, emotional and economic needs. With the client, formulates objectives and identifies actions to resolve the clients' problems.
Advocates for and assists families and individuals in obtaining services (e.g., mental health, mental retardation, alcohol and drug, housing referrals, financial assistance for basic needs, home based services, training and medical services).
Works with the community to identify families, children and individuals needing social services and coordinates these services using a wrap-around approach.
Provides family counseling and conducts mediation services to families in conflict.
Performs emergency removal of children from their homes when required, places children in foster homes and residential programs, and coordinates services for them as needed.
Investigates complaints of alleged abuse or neglect, and in consultation with supervisor, makes assessment of risks posed to clients in accordance with state and local policies, and works to ensure risks are eliminated or minimized.
Provides crisis intervention on a timely basis to clients or families whose well being are seriously and imminently-threatened to include Adult Protective Services and Child Protective Services after-hours.
Represents the agency in court proceedings and prepares testimony and testifies in Juvenile, Circuit, Criminal, Civil and Federal Courts.

Interviews and counsels natural parents, adoptive parents, foster parents and children to be placed in foster homes or residential facilities and those involved in adoption placement.
Evaluates child's readiness for placement and recommends placement ensuring compliance with legal provisions.
Conducts and documents interstate and intrastate family home studies to evaluate and make recommendations on the family's ability to provide a safe and nurturing environment for children.
Evaluates and may assist in training foster and adoptive parents.
Communicates and works with colleagues, clients and the community in a manner that supports the agency and program goals and objectives.
Participates as a contributing member on interagency, multi-disciplinary teams, community groups and professional organizations.
Collaborates and contributes to child specific teams on non-agency cases as assigned to assist in identifying community resources and services for families.
Participates, collaborates and contributes to Comprehensive Services Act activities for families on caseload.
Provides training and community education on a variety of social work topics.
Assesses and authorizes purchase of social services to qualifying clients that will help to meet their social, health, emotional and economic needs.
Conducts home visits to families for the purpose of monitoring, counseling and supervision.
Recruits, develops, trains, and monitors individual service providers.
Recruits volunteers and manages volunteer services.
Uses automated technology and hard copy files to maintain and update case data, notes, documents, records, contacts and summaries of information.
Maintains case notes, documents and records, enters and updates case load data, contacts and summaries of information. Prepares and provides reports on casework.
Performs or reviews initial assessment of client's presenting need and conducts additional assessment as necessary to develop a coordinated service plan which establishes goals, tasks, and time frames with appropriate County and community based service providers.
Addresses, and if necessary diffuses, initial crisis situation with clients, assesses safety issues and refers clients to emergency services as needed (e.g., mental health services, child protective services, adult protective services, women's shelter, homeless shelter).
Demonstrates expertise in community service resources to identify, classify and describe services that address a broad array of client service needs -- collaborates with service delivery professionals from all disciplines to identify service resource information requirements -- translates those requirements into an automated catalog of resources necessary for client referrals and the development of client service plans.
Negotiates, facilitates, and coordinates the creative use of limited community-based service alternatives and assists staff from other County human service agencies in creative use of community resources; consults with community-based organizations (CBO) staff on resources and service strategies which support service area work with individuals and families.

REQUIRED KNOWLEDGE, SKILLS, AND ABILITIES:
Knowledge of the principles and practices of social work.
Knowledge of current social service problems and methods/approaches to address issues.
Knowledge of regulations and guidelines relating to the assigned area of social service specialization.
Ability to analyze case information and to reach sound decisions on the basis of such information.
Ability to communicate clearly and concisely, both orally and in writing.
Ability to use automated technology to establish and maintain case records.
Ability to maintain professional ethics and confidentiality of client information.
Ability to establish and maintain effective working relationships with a variety of individuals.
Ability to schedule and manage workload sufficiently to meet deadlines.

EMPLOYMENT STANDARDS:
Graduation from an accredited four-year college or university with a bachelor's degree, plus two years of professional social work experience. A Master's degree in a related field may be substituted for one year of the required experience.

CERTIFICATES AND LICENSES REQUIRED:
None.

NECESSARY SPECIAL REQUIREMENTS:
New County employees must satisfactorily complete a criminal background check and a check of the Child Protective Services Registry.
Driver's license or ability to efficiently access other means of transportation in order to visit clients in their homes and to meet with community service providers.
Some positions may require oral and written bilingual competency in English and a second language.

RETITLED:	July 1, 2013
REGRADED:	July 8, 2006
REVISED:	June 17, 2005

COMPENSATION PLAN - FISCAL YEAR 2013 (Effective Jan 12, 2013)
PAY PLAN - S

PAY GRADE	RATE	MINIMUM RATE	MIDPOINT RATE	MAXIMUM RATE
S-01	ANNUAL	16,313.86	23,127.10	29,941.18
	BIWEEKLY	627.46	889.50	1,151.58
	HOURLY	7.8432	11.1188	14.3948
S-02	ANNUAL	17,872.19	24,819.39	31,766.18
	BIWEEKLY	687.39	954.59	1,221.78
	HOURLY	8.5924	11.9324	15.2722
S-03	ANNUAL	19,756.67	26,858.42	33,960.37
	BIWEEKLY	759.87	1,033.02	1,306.17
	HOURLY	9.4984	12.9127	16.3271
S-04	ANNUAL	21,743.07	28,990.42	36,238.38
	BIWEEKLY	836.27	1,115.02	1,393.78
	HOURLY	10.4534	13.9377	17.4223
S-05	ANNUAL	22,719.42	30,292.70	37,865.78
	BIWEEKLY	873.82	1,165.10	1,456.38
	HOURLY	10.9228	14.5638	18.2047
S-06	ANNUAL	23,785.01	31,713.34	39,641.47
	BIWEEKLY	914.81	1,219.74	1,524.67
	HOURLY	11.4351	15.2468	19.0584
S-07	ANNUAL	24,849.76	33,133.36	41,417.17
	BIWEEKLY	955.76	1,274.36	1,592.97
	HOURLY	11.9470	15.9295	19.9121
S-08	ANNUAL	25,991.06	34,655.09	43,318.70
	BIWEEKLY	999.66	1,332.89	1,666.10
	HOURLY	12.4957	16.6611	20.8263
S-09	ANNUAL	27,222.00	36,295.58	45,370.00
	BIWEEKLY	1,047.00	1,395.98	1,745.00
	HOURLY	13.0875	17.4498	21.8125
S-10	ANNUAL	28,453.36	37,938.78	47,422.96
	BIWEEKLY	1,094.36	1,459.18	1,823.96
	HOURLY	13.6795	18.2398	22.7995

(59)

Effective Sep 15, 07 Fairfax County adopted a Living Wage. Minimum Hourly pay rate for merit employees in grades S-01 through S-09 is $13.1300.

COMPENSATION PLAN - FISCAL YEAR 2013 (Effective Jan 12, 2013)
PAY PLAN - S

PAY GRADE	RATE	MINIMUM RATE	MIDPOINT RATE	MAXIMUM RATE
S-11	ANNUAL	29,840.93	39,787.70	49,734.46
	BIWEEKLY	1,147.73	1,530.30	1,912.86
	HOURLY	14.3466	19.1287	23.9108
S-12	ANNUAL	31,150.08	41,533.23	51,916.80
	BIWEEKLY	1,198.08	1,597.43	1,996.80
	HOURLY	14.9760	19.9679	24.9600
S-13	ANNUAL	32,702.38	43,603.25	54,504.53
	BIWEEKLY	1,257.78	1,677.05	2,096.33
	HOURLY	15.7223	20.9631	26.2041
S-14	ANNUAL	34,255.94	45,674.30	57,093.09
	BIWEEKLY	1,317.54	1,756.70	2,195.89
	HOURLY	16.4692	21.9588	27.4486
S-15	ANNUAL	35,896.85	47,861.84	59,827.66
	BIWEEKLY	1,380.65	1,840.84	2,301.06
	HOURLY	17.2581	23.0105	28.7633
S-16	ANNUAL	37,527.57	50,036.90	62,545.81
	BIWEEKLY	1,443.37	1,924.50	2,405.61
	HOURLY	18.0421	24.0562	30.0701
S-17	ANNUAL	39,334.46	52,446.58	65,557.86
	BIWEEKLY	1,512.86	2,017.18	2,521.46
	HOURLY	18.9108	25.2147	31.5182
S-18	ANNUAL	41,132.83	54,843.36	68,554.93
	BIWEEKLY	1,582.03	2,109.36	2,636.73
	HOURLY	19.7754	26.3670	32.9591
S-19	ANNUAL	43,095.10	57,460.00	71,825.10
	BIWEEKLY	1,657.50	2,210.00	2,762.50
	HOURLY	20.7188	27.6250	34.5313
S-20	ANNUAL	45,137.66	60,183.55	75,228.61
	BIWEEKLY	1,736.06	2,314.75	2,893.41
	HOURLY	21.7008	28.9344	36.1676

(09)

Effective Sep 15, 07 Fairfax County adopted a Living Wage. Minimum Hourly pay rate for merit employees in grades S-01 through S-09 is $13.1300.

COMPENSATION PLAN - FISCAL YEAR 2013 (Effective Jan 12, 2013)
PAY PLAN - S

PAY GRADE	RATE	MINIMUM RATE	MIDPOINT RATE	MAXIMUM RATE
S-21	ANNUAL	47,354.53	63,139.44	78,924.14
	BIWEEKLY	1,821.33	2,428.44	3,035.54
	HOURLY	22.7666	30.3555	37.9443
S-22	ANNUAL	49,561.41	66,081.81	82,602.62
	BIWEEKLY	1,906.21	2,541.61	3,177.02
	HOURLY	23.8276	31.7701	39.7128
S-23	ANNUAL	51,935.10	69,246.11	86,557.95
	BIWEEKLY	1,997.50	2,663.31	3,329.15
	HOURLY	24.9688	33.2914	41.6144
S-24	ANNUAL	54,552.37	72,736.77	90,921.38
	BIWEEKLY	2,098.17	2,797.57	3,496.98
	HOURLY	26.2271	34.9696	43.7122
S-25	ANNUAL	57,210.19	76,280.26	95,350.53
	BIWEEKLY	2,200.39	2,933.86	3,667.33
	HOURLY	27.5049	36.6732	45.8416
S-26	ANNUAL	59,866.56	79,822.29	99,777.81
	BIWEEKLY	2,302.56	3,070.09	3,837.61
	HOURLY	28.7820	38.3761	47.9701
S-27	ANNUAL	62,816.21	83,755.15	104,693.47
	BIWEEKLY	2,416.01	3,221.35	4,026.67
	HOURLY	30.2001	40.2669	50.3334
S-28	ANNUAL	65,843.86	87,792.22	109,739.97
	BIWEEKLY	2,532.46	3,376.62	4,220.77
	HOURLY	31.6557	42.2078	52.7596
S-29	ANNUAL	69,028.54	92,038.13	115,048.13
	BIWEEKLY	2,654.94	3,539.93	4,424.93
	HOURLY	33.1868	44.2491	55.3116
S-30	ANNUAL	72,381.92	96,508.88	120,636.26
	BIWEEKLY	2,783.92	3,711.88	4,639.86
	HOURLY	34.7990	46.3985	57.9982

(19)

Effective Sep 15, 07 Fairfax County adopted a Living Wage. Minimum Hourly pay rate for merit employees in grades S-01 through S-09 is $13.1300.

COMPENSATION PLAN - FISCAL YEAR 2013 (Effective Jan 12, 2013)
PAY PLAN - S

PAY GRADE	RATE	MINIMUM RATE	MIDPOINT RATE	MAXIMUM RATE
S-31	ANNUAL	73,825.65	98,433.71	123,042.61
	BIWEEKLY	2,839.45	3,785.91	4,732.41
	HOURLY	35.4931	47.3239	59.1551
S-32	ANNUAL	77,403.04	103,204.61	129,005.76
	BIWEEKLY	2,977.04	3,969.41	4,961.76
	HOURLY	37.2130	49.6176	62.0220
S-33	ANNUAL	81,218.59	108,291.66	135,364.74
	BIWEEKLY	3,123.79	4,165.06	5,206.34
	HOURLY	39.0474	52.0633	65.0792
S-34	ANNUAL	85,119.63	113,492.50	141,865.57
	BIWEEKLY	3,273.83	4,365.10	5,456.37
	HOURLY	40.9229	54.5637	68.2046
S-35	ANNUAL	89,247.39	118,996.80	148,745.58
	BIWEEKLY	3,432.59	4,576.80	5,720.98
	HOURLY	42.9074	57.2100	71.5123
S-36	ANNUAL	93,699.22	124,931.66	156,164.32
	BIWEEKLY	3,603.82	4,805.06	6,006.32
	HOURLY	45.0477	60.0633	75.0790
S-37	ANNUAL	98,270.64	131,027.31	163,784.61
	BIWEEKLY	3,779.64	5,039.51	6,299.41
	HOURLY	47.2455	62.9939	78.7426
S-38	ANNUAL	100,215.65	133,621.07	167,026.50
	BIWEEKLY	3,854.45	5,139.27	6,424.10
	HOURLY	48.1806	64.2409	80.3012
S-39	ANNUAL	105,159.60	140,212.80	175,265.79
	BIWEEKLY	4,044.60	5,392.80	6,740.99
	HOURLY	50.5575	67.4100	84.2624
S-40	ANNUAL	113,650.58	151,533.82	189,417.49
	BIWEEKLY	4,371.18	5,828.22	7,285.29
	HOURLY	54.6397	72.8528	91.0661

62

Effective Sep 15, 07 Fairfax County adopted a Living Wage. Minimum Hourly pay rate for merit employees in grades S-01 through S-09 is $13.1300.

State of Maryland
PHYSICIAN CLINICAL STAFF (#004603)

- Hourly / - BiWeekly /
- Monthly / $93,261.00-$153,550.00 Yearly

GRADE

33

NATURE OF WORK

A Physician Clinical Staff is the full performance level of work providing clinical services to patients who are mentally ill, chronically ill or developmentally disabled or are in need of medical and preventive treatment. The majority of positions are located at Department of Health and Mental Hygiene facilities and local health departments. Employees in this classification do not supervise other physicians but may supervise health care support staff.

