Scope of Practice Alignment with Job Tasks for Paraprofessionals and Addiction Counselors

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KEY FINDINGS

Recent policy changes expanding access to mental health and addiction services for millions of Americans are increasing demand for behavioral health services and reshaping the behavioral health workforce. Unfortunately, many counties across the United States report a need for behavioral health providers. Paraprofessionals are increasingly being recognized as a solution to mitigating provider shortages and increasing access to care and Addiction Counselors continue to play an important role in substance use disorder treatment and prevention. Professional and legal scopes of practice (SOPs) guide the roles and responsibilities for these workers; however, there is some question as to whether SOPs accurately reflect their increasing daily responsibilities.

This study included a survey of 108 NAADAC Level I Addiction Counselors, Community Health Workers, Peer Recovery Specialists, Case Managers, and Health Navigators in 10 states to investigate the alignment of job responsibilities with SOPs.

Study findings indicate that many of the paraprofessional occupations lack clearly defined SOPs, with many SOPs coming from provider organizations rather than state regulating bodies. Survey results showed substantial overlap of daily job tasks among the occupations.

Entry level providers are an integral part of the behavioral health workforce, however their job responsibilities are ill-defined. Further role standardization may help fully leverage the skills and competencies of paraprofessionals and Addiction Counselors to improve access to behavioral health services. Future research should investigate the billing and reimbursement structure of these providers in order to holistically understand polices that may limit the delivery of behavioral health services.

CONTENTS:

BACKGROUND

In 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that nearly 1 in 5 Americans live with a mental health or substance use disorder (SUD).[1] Meanwhile, the Health Resources and Services Administration (HRSA) reported in 2012 that more than 7,800 workers are needed to address the lack of behavioral health services in the nearly 3,700 workforce shortage areas throughout the country.[2] Further, about 55 percent of rural counties report that they do not have any practicing behavioral health workers (such as psychologists, social workers, case managers), and nearly three-quarters of all counties report serious shortage of behavioral health providers.[2]

Efforts have long been made to deal with behavioral health workforce issues, but a 2006 Institute of Medicine (IOM) report notes that most initiatives have not been sustained long enough or been comprehensive enough to remedy the problems.[3] Additionally, in 2013, SAMHSA reported to Congress that, "recruitment and retention efforts are hampered by inadequate compensation, which discourages many from entering the field".[2]

Paraprofessionals and other behavioral health technicians have been increasingly recognized for their key role in mitigating provider shortages and increasing behavioral health care access to underserved youth and minority populations;[2,4] and Addiction Counselors continue to play an important role in substance use disorder treatment and prevention. Therefore, it is important to understand the procedures, processes, and services these workers are authorized to provide, as outlined by a scope of practice (SOP).

This report examines results of a study conducted by the National Council for Behavioral Health (National Council), with a purpose of quantifying the alignment between SOPs and daily job responsibilities for four common behavioral health paraprofessions, as well as National Certified Addiction Counselors, Level I, as defined by NAADAC (Addiction Counselors).[5] This research enhances our understanding of how the behavioral health workforce is bolstered by these essential providers, and examines whether they are practicing above or below their outlined state SOP.

METHODS

The National Council identified four paraprofessional occupations common to behavioral health care for study inclusion: Community Health Workers, Peer Recovery Specialists, Case Managers, and Health Navigators. Although often not considered "paraprofessionals", Addiction Counselors are included in this

study as they are behavioral health providers who support clinical teams and provide direct services to clients. The research team conducted a gray literature review for all 50 states to gather information on state-defined SOPs and job responsibility guidelines from national certification and licensing bodies. Sources included state-based offices of mental health, state-based departments of health, state accreditation bodies, national certification bodies, and professional guilds.

Key competencies and responsibilities were identified from SOPs for each provider type. SOPs were further assessed to determine the extent to which the following factors were comprehensively covered: definition of job title, outline of educational requirements, outline of key job responsibilities, and outline of core competencies. This analysis was used to identify two states with well-defined SOPs for each of the 5 occupational categories for inclusion in the survey of providers. The ten states selected for survey participation as a result of having well-defined SOPs included: Arizona, California, Florida, Illinois, Kansas, Maryland, New Jersey, Oklahoma, Tennessee, and Washington.

A 58-item survey was used to investigate the alignment between the SOP-defined job tasks in the ten states of interest and actual job tasks reported by providers. Questions about job tasks were categorized into sections to align with four occupations: Health Navigators/Case Managers (combined based on literature review results), Addiction Counselors, Peer Recovery Specialists, Community Health Workers, or "General". Respondents were first asked to self-select the job title that best matched their work before answering questions specific to that occupation. For example, prior to the health navigation/case management section respondents were asked, "Do you perform any activities that people in your organization would consider health navigation or case management? Services could include insurance navigation, client service coordination, or care coordination. If a respondent selected "yes" they were then able to rate the frequency with which they performed each task within that occupational category, otherwise they skipped to the following section. Frequency was defined as: "I do this every day", "I do this occasionally", "I rarely do this", and "I never do this". In an effort to avoid bias when answering questions, respondents were blinded to the job title categories within the survey and asked to self-report their job title at the end of the survey for comparison purposes. A complete list of screening questions is available in the Appendix.

