Substance Use Disorders
Workforce Development Sub-Committee
Short Term Issues

Issue	Possible Suggestion	Outcome
Supervision of Satellite offices in rural and frontier areas: 1. Requirement of a QP being on-site during treatment sessions is difficult for providers to meet *Although this is a difficult requirement to meet it is one that masters level clinicians have had to meet for years in order to obtain licensure. As counseling interns (prior to LPC) they are required to have an LPC on-site until they have completed their 1,000 hours, passed their test, and completed their degree)*		
Lack of qualified individuals to deliver case management services	1. Do not require case managers to be a QP or QP trainee 2. Accept experience, education or a combination of both as qualifications 3. Accept case management experience in any mental or physical health field as qualification and require additional training in the field of substance abuse and with priority populations if individual does not already have this training/experience 4. Accept experience in other states	
The requirement that case managers must have the DHW case management training before delivering services is difficult for providers because the training is not routinely provided	1. Grant a grace period for receiving the training. For example, if the staff member meets all other qualifications but does not have the DHW training they can deliver services but must receive the training within 6 months or attend the next available	

	training 2. Provide training around delivering case management services to target populations as the supervisor sees a need 3. Provide training if needed (need determined by supervisor) around resources available to client in the local area/city/county 4. BPA/DHW develops training guidelines and allow agency supervisors and directors to train their personnel to the standards and then audit to those standards	
Supervision standards for case management are burdensome and difficult to meet especially for RSS only providers who do not have a clinical supervisor on staff Currently all documentation (including case plans, progress notes for sessions held and missed, and progress notes documenting communication with collateral providers) must be reviewed and signed off on by the clinical supervisor. This may be an effective way to assess progress on a learning plan but is not necessary on every note/plan for every client for every case manager		
Currently a clinical supervisor must have two years of supervisory experience in the field of substance abuse (in Idaho). Requiring supervisory experience before being approved as a clinical supervisor could be a challenge as many agencies do not have supervisor positions available unless they are clinical supervisor position	1. Allow Masters level Counselors and Social Workers to be clinical supervisors if they have been approved as clinical supervisors by their respective licensure boards (counselors are required to complete supervision courses prior to be certified as a supervisor) 2. Accept supervisory experience in other	

	states 3. Accept a combination of experience and/or education for clinical supervisors	
Verification of supervised hours is difficult for providers to document for a number of reasons: 1. Clinicians do not track the number of hours spent in each domain 2. Supervisors might not be available to verify hours 3. Agencies may be out of business an not able to document hours	Accept documentation such as licensure, certification, resume, diploma and/or other common documents as proof of education and experience	
Lack of clarity regarding the skills, education and experience required in the following areas: 1. Case management 2. Qualified Professional (QP) 3. GAIN-I Administrator 4. GAIN-I Trainee 5. GAIN-I Trainer 6. Clinical Supervisor 7. Treatment Supervisor	1. Evaluate the current qualification guidelines for all levels of case management and make sure they are consistent between both mental health and substance use disorders as well as Medicaid 2. Develop communication that is clear and coincides with IDAPA for each professional area (all of which may not be on this list) 3. Idaho code is made up of many IDAPA regulations (not just 16.06.03). Review and acceptance of the IDAPA regulations for other licensed mental health professionals in addition to 16.06.03 would clear up much of the confusion and it would be appropriate as all are IDAHO code	
Lack of certified GAIN-I administrators	1. Revisit the requirement that the GAIN-I has to be administered by a QP or QP trainee. Chestnut does not require any qualifications other than the person be certified by Chestnut 2. Allow certain portions of the GAIN-I to be delivered by persons other than QPs (such as demographic information)	

Lack of training in the following areas: 1. Case Management 2. GAIN-I 3. Evidence Based Best Practices 4. ASAM	1. Utilize the CRDS to provide training when appropriate 2. Look to ATTC for training assistance as they have funding 3. Explore with universities the creation of on-line/web based training that could be available to all new hires as needed with a certification of completion that could be printed and placed in personnel file once on-line test is passed. If technology majors are required to complete an internship this may meet the qualification and be free labor	
The requirement of substance abuse direct services to be a QP is eliminating otherwise qualified professionals. For example, LCSW, LCPC, etc not accepted without substance abuse treatment experience	1. Accept licensed Master level counselors and social workers under IDAPA as QPs and clinical supervisors. Scope of practice for these two professions includes assessing and diagnosing mental health and substance use disorders using the DSM and far exceeds the practice responsibilities for a QP 2. Require CEUs in the field of substance use treatment and/or co-occurring disorders (currently no CEUs required for QPs, and LCPC's and LCSW's are required to complete 20 per year in order to maintain their licensure.)	