Employees receive general supervision from a higher-level physician or an administrative official. Employees may be assigned to day, evening, night or rotating shifts which may include holidays and weekends. Employees are subject to call-in and overtime based on staffing requirements. Employees are required to observe infection control precautions in order to prevent contamination and spread of disease.

The Physician Clinical Staff is differentiated from Physician Clinical Specialist in that the Physician Clinical Specialist is an advanced level providing clinical services in a medical specialty area requiring certification by an American Medical Association Specialty Board while the Physician Clinical Staff is the full performance level of work providing medical services.

EXAMPLES OF WORK

Plans and participates in the medical care of patients in a State facility, local health department or other agency;

Develops patient treatment plans based on assessments and diagnoses;

Implements and oversees implementation of treatment plans;

Examines and treats patients based on diagnoses;

Prescribes medications and treatments as indicated by diagnoses;

Orders various tests and analyses to provide information on patient's condition;

Analyzes reports and findings in order to determine patient's progress and adjusts treatment plan accordingly;

Reviews patients' records to assure their adequacy and proper administration;

Advises health care support staff of appropriate treatment techniques needed for individual cases;

Conducts clinical rounds and reviews progress of patients;

Meets with patients and their families to discuss treatment plans and address concerns;

Attends staff meetings and participates in diagnostic and treatment discussions, lectures, seminars and case presentations;

Performs other related duties.

KNOWLEDGE, SKILLS AND ABILITIES

Knowledge of the principles and practices in the field of medicine;

Knowledge of the clinical aspects of medicine;

Knowledge of the standards of medical care;

Knowledge of current developments in medicine;

Skill in the examination and treatment of patients;

Skill in performing medical diagnosis and planning treatment based on diagnosis;

Ability to communicate effectively with other physicians, health care professionals, support staff, patients and families of patients.

MINIMUM EDUCATION OR GENERAL REQUIREMENTS

Education: Possession of a degree in medicine from an accredited college or university.

Experience: Four years of experience in the practice of medicine.

Notes: 1. A Master's degree in public health from an accredited college or university may be substituted for one year of the required experience.

2. Internships and residencies are considered as qualifying medical experience.

LICENSES, REGISTRATIONS AND CERTIFICATIONS

Applicants must be licensed by the Maryland Board of Physicians to practice medicine under Maryland State Law. A copy of the current license must be attached to the application.

SPECIAL REQUIREMENTS

Employees in this classification are subject to substance abuse testing in accordance with Code of Maryland Regulations 17.04.09, Testing for Illegal Use of Drugs.

ACKNOWLEDGEMENTS

Class specifications are broad descriptions covering groups of positions used by various State departments and agencies. Position descriptions maintained by the using department or agency specifically address the essential job functions of each position.

DATE REVISED

Sep 21 2009 12:00AM

APPROVED BY

Director, Division of Classification and Salary

64

CLASS: 004603 **EST: REV: FORMERLY JOB TITLE: REPLACES JOB TITLE:**

State of Maryland
PHYSICIAN CLINICAL SPECIALIST (#006806)

- Hourly / - BiWeekly /
- Monthly / $116,884.00-$192,830.00 Yearly

GRADE

36

NATURE OF WORK

A Physician Clinical Specialist is the advanced level of work providing clinical services in an area of medical specialization to patients who are mentally ill, chronically ill or developmentally disabled or are in need of medical and preventive treatment. The majority of positions are located at Department of Health and Mental Hygiene facilities and local health departments. Employees in this classification do not supervise other physicians but may supervise health care support staff.

Employees receive general supervision from a higher-level physician or an administrative official. Employees may be assigned to day, evening, night or rotating shifts which may include holidays and weekends. Employees are subject to call-in and overtime based on staffing requirements. Employees are required to observe infection control precautions in order to prevent contamination and spread of disease. T

he Physician Clinical Specialist is differentiated from Physician Clinical Staff in that the Physician Clinical Specialist is an advanced level providing clinical services in a medical specialty area requiring certification by an American Medical Association Specialty Board.

EXAMPLES OF WORK

Provides consultation, advice and overview of treatment in an area of medical specialization to other physicians and health care staff;

Plans and participates in the medical care of patients in a State facility, local health department or other agency;

Develops patient treatment plans based on assessments and diagnoses;

Implements and oversees implementation of treatment plans;

Examines and treats patients based on diagnoses;

Prescribes medications and treatments as indicated by diagnoses;

Orders various tests and analyses to provide information on patient's condition;

Analyzes reports and findings in order to determine patient's progress and adjusts treatment plan accordingly;

Reviews patients' records to assure their adequacy and proper administration;

Advises health care support staff of appropriate treatment techniques needed for individual cases;

(66)

Conducts clinical rounds and reviews progress of patients;

Meets with patients and their families to discuss treatment plans and address concerns;

Attends staff meetings and participates in diagnostic and treatment discussions, lectures, seminars and case presentations;

Gives lectures and presentations to medical students, heath care professionals and lay groups in an area of medical specialization;

Performs other related duties.

SPECIAL REQUIREMENTS

Employees in this classification are subject to substance abuse testing in accordance with Code of Maryland Regulations 17.04.09, Testing for Illegal Use of Drugs.

GENERAL REQUIREMENTS

Specific educational and experience requirements are set by the agency based on the essential job functions assigned to the position.

ACKNOWLEDGEMENTS

A Class Description provides information about the Nature of Work, Examples of Work and General Requirements for a classification in the Management Service or a classification in the Skilled or Professional Service in which all positions have been designated Special Appointments. Required Knowledge, Skills, and Abilities; Minimum Education and Experience Requirements; Special Requirements; and recruitment and testing procedures are set by the using agency. Class descriptions broadly define groups of positions used by various State departments and agencies. Position descriptions maintained by the using department or agency specifically address the essential job functions of each position.

DATE REVISED

Sep 21 2009 12:00AM

APPROVED BY

Director, Division of Classification and Salary

CLASS: 006806 **EST: REV: FORMERLY JOB TITLE: REPLACES JOB TITLE:**

State of Maryland

SOCIAL WORK THERAPIST, FAMILY SERVICES (#004515)

- Hourly / - BiWeekly /
- Monthly / $44,600.00-$71,399.00 Yearly

GRADE

17

NATURE OF WORK

A Social Work Therapist, Family Services is the full-performance level of professional social work providing specialized clinical casework services to individuals and families in local departments of social services. Employees in this classification do not supervise but may provide consultation to other staff.

Employees in this class receive general supervision from a social work administrator. Employees may be required to work evenings and on weekends and may be assigned to provide on-call coverage. Work is generally performed in an office setting but may be performed in customer's homes, schools, hospitals or other community settings. Employees may be required to deal with potentially hazardous situations.

The Social Work Therapist, Family Services is differentiated from the Social Worker II, Family Services in that the Social Work Therapist, Family Services is certified for independent clinical practice and provides special clinical casework services.

EXAMPLES OF WORK

Provides clinical social work services to children, adolescents, young adults and families;

Functions as primary therapist for children and adolescents and their biological and foster parents;

Completes psychosocial and diagnostic assessments;

Makes mental health diagnoses based on the Diagnostic Statistical Manual of Mental Disorders;

Attends interdisciplinary staffings to discuss and integrate the evaluation information and develop a comprehensive treatment plan;

Maintains records that include diagnostic interviews at the initiation of therapy, treatment plans, weekly progress notes, periodic reviews and termination summaries;

Interviews customers and other individuals to obtain necessary information in cases concerning suspected abuse or neglect, out of home placement and adoption;

Assists customers in identifying, developing and using their potential capabilities as well as other community resources for taking care of their social, health, emotional, behavioral and economic problems;

Uses database applications to record information, research, and track or manage cases for compliance with applicable laws, regulations, and standards;

Checks public records, such as birth records, for data and verifies other information such as income, kinship and residence;

Establishes and maintains personal contact with other helping agencies and community resources to facilitate the referral of individual customers;

Develops and implements an individualized training plan to maintain and upgrade knowledge and skills;

Testifies in legal proceedings as to the facts of a specific family service case and may testify in court as an expert witness as to professional judgement;

May work with other caseworkers in placing customers in foster and adoptive homes;

May attend Foster Care Review Board meetings to provide information regarding treatment progress;

May respond to juvenile court system through progress reports required in the court's development of a plan for a customer; May provide guidance and assistance to less experienced social workers;

Performs other duties as assigned.

KNOWLEDGE, SKILLS AND ABILITIES

Knowledge of the principles and practices of clinical social service casework;

Knowledge of individual, family and group behavioral patterns;

Knowledge of normal and abnormal growth and development throughout the age continuum;

Knowledge of medical and legal terminology related to the practice of clinical social work;

Skill in using computer applications such as email, word processing and database applications;

Ability to identify a crisis situation and initiate intervention techniques;

Ability to perform evaluations, plan treatments and carry out therapy designed to aid customers in solving problems;

Ability to work as a member of a social services team in evaluating the progress of treatment plans;

Ability to provide consultative guidance to other social work staff;

Ability to establish and maintain effective working relationships and communicate effectively with managers of related programs, with the courts and with the general public.

MINIMUM EDUCATION OR GENERAL REQUIREMENTS

Education: Determined by the Maryland State Board of Social Work Examiners under the licensing requirements for Social Workers.

Experience: One year of experience in independent clinical practice providing specialized clinical casework services.

Note: These requirements are established by the Social Services Administration by authority provided in Section 1 of Article 88A of the Annotated Code of Maryland and the Department of Budget and Management, Office of Human Resources does not have the authority to accept substitutions or equivalents.

LICENSES, REGISTRATIONS AND CERTIFICATIONS

1. Employees are required to be licensed as a certified social worker-clinical by the Maryland State Board of Social Work Examiners prior to permanent appointment.

2. Employees in this classification may be assigned duties which require the operation of a motor vehicle. Employees assigned such duties will be required to possess a motor vehicle operator's license valid in the State of Maryland.

SPECIAL REQUIREMENTS

1. Employees who have not already done so must complete an approved training program and pass a competency test before being granted permanent employment status.

2. Employees are required to meet mandatory standards for continuing education as determined by the Department of Human Resources. Employees who fail to obtain the required continuing education credits shall be subject to disciplinary action including demotion, suspension and dismissal.

3. Employees in this classification may be required to provide the employer with a telephone number at which they can be reached.

ACKNOWLEDGEMENTS

Class specifications are broad descriptions covering groups of positions used by various State departments and agencies. Position descriptions maintained by the using department or agency specifically address the essential job functions of each position.

DATE REVISED

Jul 1 2006 12:00AM

APPROVED BY

Director, Division of Classification and Salary

CLASS: 004515 **EST: REV: FORMERLY JOB TITLE: REPLACES JOB TITLE:**

Powered by Job

F70

State of Maryland
ALCOHOL AND DRUG ASSOCIATE COUNSELOR (#001563)

- Hourly / - BiWeekly /
- Monthly / $37,006.00-$58,719.00 Yearly

GRADE

14

NATURE OF WORK

An Alcohol and Drug (A/D) Associate Counselor is the full performance level of work, at the certified Bachelor's Degree level, counseling clients with substance use disorders by using intervention, treatment and rehabilitation. Employees in this classification do not supervise.

Employees in this classification receive general supervision from an Alcohol and Drug Professional Counselor Supervisor or other supervisor approved by the Board of Professional Counselors and Therapists. Employees in this classification may be required to work evenings and weekends. The work is performed in addictions programs located in State institutions and facilities, such as inpatient and outpatient facilities, jails, detention centers, prisons, halfway house facilities and community-based programs.

Positions in this classification are evaluated using the classification job evaluation methodology. The use of this method involves comparing the assigned duties and responsibilities of a position to the job criteria found in the Nature of Work and Examples of Work sections of the class specification.

The Alcohol and Drug Associate Counselor is differentiated from the Alcohol and Drug Associate Counselor Provisional on the basis of certification status and supervisory control exercised by the supervisor over these employees. The Alcohol and Drug Associate Counselor is the certified level of work and the employee performs the full range of duties under general supervision. The Alcohol and Drug Associate Counselor Provisional is the noncertified level of work and the employee learns to perform duties under close supervision. The Alcohol and Drug Associate Counselor is differentiated from the Alcohol and Drug Associate Counselor Lead in that the Alcohol and Drug Associate Counselor Lead is the certified level of work and the employee assigns, reviews and approves the work of and trains lower-level Alcohol and Drug Counselors.

EXAMPLES OF WORK

Provides counseling and case management services to clients with substance use disorders with moderately complex problems as defined by standard treatment criteria;

Provides group counseling to clients with substance use disorders;

Coordinates all treatment activities with services provided to the client by other resources;

Evaluates client progress in implementing the treatment plan and makes appropriate changes to ensure progress;

71

Screens clients with substance use disorders to determine the most appropriate initial course of action with regard to substance treatment;

Assesses clients with substance use disorders to gather and interpret information necessary for planning treatment and evaluating client progress;

Develops client treatment plans and strategies to obtain the desired treatment outcomes;

Makes referrals to facilitate the client's use of available support systems and community resources in response to needs identified in clinical evaluation;

Identifies and responds to clients in crises;

Provides life skills education relevant to the recovery process to clients with substance use disorders, their families, significant others and community groups;

Documents client information in accordance with accepted principles of client record management;

Adheres to accepted ethical and behavioral standards of conduct and participates in continuing professional development;

Performs other related duties.