Behavioral Health Providers Included in this Study:

1. Community Health Workers
2. Peer Recovery Specialists
3. Case Managers
4. Health Navigators
5. Addiction Counselors

Survey invitations were sent to points of contact at 100 member organizations with instructions to disseminate the email to eligible providers (i.e., the four paraprofessional occupations and Addiction Counselors). In addition to providing job titles for this study, the term "paraprofessionals" was defined as individuals who held a bachelor's degree and below, or held a master's degree but did not use this degree to perform their job. The invitations described the study inclusion criteria by saying: "We are seeking input from people who directly provide services to clients. These individuals are sometimes called direct service providers, peer workers, or paraprofessionals". Individuals were able to self-select into the survey based on these guidelines. Data collection took place from June-July 2016.

At the end of the data collection period, data were cleaned for completeness and duplicates were removed. The first response of two duplicate answers was retained unless it was incomplete, in which case the most complete response was retained. Responses less than 25% complete were also removed. Data were investigated using univariate methodologies including frequencies and measures of location. During analysis, respondents were classified into occupational categories based on job title, license, and degree. In many cases, results for Addiction Counselors are presented separately from the paraprofessional occupations for comparison purposes.

RESULTS

Qualitative Analysis of Scopes of Practice

The review of gray literature for SOPs for the 5 provider types across all 50 states illustrated a lack of clearly defined job titles and job responsibilities and, in some cases, SOPs were unable to be identified. A total of 40 SOPs across the 5 occupations were identified out of a possible 250 as follows: 15 state SOPs were identified for Community Health Workers, 13 for Peer Recovery Specialists, 5 each for Case Managers and Addiction Counselors, and 2 for Health Navigators (Table 1).

Table 1. Identified Scopes of Practice and Surveyed States

Occupation	Number of State SOPs Identified	States Selected for Survey Participation
Community Health Worker	15	Maryland, Washington
Peer Recovery Specialist	13	Tennessee, Oklahoma
Case Manager	5	Illinois, New Jersey
Addiction Counselor	5	Florida, Kansas
Health Navigator	2	Arizona, California

Qualitative analysis of the SOPs yielded commonalities among the documents for each job title. Each SOP was distilled into six job tasks common for each occupation. There were an additional six job tasks that appeared frequently among Addiction Counselor and paraprofessional categories, which were included in a "general" category (Table 2).

Table 2. SOP Task Themes by Occupation

Occupation	SOP Core Tasks
All occupations- General	▪ Conduct initial assessments of clients' wellness status ▪ Track client progress by conducting follow up assessments ▪ Act as a coach to assist clients to achieve and maintain identified goals ▪ Provide on-call crisis intervention services ▪ Conduct client needs assessments and address social needs (i.e. housing, employment) ▪ Maintain clinical records
Health Navigator/Case Manager	▪ Assist with scheduling medical appointments ▪ Help clients with transportation issues and accessing transportation to and from medical appointments ▪ Work with multiple providers to coordinate care ▪ Create follow up care plans to facilitate treatment adherence ▪ Conduct public/client education activities to raise awareness of the availability of health plans ▪ Help clients enroll in health plans
Addiction Counselor	▪ Provide client and family education pertaining to substance use disorders ▪ Help create plans for client relapse prevention ▪ Help clients identify group therapy sessions ▪ Help develop individual treatment plans for individuals with substance use disorders ▪ Participate in recovery group discussions ▪ Provide general informal counseling, support and follow up for the client
Peer Recovery Specialist	▪ Assist clients to craft individual wellness plans ▪ Assist clients to express their goals and needs for recovery ▪ Work with treatment professionals to develop and implement person-directed individual recovery plans ▪ Facilitate peer recovery support groups ▪ Assist clients to locate and access community support groups ▪ Screen for the presence of co-occurring disorders
Community Health Worker	▪ Assist my organization in being culturally responsive to the service population ▪ Advocate for local health needs ▪ Provide translation and interpretation services for clients and health care providers ▪ Help clients access health information ▪ Help clients complete applications and registration forms ▪ Facilitate client linkages to services

Given the overlap in job responsibilities reflected in the SOPs for Health Navigators and Case Managers, these occupations were combined into a single category for survey purposes.

Survey of Behavioral Health Providers

Respondent Characteristics

A total of 108 individuals responded to the survey, 89 (82%) of which were retained for analysis for meeting the inclusion criteria. Respondents represented all 10 states of interest (Table 3).