KNOWLEDGE, SKILLS AND ABILITIES

Knowledge of the established diagnostic criteria for substance use disorders, treatment modalities and placement criteria within the continuum of care;

Knowledge of models and theories of addiction and other problems related to substance use;

Knowledge of the social and cultural context within which addiction and substance abuse exist;

Knowledge of the effects of psychoactive substances on the user, their families and significant others;

Knowledge of ethical and behavioral standards of conduct in the helping relationship;

Knowledge of principles of learning and a variety of educational techniques;

Knowledge of medical and pharmacological resources in the treatment of substance use disorders;

Knowledge of methods of measuring treatment outcome;

Knowledge of federal, State, local and agency policies and procedures governing the delivery of treatment services;

Knowledge of a variety of helping strategies for reducing the negative effects of substance use, abuse and dependence;

Skill in tailoring helping strategies and treatment modalities to the client's stage of dependence, change, or recovery;

Skill in providing treatment services appropriate to the personal and cultural identity of the client;

Ability to make effective presentations to a variety of audiences;

Ability to document client information accurately;

Ability to establish and maintain working relationships with other professionals and agencies;

Ability to establish and maintain a therapeutic relationship with clients with substance use disorders, their families and significant others;

Ability to ascribe the role of family, social networks, self-help groups and community systems in the treatment and recovery process;

72

Ability to adapt clinical practice to the range of treatment settings and modalities;

Ability to apply crisis management skills to client crises;

Ability to apply setting-specific policies and procedures to clinical practice;

Ability to identify the support systems and community resources available to clients, their families and their significant others;

Ability to make constructive therapeutic responses when the client's behavior is inconsistent with stated recovery goals.

MINIMUM EDUCATION OR GENERAL REQUIREMENTS

Education: Determined by the Maryland State Board of Professional Counselors and Therapists under the requirements for Certified Associate Counselors-Alcohol and Drug.

Experience: Determined by the Maryland State Board of Professional Counselors and Therapists under the certification requirements for Certified Associate Counselors-Alcohol and Drug.

LICENSES, REGISTRATIONS AND CERTIFICATIONS

1. In accordance with Health Occupations Title 17 and Code of Maryland Regulations 10.58.07, candidates must be certified by the Board of Professional Counselors and Therapists as a Certified Associate Counselor-Alcohol and Drug.

2. Employees in this classification may be assigned duties which require the operation of a motor vehicle. Employees assigned such duties will be required to possess a motor vehicle operator's license valid in the State of Maryland.

SPECIAL REQUIREMENTS

Employees in this classification are subject to substance abuse testing in accordance with Code of Maryland Regulations 17.04.09, Testing for Illegal Use of Drugs.

ACKNOWLEDGEMENTS

Class specifications are broad descriptions covering groups of positions used by various State departments and agencies. Position descriptions maintained by the using department or agency specifically address the essential job functions of each position.

DATE REVISED

Jan 26 2010 12:00AM

APPROVED BY

Director, Division of Classification and Salary

CLASS: 001563 **EST: REV: FORMERLY JOB TITLE: REPLACES JOB TITLE:**

State of Maryland

SOCIAL WORKER I, FAMILY SERVICES (#006786)

- Hourly / - BiWeekly /
- Monthly / $39,366.00-$62,656.00 Yearly

GRADE

15

NATURE OF WORK

A Social Worker I, Family Services is the intermediate level of professional social work providing preventive or protective services to vulnerable adults, children or families. Cases involve suspected child or adult abuse or neglect, out of home placement, guardianship or emergency protective orders, adoption or adult case management. Employees in this classification do not supervise.

Employees receive moderate supervision from a Social Work Supervisor, Family Services. Employees in this class may be required to work evenings and on weekends and may be assigned to provide on-call coverage. Work is performed in customer's homes, schools, hospitals and other community settings. Employees may be required to deal with potentially hazardous situations.

The Casework Specialist, Family Services is differentiated from the Social Worker I, Family Services and the Social Worker II, Family Services in that the Social Worker Provisional, while eligible for licensure, has not yet been licensed as a social worker in Maryland and the Social Worker I, Family Services and Social Worker II, Family Services are licensed social workers. The Casework Specialist, Family Services, Social Worker I, Family Services and Social Worker II, Family Services are also differentiated on the basis of the degree of supervisory control exercised by the supervisor over these employees. The Casework Specialist, Family Services performs duties under close supervision, the Social Worker I, Family Services performs duties under close supervision at times and under general supervision at other times depending upon the complexity of the specific duty being performed and the Social Worker II, Family Services performs the full range of duties under general supervision.

EXAMPLES OF WORK

Applies social work values, principles and techniques in helping individuals and families obtain social services;

Interviews or investigates customers and other individuals to obtain necessary information in cases concerning suspected child or adult abuse or neglect, out of home placement, guardianship or emergency protective orders, or adoption;

Assists customers in identifying, developing and using their potential capabilities as well as other community resources for taking care of their social, health, emotional, behavioral and economic problems;

Assesses case situations and develops and implements an individualized plan of service;

74

Provides extensive counseling and crisis intervention services to customers regarding personal, economic and social problems;

Establishes and maintains personal contact with other helping agencies and community resources to facilitate the referral of individual customers;

Provides on-call coverage in cases involving suspected child or adult abuse or neglect;

Checks public records, such as birth records, for data and verifies other information such as income, kinship and residence;

Compiles evaluative reports and makes recommendations to the courts, other agencies and institutions regarding individual case situations;

Uses database applications to record information, research, and track or manage cases for compliance with applicable laws, regulations, and standards;

Prepares and manages case records and reports concerning information secured and services rendered;

Testifies in legal proceedings as to the facts of a specific family service case and may testify in court as an expert witness as to professional judgment;

Develops and implements an individualized training plan to maintain and upgrade knowledge and skills related to the delivery of services;

May prepare comprehensive evaluative reports recommending licensure of prospective homes for foster care or adoption;

May place children in foster and adoptive homes;

May participate in initial investigations of fatalities that result from suspected abuse or neglect;

May aid delinquent or mentally retarded children and adults in institutions or in foster and adoptive homes;

Performs other related duties.

SPECIAL REQUIREMENTS

1. Employees who have not already done so must complete an approved training program and pass a competency test before being granted permanent employment status.

2. Employees are required to meet mandatory standards for continuing education as determined by the Department of Human Resources. Employees who fail to obtain the required continuing education credits shall be subject to disciplinary action including demotion, suspension and dismissal.

3. Employees in this classification may be required to provide the employer with a telephone number at which they can be reached.

GENERAL REQUIREMENTS

Specific educational and experience requirements are set by the agency based on the essential job functions assigned to the position.

ACKNOWLEDGEMENTS

A Class Description provides information about the Nature of Work, Examples of Work and General Requirements for a classification in the Management Service or a classification in the Skilled or Professional Service in which all positions have been designated Special Appointments. Required Knowledge, Skills, and Abilities; Minimum Education and Experience Requirements; Special Requirements; and recruitment and testing procedures are set by the using agency.

75

Class descriptions broadly define groups of positions used by various State departments and agencies. Position descriptions maintained by the using department or agency specifically address the essential job functions of each position.

DATE REVISED

Jul 1 2006 12:00AM

APPROVED BY

Director, Division of Classification and Salary

CLASS: 006786 **EST: REV: FORMERLY JOB TITLE: REPLACES JOB TITLE:**

Powered by JobAps

76

State of Maryland
SOCIAL WORKER II, FAMILY SERVICES (#004513)

- Hourly / - BiWeekly /
- Monthly / $41,896.00-$66,880.00 Yearly

GRADE

16

NATURE OF WORK

A Social Worker II, Family Services is the full performance level of professional social work providing preventive or protective services to vulnerable adults, children or families. Cases involve suspected child or adult abuse or neglect, out of home placement, guardianship or emergency protective orders, adoption or adult case management. Employees in this classification do not supervise.

Employees receive general supervision from a Social Work Supervisor, Family Services. Employees in this class may be required to work evenings and on weekends and may be assigned to provide on-call coverage. Work is performed in customer's homes, schools, hospitals and other community settings. Employees may be required to deal with potentially hazardous situations. The Casework Specialist, Family Services, is differentiated from the Social Worker I, Family Services and the Social Worker II, Family Services in that the Casework Specialist, Family Services, while eligible for licensure, has not yet been licensed in Maryland and the Social Worker I, Family Services and Social Worker II, Family Services are licensed social workers.

The Casework Specialist, Family Services, Social Worker I, Family Services and Social Worker II, Family Services are also differentiated on the basis of the degree of supervisory control exercised by the supervisor over these employees. The Casework Specialist, Family Services performs duties under close supervision, the Social Worker I, Family Services performs duties under close supervision at times and under general supervision at other times depending upon the complexity of the specific duty being performed and the Social Worker II, Family Services performs the full range of duties under general supervision. The Social Worker II, Family Services is differentiated from the Social Work Supervisor, Family Services in that the Social Work Supervisor, Family Services has full supervisory responsibility for lower-level social workers. The Social Worker II, Family Services is differentiated from the Social Work Therapist, Family Services in that the Social Work Therapist, Family Services is certified for independent clinical practice and provides specialized clinical casework services.

EXAMPLES OF WORK

Applies social work values, principles and techniques in helping individuals and families obtain social services;

Interviews or investigates customers and other individuals to obtain necessary information in cases concerning suspected child or adult abuse or neglect, out of home placement, guardianship or emergency protective orders, or adoption;

Assists customers in identifying, developing and using their potential capabilities as well as other community resources for taking care of their social, health, emotional, behavioral and economic problems;

Assesses case situations and develops and implements an individualized plan of service;

Provides extensive counseling and crisis intervention services to customers regarding personal, economic and social problems;

Establishes and maintains personal contact with other helping agencies and community resources to facilitate the referral of individual customers;

Provides on-call coverage in cases involving suspected child or adult abuse or neglect;

Checks public records, such as birth records, for data and verifies other information such as income, kinship and residence;

Compiles evaluative reports and makes recommendations to the courts, other agencies and institutions regarding individual case situations;

Uses database applications to record information, research, and track or manage cases for compliance with applicable laws, regulations, and standards;

Prepares and manages case records and reports concerning information secured and services rendered;

Testifies in legal proceedings as to the facts of a specific family service case and may testify in court as an expert witness as to professional judgement;

Develops and implements an individualized training plan to maintain and upgrade knowledge and skills related to the delivery of services;

May act as a mentor for new family services staff members;

May prepare comprehensive evaluative reports recommending licensure of prospective homes for foster care or adoption;

May place children in foster and adoptive homes;

May participate in initial investigations of fatalities that result from suspected abuse or neglect;

May aid delinquent or mentally retarded children and adults in institutions or in foster and adoptive homes;

Performs other related duties.

KNOWLEDGE, SKILLS AND ABILITIES

Knowledge of the principles, practices and ethics of professional social work;

Knowledge of human growth and development;

Knowledge of the emotional, social, economic and physical needs of children and adults;

Knowledge of individual and group behavior; Knowledge of the social implications of various diseases or disabilities;

Skill in using computer applications such as email, word processing and database applications;

Ability to work effectively with children and adults who have social, economic, emotional, behavioral or health problems;

Ability to aid customers in the constructive use of their capabilities and in adjusting to their specific situations;

Ability to develop, initiate and follow through with an appropriate plan of service;

Ability to provide counseling to customers and treat personal information discreetly and confidentially;

Ability to establish and maintain effective working relationships with staff members, other agencies and institutions and the general public.

MINIMUM EDUCATION OR GENERAL REQUIREMENTS

Education: Determined by the Maryland State Board of Social Work Examiners under the licensing requirements for Social Workers.

Experience: One year of experience providing child welfare or adult services to vulnerable children, individuals or families.

Note: These requirements are established by the Social Services Administration by authority provided in Section 1 of Article 88A of the Annotated Code of Maryland. The Department of Budget and Management, Office of Personnel Services and Benefits does not have the authority to accept substitutions or equivalents.

LICENSES, REGISTRATIONS AND CERTIFICATIONS

1. Employees are required to be licensed as a graduate social worker, certified social worker or certified social worker-clinical by the Maryland State Board of Social Work Examiners prior to permanent appointment.

2. Employees in this classification may be assigned duties which require the operation of a motor vehicle. Employees assigned such duties will be required to possess a motor vehicle operator's license valid in the State of Maryland.

SPECIAL REQUIREMENTS

1. Employees who have not already done so must complete an approved training program and pass a competency test before being granted permanent employment status.

2. Employees are required to meet mandatory standards for continuing education as determined by the Department of Human Resources. Employees who fail to obtain the required continuing education credits shall be subject to disciplinary action including demotion, suspension and dismissal.

3. Employees in this classification may be required to provide the employer with a telephone number at which they can be reached.

ACKNOWLEDGEMENTS

Class specifications are broad descriptions covering groups of positions used by various State departments and agencies. Position descriptions maintained by the using department or agency specifically address the essential job functions of each position.

DATE REVISED

Jul 1 2006 12:00AM

APPROVED BY

Director, Division of Classification and Salary

CLASS: 004513 **EST: REV: FORMERLY JOB TITLE: REPLACES JOB TITLE:**

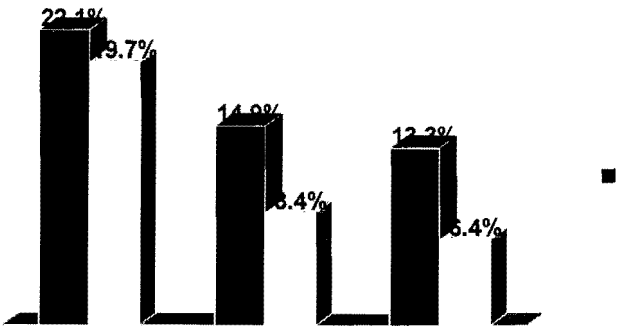
79

Assessing the Impacts of the Medicaid Expansion and Launch of HIX on BHCS Workforce Development

Council HHS Committee Hearing

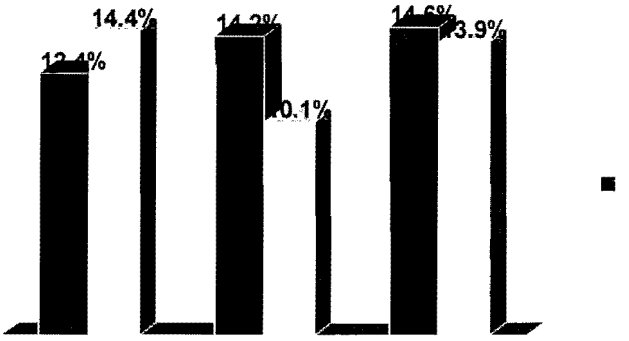
June 27, 2013

Prevalence of Serious Psychological Distress Among Adults Ages 18-64 by Current Medicaid Status and Eligibility for Medicaid Expansion or Health Insurance Exchanges



Sources: 2008-2010 National Survey on Drug Use and Health
2010 American Community Survey, the prevalence rate used for MC county is state level estimate published by SAMHSA.

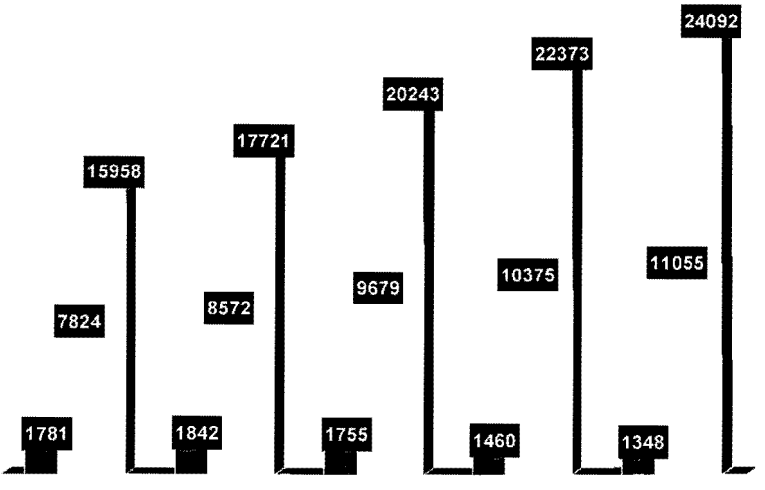
Prevalence of Substance Use Disorder Among Adults Ages 18-64 by Current Medicaid Status and Eligibility for Medicaid Expansion or Health Insurance Exchanges



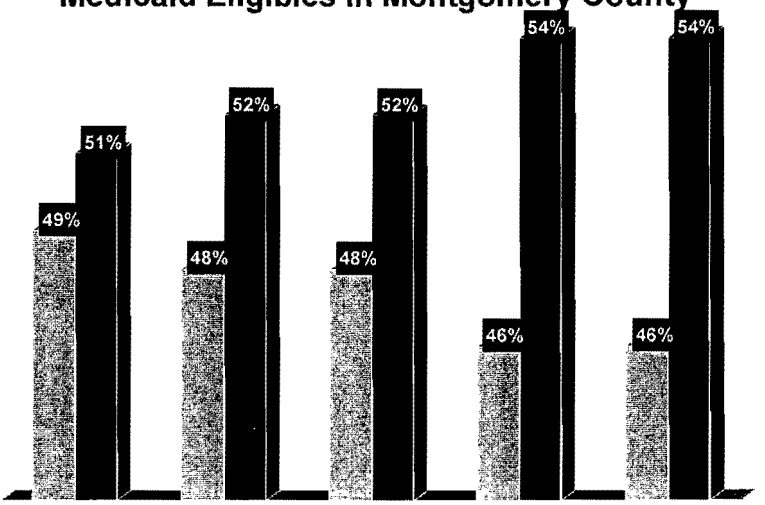
Sources: 2008-2010 National Survey on Drug Use and Health
2010 American Community Survey, the prevalence rate used for MC county is state level estimate published by SAMHSA.

Prevalence of Medicaid Eligible with Behavioral Health Needs Compared to Numbers Served

FY08 – FY12

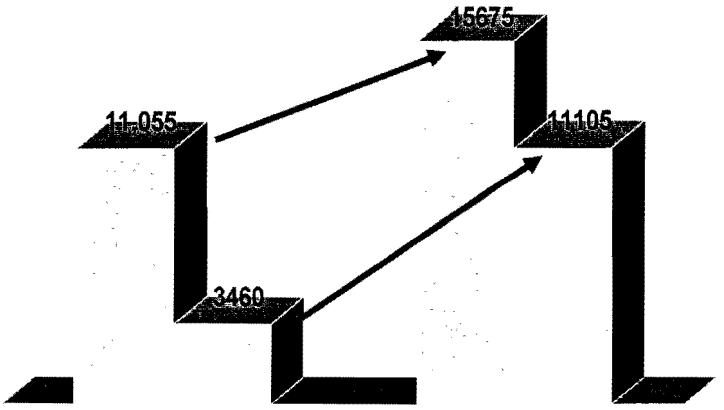


Percentage of Served vs. Underserved Mentally Ill Medicaid Eligibles in Montgomery County



5

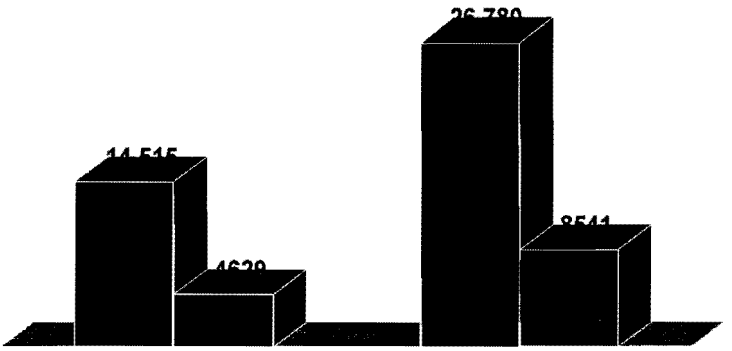
Current Numbers of Clients Served and Projected Numbers Served (meeting 50% of projected need)



The increase of MI clients is projected to be 42%, while clients needing addiction treatment will increase by 221%. Overall, the percent increase for behavioral health clients after the launch of ACA could reach 84.5%.

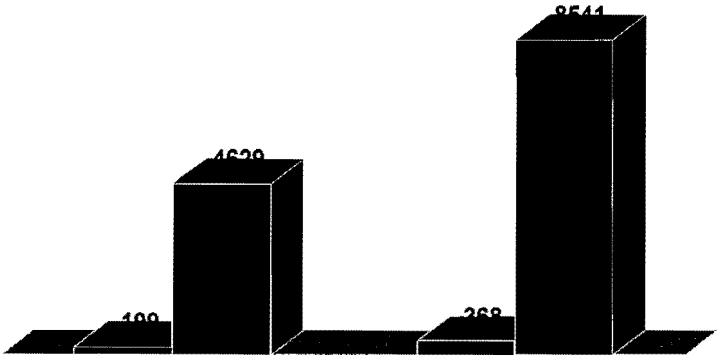
6

Montgomery County Behavioral Health Clients Served by BHCS System: before and after Jan. 2014



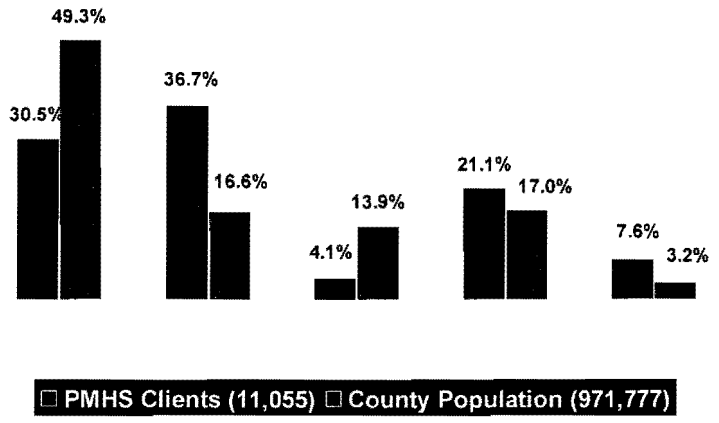
Sources: DHHS BHCS Program Data Reports for FY12
Maryland Health Connection Publication: Environmental Analysis and Market Scan Highlights and Key Data Presentation by KRC Research, Mar. 2012
SAMHSA Publication: Enrollment under the Medicaid Expansion and Health Insurance Exchange, A Focus on Those with Behavioral Health Conditions in Maryland.

Montgomery County Behavioral Health Clients Served by DHHS BHCS Programs and Numbers of Staff – Current and Projected



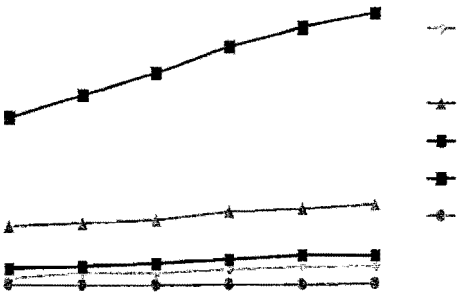
Note: Projections of future demands of behavioral health clinical and supporting staff were made based on client pool increase of mentally ill and/or substance abuse clients as shown in previous slide.

FY2012 Public Mental Health System Clients vs. 2010 Census County Population



9

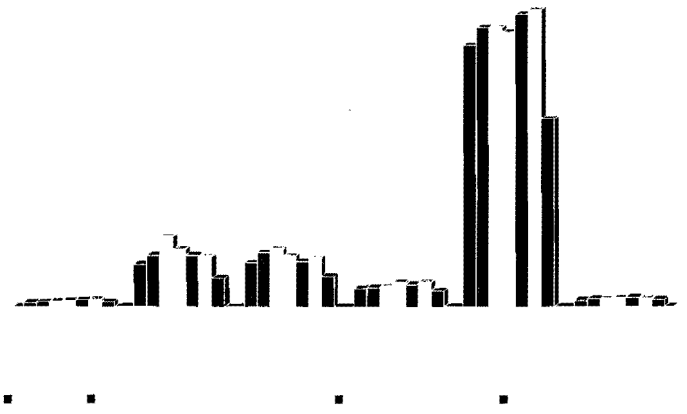
Growth in Clients Served by PMHS (Public Mental Health System)



Note: The cumulative increase between FY07 and FY12 is 57% for total number of PMHS clients in the county.

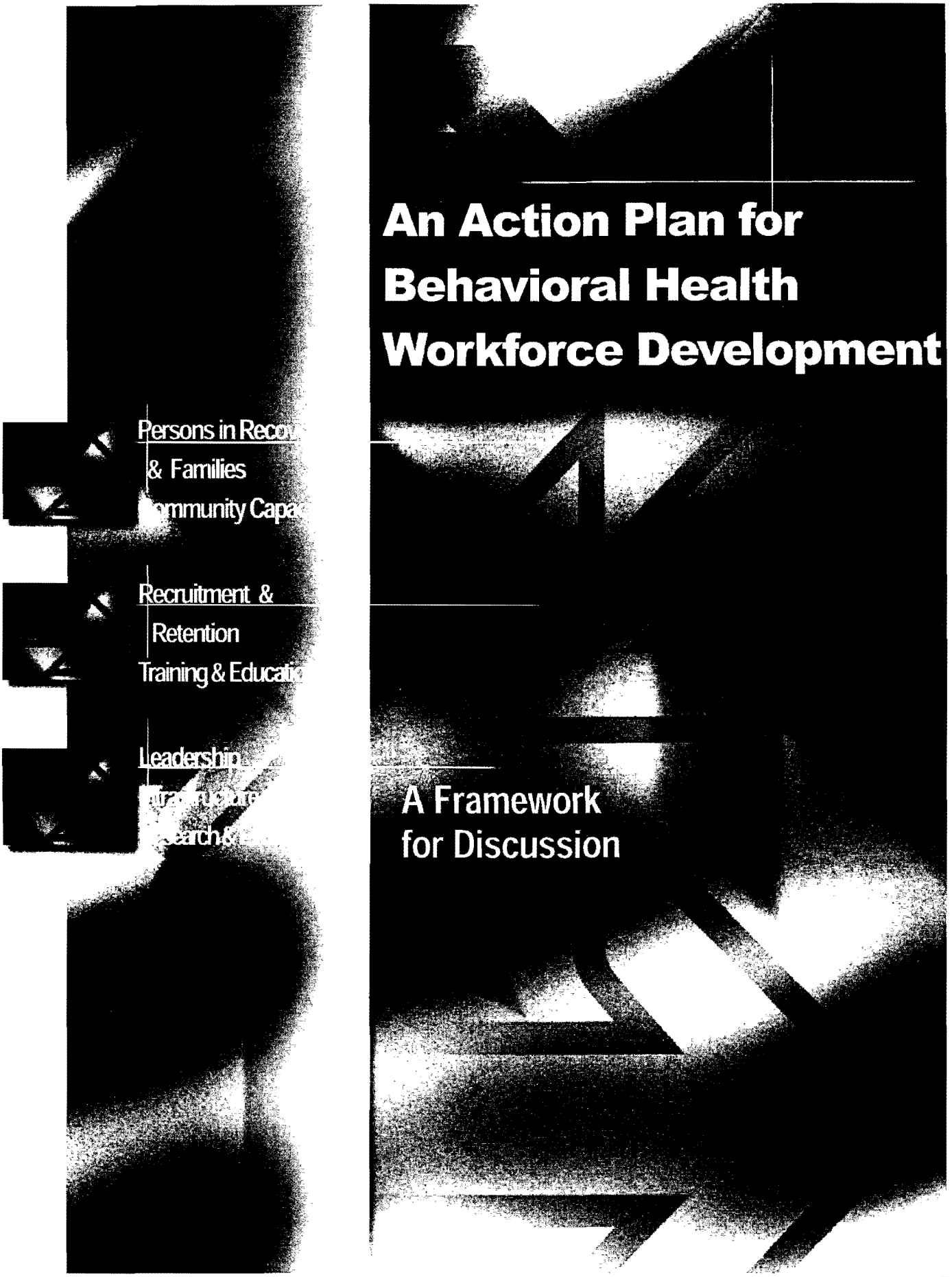
10

Public Mental Health System Units of Service for Montgomery County Clients by Age Group



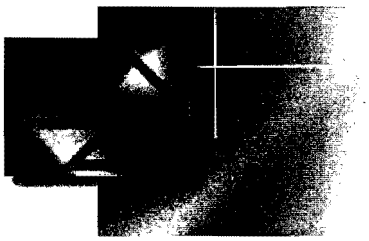
Note: From FY07 to FY12, total units of services increased by 15.6% for total Montgomery County PMHS clients.
FY13 total units of service is summarized based on Value Options Claims paid through March 31, 2013.