Table 3. Number and Percent of Survey Respondents by State (n=89)

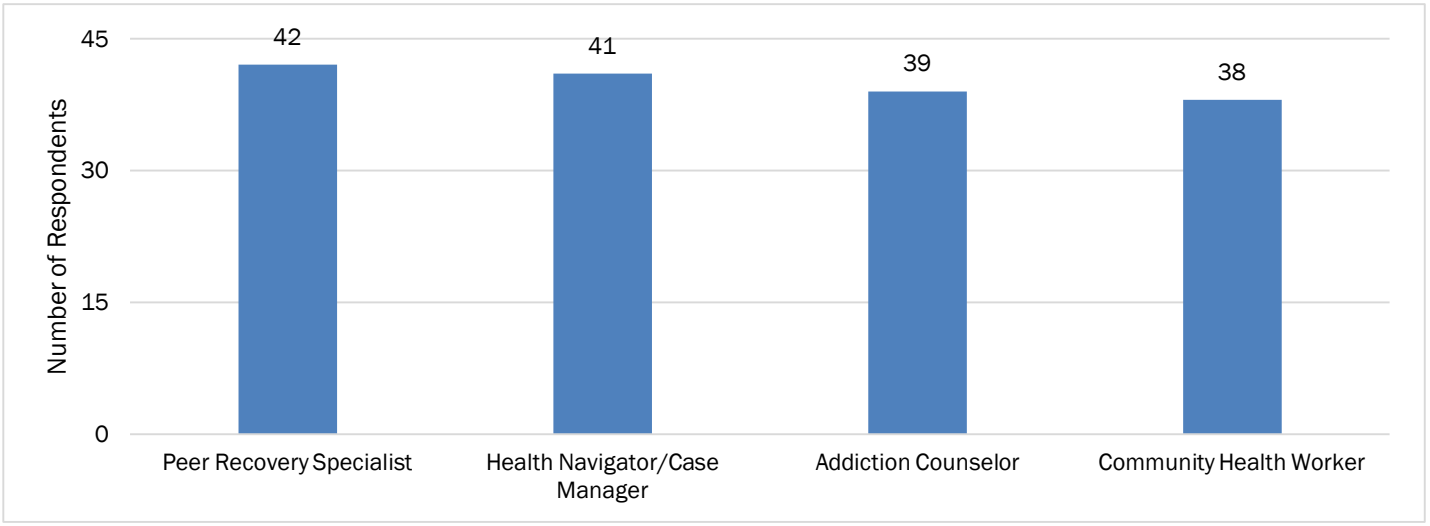
State	Number (%) of Survey Respondents
Arizona	8 (9%)
California	3 (3%)
Florida	9 (10%)
Kansas	7 (8%)
Illinois	11 (12%)
Maryland	25 (28%)
New Jersey	9 (10%)
Oklahoma	4 (5%)
Tennessee	3 (3%)
Washington	10 (11%)

Approximately 25% (22/89) of respondents obtained a master's degree or higher, and were thus excluded from additional analyses for not meeting the study's definition of "paraprofessional". The remaining respondents were educated at the bachelor's degree level (29/89; 33%), associate degree level (17/89; 19%); or high school/equivalent level (21/89; 24%). The degree types of the bachelor's-trained respondents included: psychology (8/29; 28%); sociology (3/29; 10%); public health and nursing (2/29; 7% each); and other (14/29; 48%). Other degree types included accounting, visual arts, economics, and biology.

With respect to professional licenses and certifications, 45% (30/67) of respondents reported having a professional license; 90% of those respondents noted it was related to their current job. More respondents obtained a license through a state licensing body (89%; 24/27) as compared to a national licensing body (64%; 18/28). Eighteen respondents (67%) held licenses from both a state and national body. Seventy percent (44/63) of respondents held a professional certification; 75% of these certifications came from a state certification body and 38% came from a national certification organization, and twenty respondents (32%) had a certification from both a state and national organization.

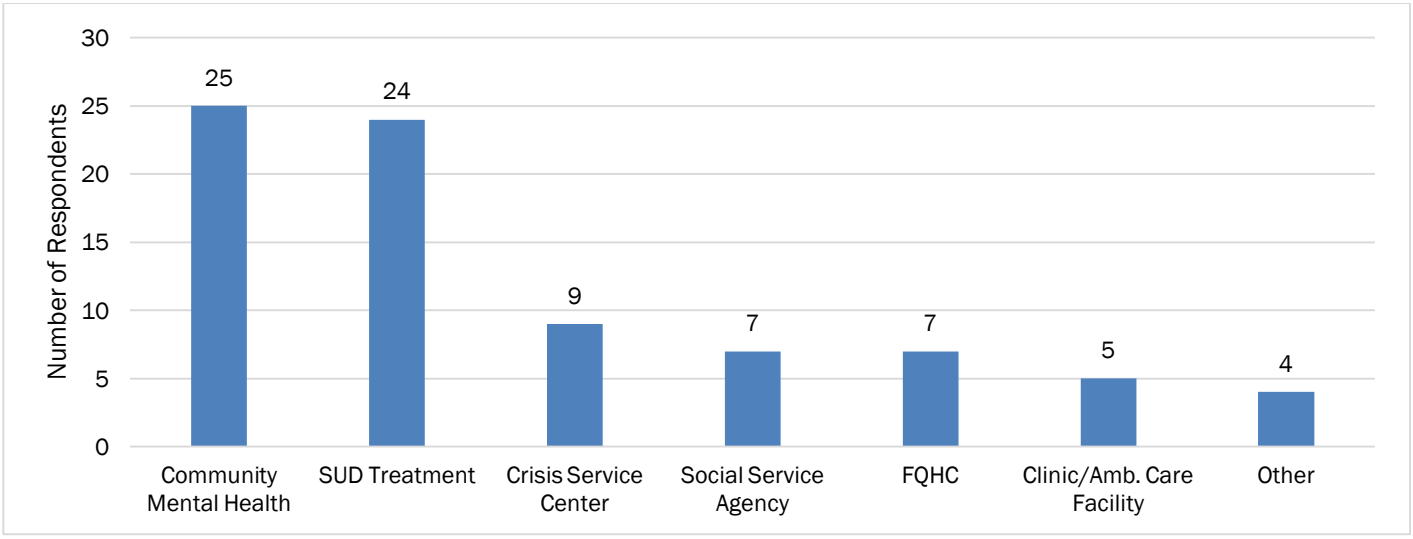
The respondents remaining in the sample self-identified as the following job titles: Peer Recovery Specialist (63%; 42/67); Health Navigator/Case Manager (61%; 41/67); Addiction Counselor (58%; 39/67); and Community Health Worker (57%; 38/67) (Figure 1). Respondents often identified with multiple job titles after reading the screening question.