11



An Action Plan for Behavioral Health Workforce Development

A Framework for Discussion



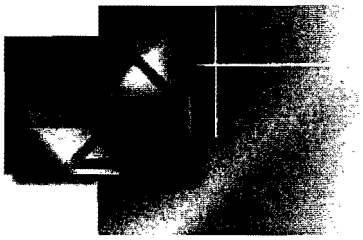
ACKNOWLEDGEMENTS

This report was prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by The Annapolis Coalition on the Behavioral Health Workforce (Cincinnati, Ohio) under Contract Number 280-02-0302 with SAMHSA, U.S. Department of Health and Human Services (DHHS). Ronald W. Manderscheid, Ph.D., and Frances L. Randolph, Dr. P.H., M.P.H., served as the Government Project Officers. Senior authors of the report by the Annapolis Coalition were Michael A. Hoge, John A. Morris, Allen S. Daniels, Gail W. Stuart, Leighton Y. Huey, and Neal Adams.

DISCLAIMER

The views, opinions, and content of this publication are those of the authors and do not necessarily reflect the views, opinions, or policies of SAMHSA or DHHS.

2007



EXECUTIVE SUMMARY

INTRODUCTION AND OVERVIEW

A Workforce Crisis

Across the nation there is a high degree of concern about the state of the behavioral health workforce and pessimism about its future. Workforce problems have an impact on almost every aspect of prevention and treatment across all sectors of the diverse behavioral health field. The issues encompass difficulties in recruiting and retaining staff, the absence of career ladders for employees, marginal wages and benefits, limited access to relevant and effective training, the erosion of supervision, a vacuum with respect to future leaders, and financing systems that place enormous burdens on the workforce to meet high levels of demand with inadequate resources.

Most critically, there are significant concerns about the capability of the workforce to provide quality care. The majority of the workforce is uninformed about and unengaged in health promotion and prevention activities. Too many in the workforce also lack familiarity with resilience- and recovery-oriented practices and are generally reluctant to engage children, youth, and adults, and their families, in collaborative relationships that involve shared decision-making about treatment options. It takes well over a decade for proven interventions to make their way into practice, since prevention and treatment services are driven more by tradition than by science. The workforce lacks the racial diversity of the populations it serves and is far too often insensitive to the needs of individuals, as these are affected by ethnicity, culture, and language. In large sections of rural America, there simply is no mental health or addictions workforce.

There is overwhelming evidence that the behavioral health workforce is not equipped in skills or in numbers to respond adequately to the changing needs of the American population. While the incidence of co-occurring mental and addictive disorders among individuals has increased dramatically, most of the workforce lacks the array of skills needed to assess and treat persons with these co-occurring conditions. Training and education programs largely have ignored the need to alter their curricula to address this problem and, thus, the nation continues to prepare new members of the workforce who simply are underprepared from the moment they complete their training.

It is difficult to overstate the magnitude of the workforce crisis in behavioral health. The vast majority of resources dedicated to helping individuals with mental health and substance use problems are *human resources*, estimated at over 80% of all expenditures (Blankertz & Robinson, 1997a). As this report documents in its complete version, there is substantial and alarming evidence that the current workforce lacks adequate support to function effectively and is largely unable to deliver care of proven effectiveness in partnership with the people who need services. There is equally compelling evidence of an anemic pipeline of new recruits to meet the complex behavioral health needs of the growing and increasingly diverse population in this country. The improvement of care and the transformation of systems of care depend entirely on a workforce that is adequate in size and effectively trained and supported. Urgent attention to this crisis is essential.

An Action Plan with National Scope

This Executive Summary gives an overview of key findings of a multiyear process that led to this Action Plan for strengthening the behavioral health workforce. In order to address the workforce crisis described above, the Substance Abuse and Mental Health Services Administration (SAMHSA) commissioned the Annapolis Coalition on the Behavioral Health Workforce (www.annapoliscoalition.org) to develop an Action Plan on workforce development that encompasses the breadth of this field and is national in scope. The planning process was funded by the SAMHSA Office of the Administrator and all three centers within the federal agency: the Center for Mental Health Services (CMHS), the Center for Substance Abuse Treatment (CSAT), and the Center for Substance Abuse Prevention (CSAP). The planning process was intended to build on previous workforce planning efforts, including the CSAT-sponsored report on *Strengthening Professional Identity: Challenges of the Addiction Treatment Workforce* (U.S. Department of Health and Human Services [DHHS], 2005a).

The Annapolis Coalition is a not-for-profit organization focused on improving workforce development in the mental health and addiction sectors of the behavioral health field. Since 2000, the Coalition has functioned as a neutral convener of diverse individuals, groups, and organizations that recruit, train, employ, license, and receive services from the workforce (Hoge & Morris, 2002; Hoge & Morris, 2004; Hoge, Morris, & Paris, 2005). The Coalition conducts strategic planning, identifies innovation, and has provided technical assistance in workforce issues to federal and state agencies, private organizations, and commissions, including the New Freedom Commission on Mental Health (2003) and the Institute of Medicine (IOM, 2006).

This strategic planning process was designed to examine current weaknesses in efforts to develop and sustain a strong workforce in behavioral health; develop a vision for a future workforce that is compassionate, effective, and efficient; and identify practical strategies that can be implemented to

achieve that vision. Because federal powers largely have shifted to state and local governments, and all governments increasingly are turning to private organizations as vehicles for action (Bryson, 2004), this Action Plan is intended to demonstrate how public and private collaboration by diverse stakeholders can strengthen the behavioral health workforce. The ultimate aim of these efforts is to improve dramatically the quality of care received by individuals and their families who are served by behavioral health care providers.

Areas of Focus

From a population perspective, this Action Plan encompasses workforce issues relevant to persons with mental health conditions, substance abuse or substance use disorders, and co-occurring mental and addictive conditions. A life-span perspective was adopted to ensure that the planning process gave specific attention to workforce development issues pertaining to children, youth, and parents, as well as older adults. Planning also was organized around the workforce needs related to culturally and linguistically diverse populations, as well as those living and working in rural and frontier areas.

With respect to workforce activities, the planning process examined health promotion, prevention, treatment, rehabilitation, recovery, and resilience-oriented approaches. It also examined the continuum of behavioral health needs, from mild problems to severe and persistent illnesses. A range of other workforce activities and processes required and received attention, including recruitment and retention, training and education, licensure and certification, workforce financing, and the use of information technology in training and service delivery.

Defining the Workforce

A broad definition of workforce was adopted for this planning process. It included the behavioral health workforce, consisting of individuals in training or currently employed to provide health promotion, prevention, and treatment services. This group includes professionals with graduate training, as well as individuals who have associate's or bachelor's degrees, high school diplomas, or even less formal education.

Persons in recovery and their family members are explicitly recognized as pivotal members of the workforce, as they have critical roles in caring for themselves and each other, whether informally through self-help and family caregiving or more formally through organized peer- and family-support services. These individuals are the unsung heroes and heroines of the workforce and provide a unique perspective that enhances the overall relevance and value of the care provided. While other health and human service providers, such as primary care providers, emergency room staff, correctional staff, and teachers,

have major roles in responding to the needs of individuals with mental and addictive disorders, these segments of the workforce were not addressed in this planning process due to time and resource constraints. Their critical role in the informal behavioral health workforce is acknowledged and their workforce development needs unquestionably warrant attention in a subsequent planning effort.

Issues of Language

Even when individuals speak the same language there are barriers to communication. One of the special challenges in developing a broadly inclusive strategic plan involved grappling with variations in terminology used by stakeholders representing the highly diverse areas in this field. The selection and use of language is an extremely important issue. However, there is a lack of consensus on terms that are broadly applicable and acceptable to all of the individuals, organizations, interests, and issues that constitute the field. The authors of this report made extensive efforts to find and use language that would be generally relevant and acceptable to all readers and nonstigmatizing to individuals and families; at the same time, the authors recognize that many of the terms used within these pages are imprecise and imperfect.

A Common Agenda

The behavioral health field has not historically spoken with one voice. As recommendations emerged from the panels and work groups formed to conduct the action planning, there often was controversy. But as the discussions progressed, as language differences were explored and resolved, and as assumptions were probed and made transparent, it became clear that there are many commonalities regarding workforce issues across the various sectors of this field. It also became abundantly clear that the people working in these diverse sectors have much to learn from each other and much to be gained by working together on a common workforce agenda.

The objective of the planning process was to examine workforce issues broadly across the behavioral health field in order to identity a set of *core*, *common* or *cross-cutting* goals and objectives that have broad relevance to all sectors of the field. This Action Plan was not intended to be, nor can it function as, the definitive and detailed plan for a specific sector, population, government agency, or private organization. However, it is designed to serve as a resource that can inform, focus, and help guide any agency, organization, or sector of the field as it devises a detailed action plan tailored to its specific history, needs, and current priorities. In fact, the value of this planning effort rests on the assumption that a broad array of stakeholders will move the workforce development agenda forward in their own spheres of influence, informed by the recommendations of their peers as outlined in this report.

While more than 5,000 individuals were involved in this planning process, there undoubtedly are many individuals who have opinions on these issues who did not have the opportunity to contribute. This Action Plan is considered a work in progress that must continue to evolve as others add their voices, as the health care environment continues to change, as more experience is gained with the recommendations, and as better evidence is generated about effective strategies to strengthen the workforce.

THE PLANNING PROCESS

Given the intended breadth of this Action Plan and the need for multiple methods of data collection, an array of planning vehicles was adopted. Nationally recognized experts in workforce development from diverse sectors of the field were engaged as senior and technical advisors to manage planning in their respective areas of expertise, to function as emissaries in this process to their peers, and to serve on the National Steering Committee of the Annapolis Coalition, which reviewed and vetted all recommendations and the content of the final report. The advisors convened and chaired 12 expert panels and work groups, which were responsible for reviewing prior workforce reports and recommendations; obtaining input from colleagues via professional meetings and planning sessions conducted across the country; identifying workforce development innovations; and formulating a set of proposed goals, objectives, and actions. Expert panels were generally larger in membership or had a longer life span than the work groups. The panels and work groups were as follows:

- Child, Adolescent, & Family Panel
- School-based Mental Health Panel
- Consumer & Family Panel/Adult Mental Health
- Cultural Competency & Disparity Panel
- Substance Use Disorders Treatment Panel
- Substance Abuse Prevention Panel
- Older Adults Panel
- Rural Panel
- Provider Accreditation Panel
- Educators Work Group
- Information Technology/Distance-Learning Work Group
- Financing Work Group

The Annapolis Coalition issued an open call for submission of information and recommendations via the Internet and extended specific invitations to a wide range of groups and organizations through a variety of mechanisms. Recommendations submitted through all sources were organized into seven goal areas,

which were expanded into detailed implementation tables, clustered around the specific objectives necessary to achieving each goal. These implementation plans, along with the text developed to explain the recommendations, were reviewed and revised by the National Steering Committee. Senior and technical advisors then drafted additional sections of the report that focused on their sector, population, or other area of expertise. The draft report was vetted through a national conference held by SAMHSA in July of 2006 with more than 200 participants drawn from all sectors of the field. Modifications to the report were made based on feedback from participants.

For a strategic plan that is national in scope to have credibility it must attend to the critical issues of both content and process. Within the time and resource constraints of this endeavor, achieving broad participation and wide-ranging input (grounded in a thorough review of available reports and the published workforce literature) were of paramount importance. With respect to process, a conservative estimate is that more than 5,000 individuals were engaged in some way in contributing to this planning process, with every individual specifically invited to provide verbal or written input. The credit for the thoroughness and quality of the final report belongs to the many individuals who contributed to the process. The Annapolis Coalition accepts responsibility for any limitations, errors, or omissions in the final report.

The planning process resulted in an overview of the workforce and the environment in which it functions; general findings about the characteristics of the workforce crisis; and a set of seven strategic goals, accompanied by specific objectives and recommended actions necessary to achieve these goals. The following sections provide summaries of these topics.

THE CURRENT WORKFORCE AND ITS ENVIRONMENT

The Mental Health Workforce

Historically, neither state agencies nor professional associations have collected information routinely on the workforce using a standardized data set or common schedule. Thus it has been difficult to assemble a unified picture of the mental health workforce or to compare the various disciplines that constitute it. The Alliance of Mental Health Professions has been developing a standardized data set and working to generate comparable data across disciplines (Duffy et al., 2004). However, further progress on this agenda is sorely needed.

The best available estimates indicate that there were slightly more than a half million clinically trained and active mental health professionals in the United States in 2002 (Manderscheid & Henderson, 2004). There are differing trends regarding the growth rates of the various disciplines within the field, with

psychiatry essentially static in terms of growth, psychology doubling in size over the past 25 years, and social work increasing by 20% over the past 1 ½ decades. Increases in the number of psychiatric nurses with graduate-level preparation largely have been offset by the number of nurses leaving the active workforce and by sharp reductions in the number of students who are enrolling in this discipline's graduate programs.

There is a notable lack of racial and cultural diversity among the mental health disciplines. The vast majority of professionals are non-Hispanic Whites, often exceeding 90% of discipline composition (Duffy et al., 2004). For most disciplines, substantially more than half of the clinically trained professionals are over the age of 50, raising serious concerns about whether the pipeline of young professionals will be adequate to compensate for both the growing service demand and the approaching retirement of large segments of the workforce (Duffy et al., 2004).

Compounding concerns about workforce size are problems with its geographic distribution. Holzer, Goldsmith, and Ciarlo (2000) provide evidence that the heaviest concentrations of highly trained professionals are in urban centers. In fact, more than 85% of the 1,669 federally designated mental health shortage areas are rural in nature (Bird, Dempsey, & Hartley, 2001). Half of the counties in the United States do not have a single mental health professional.

In addition to graduate degreed professionals, there are 145,000 members of the mental health workforce who do not have graduate-level professional training but rather possess a bachelor's degree or less (Morris & Stuart, 2002). This segment of the workforce includes registered nurses, bachelor's-prepared social workers, and various technicians or aides. This group of individuals too seldom receives systematic training and support despite the fact that it accounts for up to 40% of the workforce in many public-sector service settings.