Figure 1. Job Titles of Survey Respondents (n= 67)



For practice setting, the majority of respondents were employed at either a community mental health center (25/67; 37%), SUD treatment organization (24/67; 36%), or crisis service center (9/67; 13%). Others reported employment at Federally Qualified Health Centers (7/67; 10%), social service agencies (7/67; 10%), clinic/ambulatory care facilities (5/67; 7%), and other facilities (4/67; 6%) (Figure 2).

Figure 2. Employing Organization Type of Survey Respondents (n= 67)



Amb.=Ambulatory; FQHC=Federally Qualified Health Center; SUD=Substance Use Disorder

Researchers further investigated the overlap between community mental health settings and substance use disorder treatment organization settings (Table 4). Sixteen of the 24 (66%) respondents who noted working in a substance use disorder treatment organization only work in this one practice setting. Additionally, ten (40%) of the 25 respondents working in a community mental health organization work exclusively in this setting. Combined, ten (20%) of 49 respondents noted working in both community mental health centers and substance use disorder treatment organizations. Community mental health organizations appeared in combination with other practice settings, but substance use disorder treatment organizations only appeared in combination with community mental health organizations.

Table 4. Number and Percent of Survey Respondents by Practice Setting

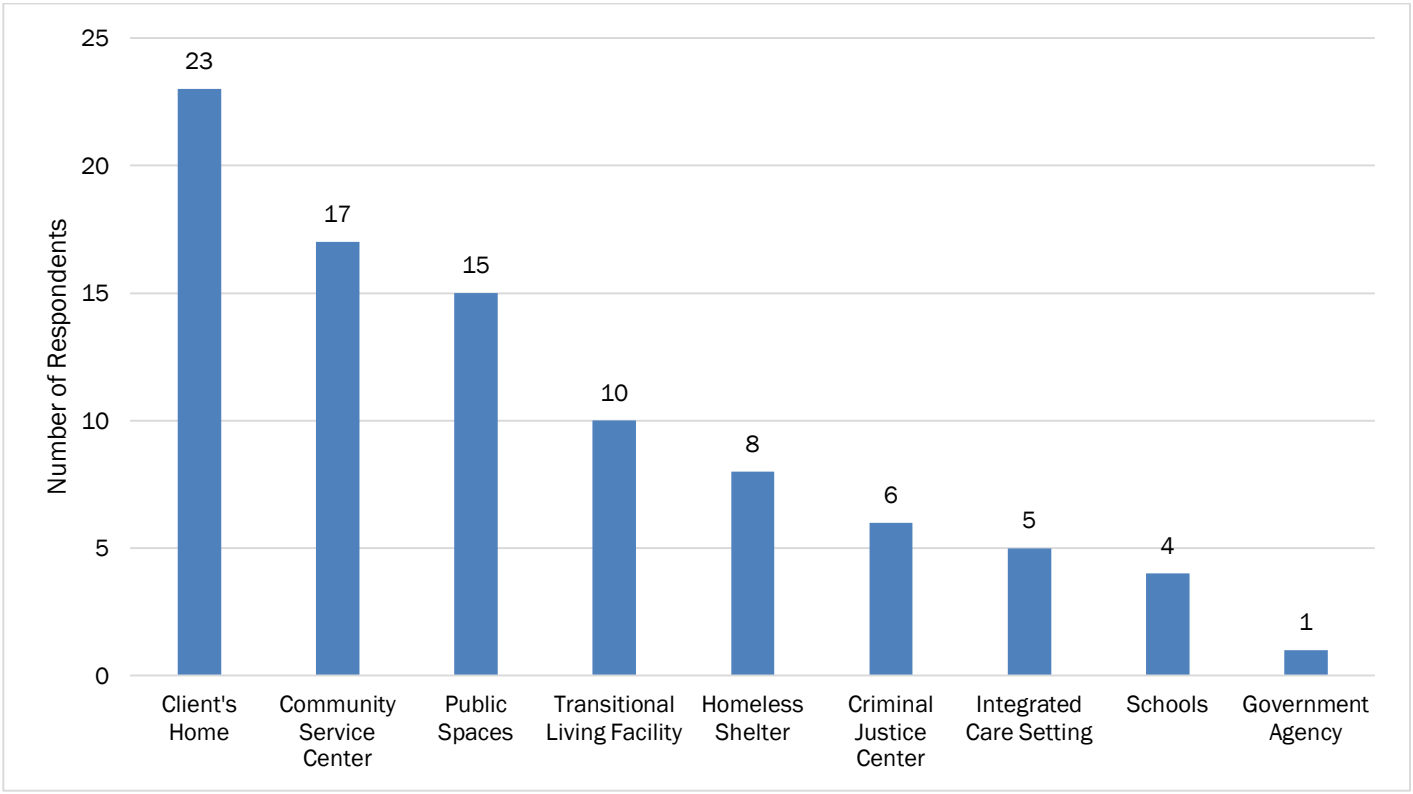
Practice Setting	Number (%) of Survey Respondents
Substance Use Disorder Treatment Organization Only	16/24 (66%)
Community Mental Health Organization Only	10/25 (40%)
Both Substance Use Disorder Treatment Organization and Community Mental Health Organization	10/49 (20%)