The Substance Use Disorders Treatment Workforce

The workforce that is specifically trained and credentialed to provide substance use disorders services is small in comparison to the identified need. Only 1 person in 10 who has a drug use disorder and 1 person in 20 who has an alcohol use disorder receive treatment for the condition (Wright, 2004). The workforce implications of these statistics are simply staggering.

An estimated 67,000 licensed and unlicensed counselors provide substance use disorder treatment and related services (Harwood, 2002). An additional 40,000 professionals are licensed or credentialed to provide such care (Keller & Dermatis, 1999). These professionals are predominately social workers,

complemented by small contingents from general medicine, psychiatry, psychology, nursing, and marriage and family therapy.

The substance use disorders treatment workforce is primarily female, older, and White. For example, among new counselors entering the field, 70 percent are female (NAADAC, 2003). The average age of treatment staff is mid-forties to early fifties (NAADAC, 2003; RMC, 2003). Studies indicate that from 70 percent to 90 percent of substance use disorder treatment personnel are Caucasian (Harwood, 2002; Knudsen, Johnson, & Roman, 2003; Mulvey, Hubbard, & Hayashi, 2003; RMC, 2003). The characteristics of staff working in this sector of the field frequently differ from their predominantly young, male, and minority clientele.

The Substance Abuse Prevention Workforce

The workforce in substance abuse prevention has been estimated at ½ million in number. However, there is no standard inventory or methodology for defining and counting this sector of the workforce. In terms of composition, it includes professionals from the fields of social work, education, psychology, criminal justice, health care, counseling, and the clergy. This workforce also includes parents, teachers, youth leaders, indigenous workers, law enforcement officers, school personnel, and civic and volunteer groups, often organized as community coalitions (www.cadca.org).

The substance abuse prevention workforce typically falls into three distinct yet overlapping subgroups: (1) tribal, state, territory, or substate managers of prevention funding and delivery systems; (2) direct implementers of prevention programs and activities; and (3) community or coalition members engaged in promoting behavioral health and wellness in their communities. Some members of this prevention workforce have obtained state credentialing in addictions, while many others have chosen not to pursue or are not eligible for credentialing due to the educational prerequisites.

The Environment of Care

Each day, environmental forces shape, promote, challenge, block, or defeat the activities of the workforce and thus heavily influence how well the behavioral health needs of individuals, families, and communities are met. A well-prepared workforce has little meaning in an environment that does not actively support its values or effective practice, or offer employees competitive wages and benefits. As noted by an expert in the field of human performance, "When you pit a bad system against a good performer, the system almost always wins" (Rummler, 2004).

With respect to service delivery, both organizational and system characteristics are at least as influential as the education and training of individual personnel (IOM, 2001, 2004). Throughout the planning process, participants repeatedly expressed concerns that the health care environment is actually "toxic" to adults in recovery, to children and youth, to their families, and to the workforce that strives to provide prevention and treatment services.

A broad range of other environmental issues has a negative impact on the workforce. It has been frequently reported that staffing levels are reduced as a cost-cutting measure, while patient caseloads and acuity levels increase. Financing mechanisms and organizational constraints create conflict for the provider who is asked to be responsive to the bottom line of his or her organization but, in so doing, may jeopardize the interests of the individuals in need of care (Wolff & Schlesinger, 2002).

Members of the workforce routinely struggle with the ambiguity of the rules, regulations, standards, and procedures that govern service delivery, and which sometimes conflict with one another. These rules may not be grounded in an evidence base. They often limit professional judgment, and can constrain efforts to tailor interventions to individual need. Productivity is reduced because of administrative burdens, most notably those involving extensive and often repetitive documentation. Members of the workforce have repeatedly described their low morale and low levels of commitment to their organization and to the field because of low pay, the absence of career ladders, excessive workloads, tenuous job security, the lack of supervision, and an inability to influence the organization or system in which they are working (Blankertz & Robinson, 1997b; Center for Health Workforce Studies, 2006; Gellis & Kim, 2004; Hanrahan & Gerolamo, 2004; IOM, 2003, 2004; Zurn, Dal Poz, Stilwell, & Adams, 2004).

In recent reports on the addiction treatment workforce, CSAT (DHHS, 2003, 2005b) identified several conditions and trends that have broad relevance for the workforce in all sectors of behavioral health. These include:

- A workforce and treatment capacity insufficient to meet demand.
- A changing profile of the people in need of services, which includes increased co-occurring mental illnesses and substance use disorders, medical comorbidity, rapidly evolving patterns of licit and illicit drug use, and involvement in the criminal justice system.
- A shift to increased public financing of treatment, accompanied by declining private coverage, budgetary constraints in publicly funded systems, managed care policies and practices, and the large number of undocumented and uninsured individuals.
- Major paradigm shifts within the field, including the movement toward a recovery management (and resilience-oriented) model of care.

- A continual escalation of demands on workers to change their practices, including the adoption of best practices and evidence-based interventions.
- An increase in the use of medications in treatment, with the resultant demand that the workforce be knowledgeable and skilled in managing medications.
- A challenge to provide services more frequently in nonbehavioral health settings.
- An expansion of requirements to implement performance measures and to demonstrate patient outcomes through data.
- A climate of ongoing discrimination or stigma related to people who receive *and* provide care.

Perhaps no change has as much impact on the workforce as the emerging redefinition of the role of the consumer in making health care decisions. This is as true in behavioral health as it is in general medicine. Trends such as illness self-management, peer-support approaches, and increased access to information via the Internet are remodeling the relationships among practitioners, patients, and their families, thus posing new challenges for the workforce as well as new opportunities for genuine partnerships between consumer and provider in the decision-making process (Morris & Stuart, 2002).

GENERAL FINDINGS

Workforce problems are evident in every element or dimension of the behavioral health field. Concerns about the workforce also exist among every group of stakeholders concerned about the future of prevention and treatment for mental health and substance use problems. General findings about the workforce crisis are described below, and are treated indepth in the larger report.

There is a critical shortage of individuals trained to meet the needs of children and youth, and their families. As just one example, the federal government has projected the need for 12,624 child and adolescent psychiatrists by 2020, far exceeding the projected supply of 8,312. Currently there are only 6,300 such psychiatrists nationwide, and relatively few are located in rural and low-income areas (American Academy of Child and Adolescent Psychiatry [AACAP] Task Force, 2001). There is an even more severe shortage of practitioners trained and credentialed to treat adolescents with substance use disorders.

Only five states require adolescent-specific knowledge for licensure (Pollio, 2002). Furthermore, behavioral health professionals who have been trained to provide behavioral health prevention and intervention in the nation's schools are in significantly short supply, or are hindered by the constraints of their position to use such skills. Beyond the issue of workforce size, the training programs that do focus on prevention and treatment for children and youth, and their families, have not kept pace with current

trends in the field, which have been shifting toward strengths-based and resilience-oriented models, a systems-of-care approach, and the use of evidence-based practices (Curie, Brounstein, & Davis, 2004; McLellan & Meyers, 2004; Meyers, Kaufman, & Goldman, 1999).

There is a pronounced shortfall in the current workforce of providers with expertise in geriatrics, and this deficit is expected to worsen. Only 700 practicing psychologists view older adults as their principal population of focus, well short of the estimated 5,000 to 7,500 geropsychologists necessary to meet current needs (Jeste et al., 1999). Similarly, only 640 members of the American Psychiatric Nurses Association (APNA, 2002) have a subspecialization in geriatrics. In 2001, there were only 81 geriatric psychiatry fellows in training in this nation, and 39% of the available fellowships went unfilled (Warshaw, Bragg, Shaull, & Lindsell, 2002). These numbers suggest that creating more training opportunities may be a necessary, yet insufficient, workforce strategy.

As described in the introduction to this report, only 20% of the individuals in this country who need substance use disorders treatment each year receive it. This is due, in part, to severe difficulties in recruiting and retaining qualified staff in sufficient numbers (Gallon, Gabriel, & Knudsen, 2003; Hall & Hall, 2002; Northeast Addiction Technology Transfer Center, 2005). In the most compelling study of this issue, McLellan, Carise, and Kleber (2003) found a 50% turnover in frontline staff *and* directors of substance use disorder treatment agencies in a single year. Furthermore, 70% of the frontline staff members in these agencies did not have access to basic information technology to support their daily work.

In rural America, the workforce crisis is particularly acute. More than 85% of the 1,669 federally designated mental health professional shortage areas are rural (Bird, Dempsey, & Hartley, 2001), and they typically lack even a single professional working in the mental health disciplines. It has been extraordinarily difficult to recruit, train, and retain professionals in rural areas. Traditional approaches to workforce development center on "programs and professionals" and often fail to address local needs. Few training programs offer any significant focus on rural behavioral health service delivery.

Workforce distribution issues relate not only to geography but also to race and culture. U.S. Census figures indicate that 30% of the nation's population is drawn from four major ethnic groups: Latinos, African Americans, Asian American/Pacific Islanders, and Native Americans. However, the behavioral health workforce lacks such cultural diversity, particularly in mental health. For example, non-Hispanic Whites currently account for 75.7% of all psychiatrists, 94.7% of psychologists, 85.1% of social workers, 80% of counselors, 91.5% of marriage and family therapists, 95.1% of school psychologists, and 90.2% of psychiatric nurses (Duffy et al., 2004). Cross-cultural training has the potential to improve quality of

care and service use among people of color (Fortier & Bishop, 2003), but the workforce at large cannot be characterized as culturally or linguistically competent.

Workforce issues are a personal matter for individuals with mental health and substance use problems. While the experiences of those who receive care vary greatly, the individuals whose voices were heard during the process of compiling this Action Plan were, by and large, very dissatisfied with the workforce. There was considerable anger about what many of these individuals described as the stigmatizing attitudes among the workforce about persons with mental and addictive disorders. Other complaints about the workforce focused on inadequate understanding and support for recovery- and resilience-oriented approaches to care and a basic lack of empathy and compassion. These complaints should be of deep concern to the field, given the importance of therapeutic relationships as a basic foundation for all efforts to care effectively for people in need.

Another group that voiced strong concerns comprised managers within organizations that employ the workforce. Their constant lament was that recent graduates of professional training programs are unprepared for the realities of practice in real-world settings, or worse, have to unlearn an array of attitudes, assumptions, and practices developed during graduate training that hinder their ability to function. In an era of scarce resources, the specter of education and training programs that lack relevance to the needs of the American population and to current prevention and treatment approaches raises considerable alarm.

As in general health care, the delay in translating science into services is a major concern in behavioral health. Within the workforce, the change in practice patterns appears to occur with the changing generations of treatment providers and prevention specialists. Underlying this troubling dynamic is the fact that educational systems emphasize the teaching of specific practices. Their focus is typically on teaching "content" as opposed to teaching and instilling in students a "process" of continuous, lifelong, real-world learning.

Training in behavioral health now occurs in disciplinary or sector silos. Furthermore, there is little collaboration among the disciplines on workforce development efforts, such as competency development, despite the presence of many shared competencies across professions. Three other tensions impede cooperation on a strengthened national workforce development agenda or dissemination of workforce innovations across sectors and disciplines: the divide between the mental health and addiction portions of the field; the split between treatment and prevention that exists within mental health and within addictions; and, in all sectors, the separation between the traditional treatment system and the recovery community.

There is a striking lack of data, not only about the workforce but also about workforce development practices. The scattered information that does exist has no uniformity, which hinders cross comparison or aggregation of the data to examine trends. The reliability of workforce data is generally open to question. There is little consensus about key workforce variables, and there are few benchmarks that organizations can use as a reference point in assessing the magnitude of their workforce problems or success in addressing them. Published studies on interventions to strengthen the workforce seldom use solid research designs and methods and are often simply anecdotal reports.

As training, prevention, and treatment organizations attempt to address workforce issues, there is a notable tendency to do what is affordable rather than what is effective. The most glaring example is the provision of single-session, didactic in-services or workshops, which are the most frequent approach to staff training and development. These are the mainstay of training efforts even though there is clear evidence of their ineffectiveness in changing practice patterns. System and agency managers are increasingly hungry for workforce tools of proven effectiveness, yet relatively few interventions or models are well described, portable, and easily adapted to different settings. There are pockets of innovation across the nation, but these are uniformly underfinanced and difficult to sustain, and are seldom disseminated or replicated in other locales; the full Action Plan includes many examples of promising innovation.

Despite the dire state of the workforce, there are a number of causes for optimism about the future. Many dedicated members of the workforce and many committed leaders in the behavioral health field understand the critical need to address seriously the many issues outlined above. The issues now are receiving federal, state, and local attention. The existing pockets of innovation are good starting points as building blocks for more comprehensive and systematic solutions to current workforce dilemmas. The field can and must move forward to tackle the workforce challenge.

SEVEN STRATEGIC GOALS: AN OVERVIEW

The distillation of the reports and recommendations of the multiple expert panels and work groups yielded a set of seven final action goals (Table 1). Goals 1 and 2 focus on broadening the concept of workforce. Persons in recovery, children, youth, families, and communities are not simply recipients of prevention and treatment services. They are active in promoting and maintaining health and wellness, defining their unique needs, caring for themselves, supporting each other, and providing guidance about when, where, and how services should be delivered. Their roles as both formal and informal members of the behavioral health workforce must be greatly expanded. Goals 3, 4, and 5 are traditional workforce goals that focus on strengthening the workforce. The recommended objectives and actions identified for these goals reflect activities related to best practices in recruitment and retention, training and education, and

leadership development. Goals 6 and 7 involve creating improved structural supports for the workforce, such as technical assistance on workforce practices, stronger human resources departments, greater use of information technology, and a national research and evaluation initiative to yield improved information on effective workforce practices. These goals are reviewed in the sections that follow.

A set of objectives was identified for accomplishing each of the seven goals. The goals and objectives are presented in the Quick Reference Guide, which appears as an appendix of this Executive Summary. The full report of this Action Plan contains detailed Preliminary Implementation Tables that identify specific action steps for each objective, linked to potential stakeholders who could take those actions. Readers interested in adopting for their workforce development efforts the framework provided in this report should reference the implementation tables as a guide to action.

TABLE 1
STRATEGIC GOALS AT A GLANCE

BROADENING THE CONCEPT OF WORKFORCE

GOAL 1: Significantly expand the role of individuals in recovery, and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others; and educate the workforce.

GOAL 2: Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness.

STRENGTHENING THE WORKFORCE

GOAL 3: Implement systematic recruitment and retention strategies at the federal, state, and local levels.

GOAL 4: Increase the relevance, effectiveness, and accessibility of training and education.

GOAL 5: Actively foster leadership development among all segments of the workforce.

STRUCTURES TO SUPPORT THE WORKFORCE

GOAL 6: Enhance the infrastructure available to support and coordinate workforce development efforts.

GOAL 7: Implement a national research and evaluation agenda on behavioral health workforce development.

GOAL 1: Significantly expand the role of individuals in recovery, and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others; and educate the workforce.

From the perspective of workforce planning and development, priority attention must be given to the role that persons in recovery, children, and youth, and their families, have in caring for themselves and each other and could have in educating the traditional workforce. The amount of service provided by behavioral health professionals and other health and human services providers simply pales in comparison to the volume of self-care, peer support, and family caregiving. Individuals with mental health and addiction problems, along with their families, are a human resource that too often has been overlooked or underutilized. A core strategic goal must be to recognize these persons as part of the workforce and to develop their capacity to care for themselves and each other effectively, just as the field must attempt to strengthen the professional workforce.

Goal 1 in this Action Plan calls for a significantly expanded role for individuals in recovery and families in the workforce. Five major objectives have been identified to achieve this goal. The first is to create fully informed individuals and family members by providing better knowledge through educational supports. Shared decision-making is a second objective, to be accomplished by training individuals, families, and providers in collaborative approaches to care. Two additional objectives focus on formal roles in the workforce for persons in recovery and family members through expanded peer- and family-support services and through increased employment of these individuals as paid staff in prevention and treatment systems. As a final objective, engaging persons in recovery and family members as educators of the workforce is designed to shape the education of providers and to foster more collaborative relationships between those receiving and providing care.

Inherent in the concept of transforming mental health service systems and models of care, as called for by the President's New Freedom Commission (2003), is a shift in power. Emerging approaches to care in behavioral health involve shifts in the locus of decision making that result in more equal partnerships between persons in recovery, family members, and providers. Many individuals who participated in the development of the Action Plan considered this strategic goal, focused as it is on an expanded role for persons in recovery and family members, to have the greatest potential to transform systems of care.

GOAL 2: Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness.

The importance and centrality of the role of communities in promoting and maintaining behavioral health and wellness was captured by Wagenaar and colleagues (1994), who stated that "[T]he community is not

simply the *site* for the intervention but the *vehicle* for change." Expanding on this notion, it is clear that communities are the locus for defining their health needs, priorities, and strategies, which leads to a broad vision of person-centered, family-centered, and community-centered approaches to behavioral health and wellness. Communities are a key element of the workforce in a manner quite parallel to the way in which persons in recovery, children, youth, and families are core to the workforce, as described above under Goal 1.

Expanding the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness emerged as a core strategic goal, which is relevant to all sectors of behavioral health. The proposed vehicles for accomplishing this goal center around three objectives. Most critical is an expanded effort to build five core competencies in communities, related to assessment, capacity building, planning, implementation, and evaluation (www.cadca.org; DHHS, 2004). A second objective involves renewed efforts to develop competencies within the behavioral health workforce related to community development and community collaboration. As a final and more immediate objective, it is recommended that every behavioral health organization formally reassess its current connections to local groups, organizations, and coalitions, and implement a plan to increase, strengthen, and diversify these ties.

In selected towns and cities, community coalitions have had a major role in identifying and addressing behavioral health needs, particularly around issues related to substance abuse. To varying degrees, behavioral health providers from all sectors of the field have supported and partnered with their host communities. There are enormous opportunities, however, for communities to build much greater capacity to promote behavioral health and wellness and to function as a critical element of the workforce, driven by their personal investment in the outcome.

GOAL 3: Implement systematic recruitment and retention strategies at the federal, state, and local levels.

Recruiting and retaining competent staff members in adequate numbers is a major problem for individuals managing local prevention and treatment organizations and state behavioral health systems. Qualified providers clearly are not available in sufficient numbers in some sections of the country, largely rural in nature, and for some populations, such as children, youth, and the elderly. Most organizations and systems have been unsuccessful in recruiting a culturally and linguistically diverse workforce. While stability in staffing over time is considered a cornerstone of program and treatment consistency and therapeutic relationships (Connor et al., 2003), high rates of turnover among counselors, for example, has been noted to threaten the stability of addiction counseling centers, undermine quality of care, and strain finances due to the costs associated with recruiting, hiring, and training replacements (Knudsen, Johnson, & Roman, 2003). The retention problem among the behavioral health workforce appears to

exceed that of teachers and nurses, professions considered by society to have unacceptably high rates of turnover.

A set of eight objectives has been identified to address the recruitment and retention crisis. Information and evidence on effective recruitment and retention practices must be disseminated routinely to managers in the field as a form of technical assistance. As a second objective, it is incumbent on each prevention or treatment organization to implement a data-driven continuous quality improvement process in which interventions tailored to the recruitment and retention problems that face each organization are implemented and evaluated. Expanded financial incentives are necessary in the form of training stipends, tuition assistance, and loan forgiveness. Wages and benefits must become commensurate with education, experience, and levels of responsibility if members of the workforce are to be retained. Progress on this objective should begin with closer collaboration between behavioral health systems and federal or state departments of labor, which have expertise in benchmarking wages and benefits across professions and estimating a "living wage" for each area of the country.

A comprehensive public relations campaign promoting careers in the mental health and addiction sectors should be launched. The campaign should be combined with a Web portal on careers and job opportunities that meets the needs of prospective students, employees, and employers. Formal regional partnerships should be established between behavioral health and education systems to foster a pipeline of new recruits trained in the skills that are essential and relevant to contemporary systems of care. These partnerships should map and enhance existing career ladders to ensure a progressive set of educational steps linked to advanced certification, licensure, and increased reimbursement. These are the elements of a career ladder that allow an individual to advance within a profession or field.

It is recommended that state and local organizations implement "grow-your-own" strategies to recruit and develop a more diverse and stable workforce, with a priority focus on residents of rural areas, culturally and linguistically diverse populations, persons in recovery, youth, and family members. This strategy involves engaging local residents in entry-level positions and promoting their long-term professional growth, development, and advancement within the organization or system of care. Increasing the cultural and linguistic diversity of the workforce is a specific objective that can be fostered by establishing a clearinghouse for dissemination of culturally competent practices; increasing staff development on such practices across all levels of the workforce; ensuring a critical mass of culturally competent faculty, trainers, and mentors; and developing standards and adequate reimbursement for interpreters who are trained to work in behavioral health.

Concerted efforts are required to recruit and retain a workforce in behavioral health. The wise counsel of one participant in the planning process emphasized the importance of first keeping the workers who

already are in the field, followed by efforts to improve the tactics for bringing new recruits into the field. The research on recruitment and retention reveals that individuals employed or considering employment in this field want what any person seeks: a living wage with health care benefits; opportunities to grow and advance; clarity in a job role; some autonomy and input into decisions; manageable workloads; administrative support without crushing administrative burden; basic orientation and training for assigned responsibilities; a decent and safe physical work environment; a competent and cohesive team of coworkers; the support of a supervisor, and rewards for exceptional performance. These are the core needs of the workforce that the field must strive to address.

GOAL 4: Increase the relevance, effectiveness, and accessibility of training and education.

In virtually every setting in which the Annapolis Coalition sought input for the Action Plan, three interrelated themes emerged: (1) The content of current training and education frequently is not relevant to contemporary prevention and treatment practices, nor is it informed by empirical evidence; (2) teaching methods often are ineffective in changing the actual practice patterns of the people being trained; and (3) access to training and education is often quite limited, particularly in rural communities and for culturally diverse populations. These concerns were expressed about preservice professional training, the initial training offered to direct-care nondegreed or bachelor's-prepared staff, and the continuing education of all members of the workforce. The concerns were not specific to a particular sector of the field or discipline, but were described as generally applicable to the field as a whole.

The strategic planning process yielded seven objectives designed to promote the relevance, effectiveness, and accessibility of training and education. The first objective centers on the further development of core competencies and focused competencies for specific areas of practice. There is a glaring need to develop core competencies for mental health practice, similar to those developed in the substance use disorders sector of the field. Equally important is the need to link organizations that are working on competency development in different sectors of the field, so that they can inform each other's efforts and avoid duplication or, much worse, the development of narrow competency sets that miss essential elements of practice. The second objective focuses on the development of competency-based curricula. Further work on this objective is needed across the many areas of practice in behavioral health, and there is an immediate need for portable, model curricula to be developed for entry-level nondegreed and bachelor's-degreed personnel working in mental health systems. As a third objective, it is incumbent on organizations that provide education and training to adopt teaching practices that have evidence of effectiveness, and for organizations that accredit training programs to require such adoption.

Expanded use of information technology can serve to increase access to training, and thus constitutes a fourth objective for this goal. The fifth goal is to ensure that every member of the behavioral health

workforce develops basic competencies in the assessment and treatment of persons with substance use disorders and co-occurring mental and addictive disorders. This will require a national initiative to identify and overcome the obstacles that have prevented major progress on this critical objective. An additional objective is to shape demand for relevant and effective training by educating prospective students about best practices in education to help them become more informed consumers as they select from among educational options. Finally, the field must identify and implement strategies to encourage and sustain the use of newly acquired skills in practice settings to counter the tendency for systems, organizations, and supervisors to thwart rather than support constructive changes in practice patterns.

Given the scarcity of resources, it is imperative to provide the next generation of prevention and treatment specialists with current knowledge and the practical skills needed to work in modern health care systems. To accomplish this, it is essential to first understand and then address the roadblocks that prevent the timely updating of curricula, training programs, accreditation standards, and certification and licensure processes. These are the key elements and drivers of education and training systems.

GOAL 5: Actively foster leadership development among all segments of the workforce.

The stark reality is that most leaders currently in the behavioral health field are part of the "graying" workforce, nearing retirement. Unfortunately, many of the federally funded training stipends and leadership programs that supported both the entry of these individuals into the field and their professional development no longer exist. Simultaneously, the pressure on leaders has increased exponentially, driven by demands for increased access, efficiency, and quality in the organizations that they manage. Leadership is essential and needs to be explicitly developed among all segments of the behavioral health workforce, including persons in recovery and families, educators, prevention specialists, treatment providers, policy makers, and the individuals who manage accreditation, certification, and licensure systems. In fact, developing and expanding a cadre of leaders among persons in recovery, youth, and family members is particularly critical in achieving transformation of current service systems and models of care. Leadership must be broadly defined to encompass not only organizational and change management, but also coalition and community building, team and program management, and the provision of supervision.

To achieve this strategic goal, the competencies necessary for leadership roles in behavioral health must be identified. Particular attention must be given to developing core leadership competencies that can be adapted to the different sectors of this field. The development of competency sets for supervisors is also a high priority. Available curricula for leadership development must be identified and further developed to ensure that the core competencies are adequately addressed. Increased support should be allocated to

the formal, continuous development of emerging leaders in the field. This will involve expanded training initiatives, release time to participate in training, mentorship opportunities, and recognition and rewards tied to advancement. Leadership development initiatives should be formally evaluated and refined based on the resulting data regarding the impact of these efforts.

Directing scarce resources toward the development of leaders in all sectors of the field and at multiple levels of the workforce will increase the numbers and skills of individuals who are positioned to educate the workforce effectively and to mold the environment in which the workforce will function. Both organizational development and human resource development are essential tasks in the effort to achieve improvements in prevention and treatment. Because leaders are uniquely positioned to impact systems and the workforce within them, the Annapolis Coalition has concluded that leadership development, as a strategic goal, offers high potential to transform behavioral health care.

GOAL 6: Enhance the infrastructure available to support and coordinate workforce development efforts.

The issue of infrastructure to support and sustain the workforce emerged at every turn in the planning process. There are few structures through which to coordinate existing efforts to develop the workforce, and the structures that do exist tend to be specific to content, discipline, or practice setting. Few organized vehicles exist for assembling, analyzing, and disseminating knowledge on workforce practices or providing technical support. There are few sources of financial support to develop innovative workforce practices. The current financing infrastructure for behavioral health services actually undermines the workforce, in various ways, as it strives to provide safe and effective care. Other infrastructure problems involve the paucity of reliable and valid data to inform workforce practices, the generally weak capacity in the human resources departments and training units of behavioral health organizations, and the limited information technology available as an aid for training, a tool to assist the workforce in providing prevention and treatment services, or as a vehicle for tracking and managing workforce activity.

Eight objectives were identified to support the achievement of this strategic goal. First and foremost is the need to develop a technical assistance infrastructure that links existing sources of workforce expertise and expands capacity to provide information, guidance, and support to the field on effective workforce development practices. This should be complemented by a standing SAMHSA workforce team and a federal task force charged with prioritizing, coordinating, and implementing federal interagency efforts on workforce development. It is recommended that the federal government and private foundations establish workforce development funds to support demonstrations and dissemination of innovative workforce practices. The economic market for services must be altered so that it more effectively

supports improvement in care and strengthens the workforce, through mechanisms such as increased parity in coverage for behavioral health and greater use of provider payment incentives.

Additional infrastructure objectives focus on the increased use by all stakeholders of data to track, evaluate, and manage key workforce issues through their continuous quality improvement processes. The human resources and training infrastructures, which have been downsized in many organizations, must be strengthened in terms of their role, resources, and levels of expertise. Information technology should be increasingly employed, not only to train the workforce, but also to provide it with real-time decision support, to track and manage work flow, and to reduce the enormous burden of redundant and purposeless reporting of clinical and administrative data. Many of these objectives can be promoted by identifying and accrediting "Magnet Centers" in workforce best practices that can model and disseminate effective practices in recruitment, retention, training, and education.