Fifteen (94%) of the 16 respondents who work exclusively at substance use disorder treatment organization are employed fulling (more than 35 hours a week) and are permanent employees. The remaining respondent is a volunteer. Four (40%) of the 10 respondents who work exclusively at community mental health organizations are employed fully time, while five (50%) are employed part time, and one (10%) is a volunteer. Finally, all the respondents (100%) who work in both practice settings are employed full time.

Organization size, denoted by number of clients served, was fairly evenly distributed between small, midsized, and larger client bases. About one-third of respondents (15/41; 36%) were employed by an organization that serves fewer than 1,000 clients a year, an additional one-third (14/41; 33%) were employed by an organization that serves between 1,000-4,999 clients a year, and 31% (13/41) were employed by an organization serving 5,000 or more clients per year. The size of the community in which the respondents' employing organization was located was variable. Nearly half (19/42; 46%) of respondents worked in communities with between 2,500 and 49,999 residents; approximately 10% (4/42) worked in communities of fewer than 2,500 residents, 24% (10/42) in communities with 50,000-249,000 residents, and 19% (8/42) with 250,000 or more residents.

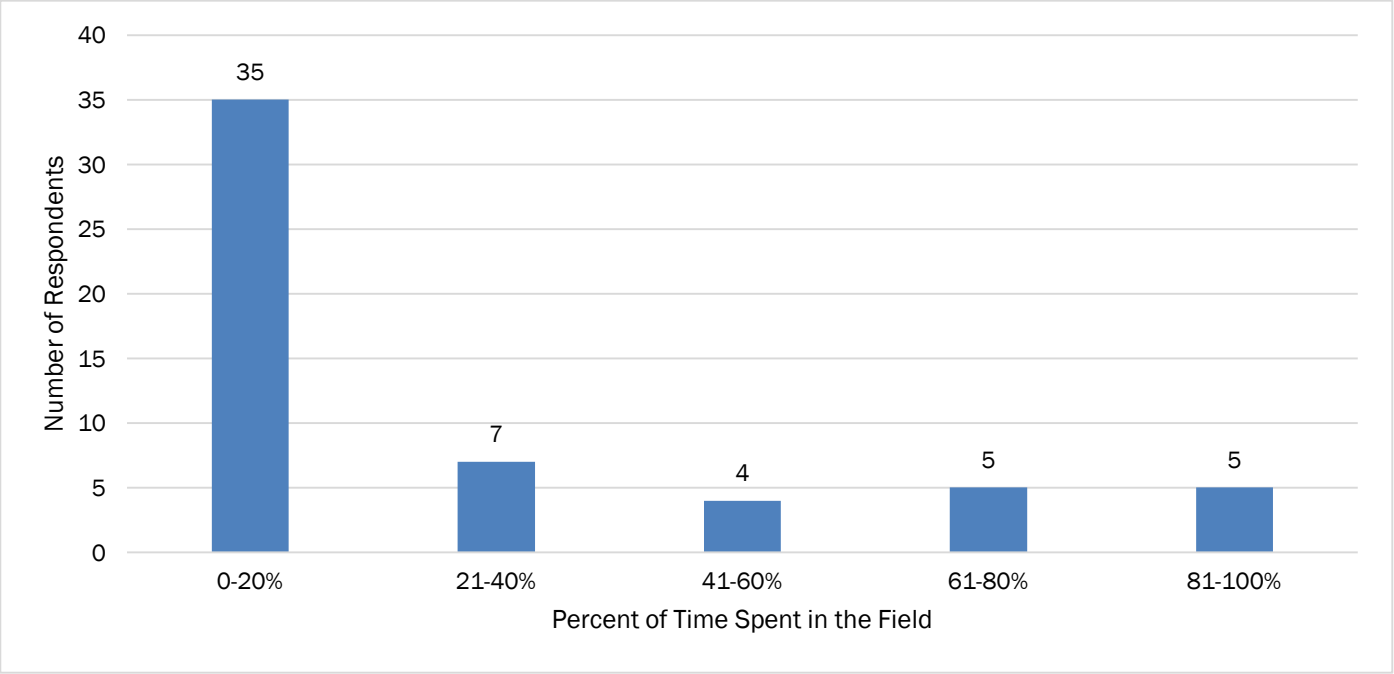
Respondents were asked to report any additional settings in which they provide services outside of their primary practice location and how often they spend time away from their employing organization's primary facility, defined as "in the field". Respondents reported providing services in clients' homes (23/67; 34%), as well as in community service centers (17/67; 25%), public spaces (15/67; 22%), transitional living facilities (10/67; 15%), homeless shelters (8/67; 12%), criminal justice centers (6/67; 9%), integrated care settings (5/67; 7%), schools (4/67; 6%), and government agencies (1/67; 1%) (Figure 3).

Figure 3. Additional Service Settings of Survey Respondents (n= 67)



Approximately 63% (35/56) of respondents reported spending 20% or less of their time in additional service settings; 13% (7/56) reported spending 21-40% of their time in the field, 7% (4/56) spent 41-60%, 9% (5/56) spent 61-80%, and 9% (5/56) spent over 80% of their time in additional service settings (Figure 4).

Figure 4. Time Spent "In the Field" (n=56)



A majority of the respondents designated as paraprofessionals or Addiction Counselors were full time employees (44/67; 66%) of their organization. Approximately 18% (12/67) of respondents worked part time; 3% (2/67) were volunteers.

All respondents were employed at organizations that serve a range of different patient populations including: individuals with serious mental illness (90%, 52/58), individuals with substance use disorders (73%, 42/58), individuals in an acute crisis (50%, 29/58), individuals with chronic health conditions (80%, 46/58), and individuals with co-occurring substance use and mental health disorders (68%, 39/58). Additionally, they provide services to the following populations: racial and ethnic minorities, individuals across the age spectrum, homeless individuals, and unemployed individuals. About half (28/58; 48%) of the paraprofessional and Addiction Counselor respondents provided services in a language other than English, including Creole, German, French, with Spanish as the most frequently noted languages.

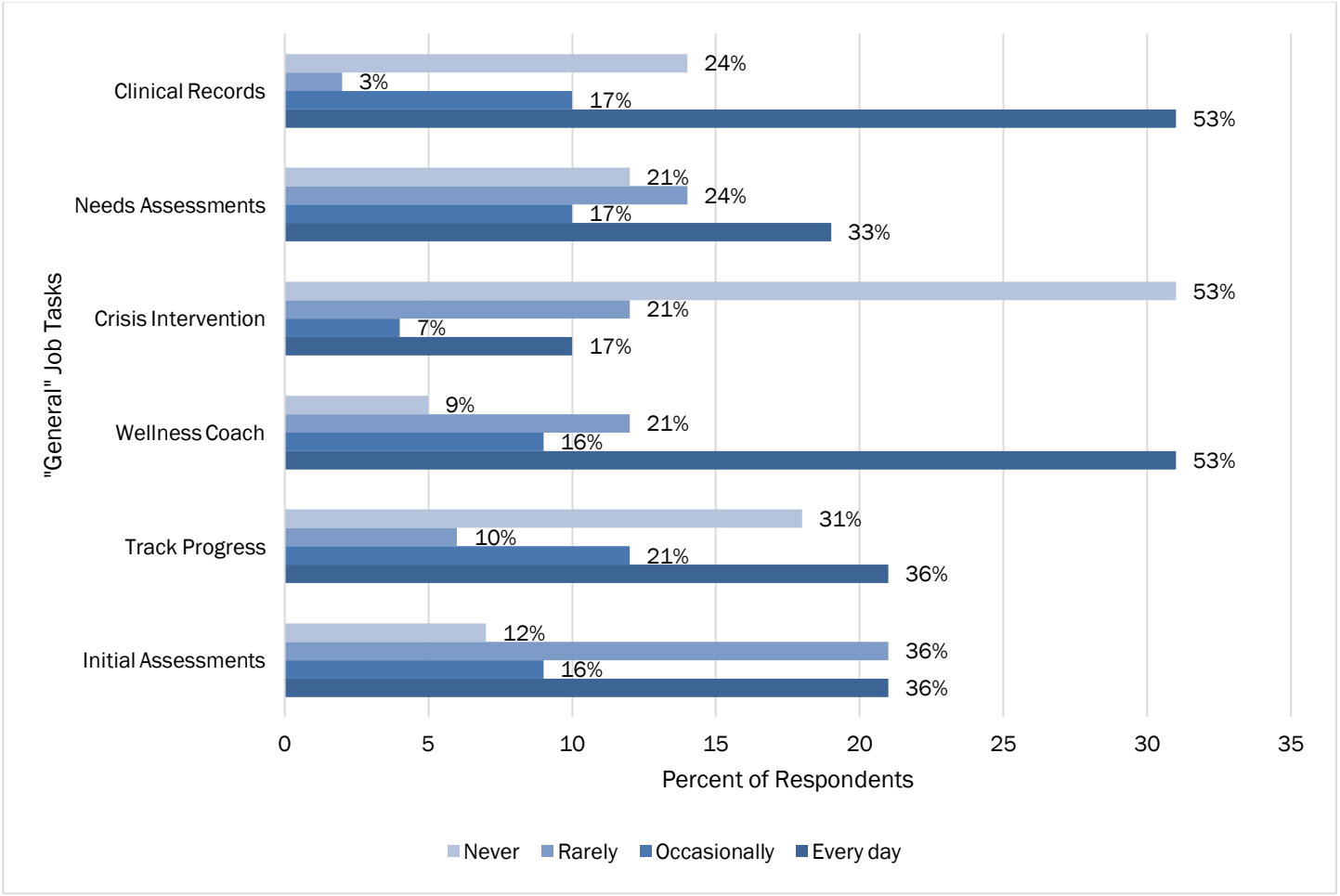
Job Tasks Performed by Respondents