With so many unmet needs among persons with mental illnesses and substance use disorders, there is a natural reluctance to invest in infrastructure. Policy makers and program managers tend to pour every available dollar into direct service. And yet, this is precisely the dynamic that has contributed to a workforce that is now inadequately prepared and supported. The cogent analysis of workforce financing provided by Horgan and colleagues as part of this planning process, which appears in the full report, describes how organizations have "stretched" or "diluted" inadequate resources to meet demand, leading to "...under-capitalization, substitution of lower-cost workers, ... downward pressure on workers' incomes..." and difficulty providing evidence-based, quality care. Like most other resources, human resources require maintenance, development, and support in order to be effective and efficient. Infrastructure development is simply essential to sustain the human resources in this field.

GOAL 7: Implement a national research and evaluation agenda on behavioral health workforce development.

A recurrent finding during the planning process was the lack of reliable and valid data on the status of the workforce and on workforce development strategies. Despite the centrality of the workforce to the delivery of care, it is but occasionally the focus of scholarly articles and reviews (Hall & Hall, 2002; Mor Barak, Nissly, & Levin, 2001), and seldom the focus of research. While many behavioral health organizations are increasing efforts to address their workforce problems, it is uncommon for the outcome of these efforts to be evaluated with even a modicum of rigor. With few exceptions, the evidence on workforce practices and interventions remains largely anecdotal.

It is imperative to build a strong workforce research and evaluation base within behavioral health. Developing a substantive body of empirical knowledge on workforce development requires a national research agenda that systematically examines the effectiveness of practices related to recruitment,

retention, education, training, and the sustained adoption of newly learned skills in real-world service environments. The Annapolis Coalition recommends the development of a national research agenda that (1) supports empirical investigation principally focused on workforce topics, and (2) greatly expands the examination of workforce variables and practices in the portfolio of all other ongoing behavioral health prevention and treatment research. The recommended mechanism for building this national research agenda involves the creation of a federal Research Collaborative on Workforce Development comprising representatives from the numerous federal agencies that fund behavioral health research.

As a second objective, behavioral health organizations should use data-driven continuous quality improvement processes as the foundation for formal evaluation of their workforce development efforts. This necessitates that organizations develop, or perhaps acquire through consultation, greater technical expertise on evaluation methods.

The absence of a timely, robust, reliable, and valid body of data on which to base workforce development efforts cannot be addressed overnight. Federal research priorities must be shifted to include a more thorough examination of workforce variables in the context of prevention and treatment studies, and to fund workforce development research as an explicit area of study. Behavioral health organizations need to adopt data-driven approaches to assessing and addressing workforce needs, and routinely evaluate the impact of their interventions. Mechanisms must be created to summarize, synthesize, and disseminate the new knowledge that is generated so that it can inform subsequent workforce development efforts in the field.

FOCUSED TOPICS & THE SEARCH FOR INNOVATION

The core set of strategic goals and objectives was derived from reviews by the expert panels and work groups of workforce issues affecting diverse populations and sectors of the field. The desired outcome was to provide strategic direction to the field by focusing on core, common, or cross-cutting goals, as described in the preceding sections. While detailed strategic plans for specific sectors or populations were not developed, the panels examined their respective areas in detail and generated a summary that is included in the section of the full report on "focused topics". These topics focus on children and youth, and their families; consumers and families (adult mental health); cultural competency and disparities; older adults; rural health care, school-based mental health; substance abuse prevention; and substance use disorders treatment. In addition, there is a report on the critical issue of workforce financing.

Many of the recommendations in this plan are drawn from exemplary workforce practices identified by the expert panels and work groups. Pockets of innovation in recruitment, retention, education, and training

exist throughout the country and serve as models, demonstrating practical and affordable strategies for strengthening the workforce. Replicating a previous search for innovation (O'Connell, Morris, & Hoge, 2004), senior advisors and their expert panels and work groups were asked to identify up to three innovative practices for each focused topic using criteria adopted from the Kennedy School at Harvard University for its annual Innovations in Government award (Hassel & Steiner, 2000). Those criteria focus on the novelty, significance, transferability, and effectiveness of a practice. The identified innovations are referenced and briefly described in various sections of the Action Plan as Innovation Highlights. More detailed descriptions of the innovations are available through the Annapolis Coalition's Web site (www.annapoliscoalition.org).

NEXT STEPS: LEVERAGING CHANGE

This Action Plan provides a blueprint for strengthening the behavioral health workforce. Guided by senior experts in workforce development from diverse sectors of the field, the expert panels and work groups have reviewed the relevant literature, examined available evidence, sought the opinions of thousands of stakeholders, and scoured the country for innovative recruitment, retention, training, and other workforce development practices. The product is a priority set of seven strategic *goals*, each of which has been translated into specific *objectives* and highly specific *actions* that are needed to achieve the broad goals. Preliminary Implementation Tables, which appear as an appendix of the full report, carefully link the goals, objectives, and actions to recommended stakeholders so that the reader can identify possible action steps that may be most relevant to his or her organization or role.

There is a compelling need for stakeholders throughout the field to take concerted action to stem the growing workforce crisis – and concern that such action will not occur. The problems and issues identified in this report are not new, as they have been previously documented and, for decades, have been the nemesis of managers and administrators throughout prevention and treatment systems. In a recent report, the Institute of Medicine Committee on Improving the Quality of Health Care for Mental and Substance-Use Conditions concluded that workforce issues "...have been the subject of many short-lived, ad hoc initiatives that overall, have failed to provide the sustained leadership, attention, resources, and collaborations necessary to solve these multifaceted problems" (IOM, 2006, p. 286).

Translating recommendations into action requires significant attention to the *levers of change*; the seemingly small forces that can exert enormous influence on a much larger mass. This metaphor borrows directly from the concept of a lever in physics: Properly placed, balanced, and utilized, a lever creates a mechanical advantage that produces significant movement beyond that which could be expected if the same amount of force were applied in less strategic ways.

It is worth noting that the workforce, itself, is viewed as a lever of change for improving the quality of services provided in this country (IOM, 2001, 2004). More effective recruitment, retention, and training practices are considered levers of change for achieving transformation in our systems of care (New Freedom Commission on Mental Health, 2003).

Several levers of change that can have a positive impact on the workforce have been identified by the Institute of Medicine (IOM) in its report *Health Professions Education: A Bridge to Quality* (IOM, 2003) and the recent report on mental and substance use conditions (IOM, 2006). These levers include financing, licensing, credentialing, accreditation, and faculty development. Organized advocacy is another potential lever that warrants focused attention. In addition to the IOM reports, SAMHSA/CSAT's *Changing the Conversation: Improving Substance Use Treatment; The National Treatment Plan Initiative* (DHHS, 2000) and its more recent *Strengthening Professional Identity: Challenges of the Addiction Treatment Workforce* (DHHS, 2005a) represent two additional clear and relevant guides to workforce development that identify levers of change in the substance use arena.

If the behavioral health field is to address the workforce crisis seriously, a number of key elements will be required: a clear vision; a practical blueprint; a structure for implementation; methods for monitoring progress; collaboration across the various sectors in the field; and careful attention to the levers of change. The fate of this agenda at the national level will be influenced by a complicated set of political and economic forces. No matter what that fate, the Action Plan has significant relevance for the individual reader, who is encouraged to pursue the following course of action:

- Develop a personal, professional development plan, designed to strengthen your own skills. Pursue it with fervor. Revisit it and update it often.
- Ensure that the organization in which you work has a written workforce development plan that addresses the seven strategic goals. Pursue it with fervor. Revisit it and update it often. Collect workforce data to evaluate progress.
- Learn from persons in recovery, youth, and their families. Seek them out as full partners in all efforts to strengthen your workforce.
- Reconnect with the community that surrounds you. Build its capacities. Offer it support. Accept support from it.
- Become a mentor. Encourage young people to join the workforce. Extol the virtues of caring for others and of changing lives.
- Convey hope about the future to all whom you encounter.

The collective efforts of many individuals, institutions, and organizations, all working to strengthen themselves and each other, will make a difference. There can be no excellent general health care without competent behavioral health care, and the workforce remains the most essential ingredient for success in the development of resilience and for ensuring positive outcomes for people in recovery and their families.

Latino Youth Collaborative
Responsible Entity Report to the Oversight Workgroup

Name of Entity Responsible: Department of Health and Human Services (HHS) Last updated: June 12, 2013
Please rank the straightforward recommendations both in order of the importance to your ongoing work and in order of ease of accomplishment.

Recommendation:	Increase support for the Latino Health Initiative Foreign Trained Health Professionals initiative (became the Welcome Back Center in 2010) to increase the number of bilingual mental health therapists in the County.
What is currently being done to address this recommendation?	During FY13, began process to understand how to best work with internationally trained behavioral health professionals and to prepare to request private or other public funding to support this effort by: - Providing training to Center staff from Welcome Back Initiative and sister Centers staff on how to work with these professionals to obtain licensure or certification. - Consulted potential employers' from public and private systems to learn more about the general and types of job in the mental health field potentially available for internationally-trained professionals. - Started a very small pilot with 5 internationally trained behavioral health professionals. Some participants have been enhancing English skills while others have been assessing viability to obtain licensure to return to clinical work, or identifying certifications related to behavioral health.
Please provide your feedback as to whether this recommendation can be addressed on a short term (0-1 years), medium term (2-4 years), or long term (5 or more years).	In the medium to long term range to be able to yield a significant pool of mental health professionals.
Please state your plans for preparing for its implementation.	We continue actively seeking federal and/or private funds to be able to enhance services during the pilot phase and expand to serve more participants in the future. Continue pilot phase implementation with "test cases" to enhance the Center's capacity to serve behavioral health professionals and identifying specific obstacles in the licensure/certification and reintegration process.
What mechanisms are in place if any to ensure that your plans stay on target?	The Center's model of services that we use has proven its effectiveness, especially with the provision of individualized assistance to participants in terms of developing realistic individual plans with short-term, mid-term and long- term career goals. Continue working with our national partners to identify Federal funds to support our efforts.
What resources would be necessary to accomplish this goal?	Funding to cover staff time; costs associated with licensure, courses to enhance English skills, and pursuing higher education (Master or Doctorate levels) required to obtain licensure to do clinical work. Identification of potential employers with capacity to hire participant as required to obtain licensure.
Please identify the challenges you anticipate in working toward this recommendation?	Securing funding needed; financial and time commitment needed from participants to pursue higher education required to obtain licensure; and unexpected obstacles presented by licensure boards in Maryland.

Programs and Activities

- Ama tu Vida Campaign
- Asthma Management Program
- Welcome Back Center of Suburban Maryland
- Vias de la Salud Health Promoters Program
- Latino Youth Wellness Program
- System Navigator and Interpreter Program
- Community Health Planning
  - Community Engagement Workgroup
  - Latino Data Workgroup
- Past Programs
  - Cancer Prevention and Control Program
  - Emergency Preparedness Project
  - Tobacco Cessation Program

WELCOME BACK CENTER OF SUBURBAN MARYLAND

Welcome Back Community Overview (PDF)

Assists Internationally Trained Health Professionals to Re-enter the Health Workforce

What? The Welcome Back Center of Suburban Maryland is an innovative model that builds on the personal and professional assets of immigrants living in the United States to: further address health professional shortages; diversify the health workforce; provide economic opportunities to underutilized individuals as they return to work in the health field; and enhance health outcomes of the entire community.

Welcome Back Center Fact Sheet

- Amharic
- Chinese
- English
- French
- Korean
- Russian
- Spanish
- Vietnamese

When? In 2006, the Latino Health Initiative (Montgomery County Department of Health and Human Services) launched The Foreign-Trained Health Professionals Program to facilitate the Maryland health professions licensure process. In 2010, this program became the "Welcome Back Center of Suburban Maryland," one of several centers comprising the national "Welcome Back Initiative" network.

Where? The Welcome Back Center of Suburban Maryland serves any internationally trained health professional currently living in Maryland, with a focus on Montgomery, Prince Georges, and Frederick Counties.

Why? Many highly educated and experienced immigrants residing in Maryland with education degrees and certifications in health professions conferred by other countries are currently under-employed and not utilizing their valuable skills in the health field. The Welcome Back Center of Suburban Maryland supports the notion that greater workforce diversity may lead to improved health outcomes through better access to care by underserved populations and more effective patient/healthcare provider interactions.

How? The Welcome Back Center model accomplishes its goals by providing:

- Guidance and support, including individualized case management.
- Academic training, including English as a Second Language instruction and board exam preparation.
- On-the-job practical exposure to the U.S. healthcare system and mentoring at Maryland hospitals and other healthcare facilities.
- Pre-employment services for health-related jobs, career development support, and job readiness training.
- Leadership development for culturally competent transformative leaders.

Who? The Welcome Back Center partners and supporters are responsible for specific activities according to their area of expertise. Together, an effective working synergy is created that would not otherwise be possible.

114

The Welcome Back Center Advisory Council is a group of volunteer professionals and stakeholders willing to support the goal of the Center by providing advice and assistance to the various Center initiatives.

Welcome Back Center Resources for Foreign-Trained Health Professionals :

Steps to Obtain Registered Nurse Licensure in Maryland

Guide to Obtain the Maryland Registered Nurse (RN) License

Guide to Obtain the Maryland Registered Nurse (RN) License in Spanish

Guide to Obtain the Maryland Registered Nurse (RN) License in French

US GRADUATE MEDICAL EDUCATION (GME)

US Graduate Medical Education

Welcome Back Center Publications:

There are various Welcome Back Center Publications including documents produced during the program assessment and design stages when the pilot phase was implemented between 2004 and 2008; resource materials for foreign-trained health professionals with detailed information on steps to obtain licensure in Maryland.

Welcome Back Center In the News:

The articles about the Welcome Back Center In the News present interviews with and stories of Center participants as well as interviews to Center Director and Manager. These articles are important illustrations on the work of the Center to assist highly skilled immigrants obtain licensure to ease state health profession shortages and respond to the need to increase the number of culturally and linguistically competent health professionals working in Maryland.

To learn how you can get involved, call 240-777-3168

For additional information on the national "Welcome Back Initiative" network visit: http://www.welcomebackinitiative.org/

Back to top >>>

115