There were six "general" tasks drawn from the literature search that were common across the paraprofessional and Addiction Counselor categories of interest. These tasks include: conducting initial assessment of clients' wellness status (initial assessments); tracking client progress by conducting follow up assessments (track progress); acting as a coach to assist clients to achieve and maintain identified goals

(wellness coach); providing on-call intervention services (crisis intervention); conducting client needs assessments and addressing social needs (needs assessments); and maintaining clinical records (clinical records).

Respondents who self-identified as having a paraprofessional job title perform many of the "general" tasks on a daily basis with the exception of crisis intervention services. This skill may be more specific to individuals with training in providing crisis services. Approximately 53% of respondents (31/58) reported performing tasks related to clinical records and wellness coaching every day, followed by initial assessments and tracking progress (36%; 21/58 each), and needs assessments (33%; 19/58) (Figure 5).

Figure 5. Frequency of Performing "General" Core Tasks (n= 58)

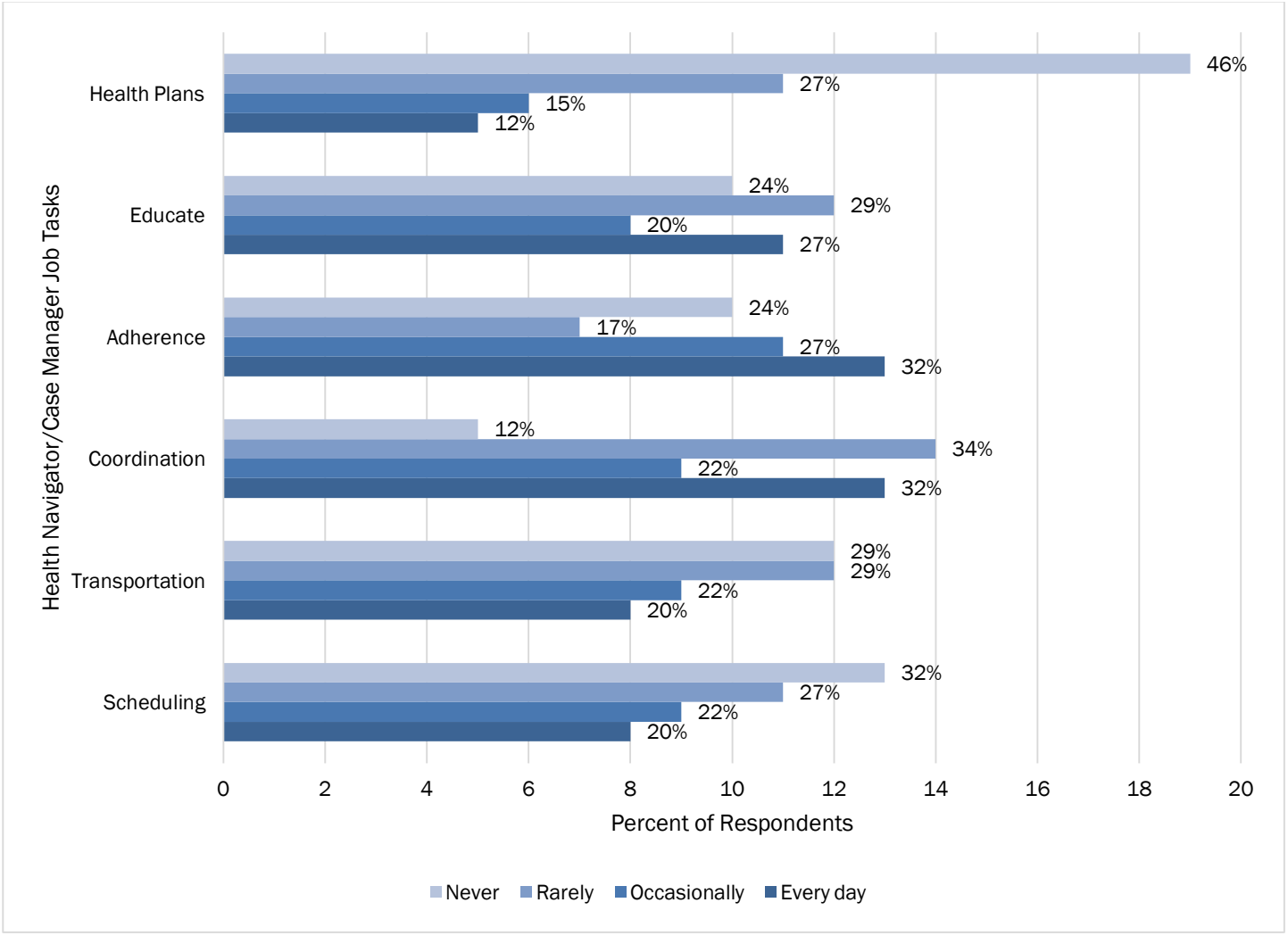


A total of 41 respondents completed questions for Health Navigators/Case Managers. According to SOPs, Health Navigators and Case Managers assist with scheduling appointments (scheduling); help clients with transportation issues and accessing transportation to and from medical appointments (transportation); work

with multiple providers to coordinate care (coordination); create follow up care plans to facilitate treatment adherence (adherence); conduct public/client education activities to raise awareness of the availability of health plans (educate); and help clients enroll in health plans (health plans).

Although these individuals initially identified with health navigation and case management, these tasks were more likely to be performed rarely or never then every day or occasionally. Respondents most frequently reported performing tasks related to adherence and coordination of care (32%; 13/41 each) every day, followed by public/client education (27%; 11/41) scheduling and transportation (20%; 9/41 each), and health plan enrollment (12%; 5/41) (Figure 6).

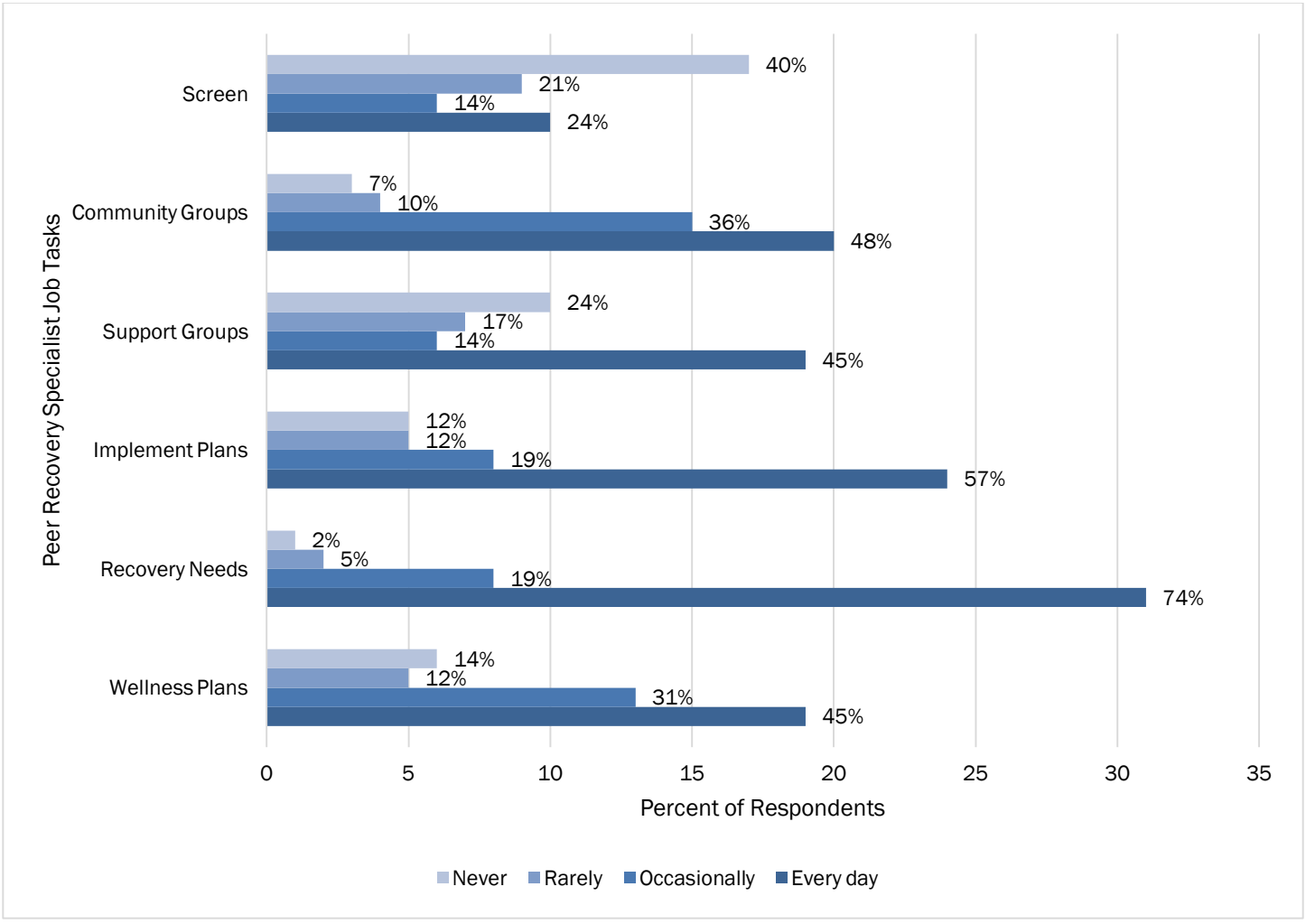
Figure 6. Frequency of Performing Health Navigator/Case Manager Core Tasks (n=41)



Forty-one respondents completed questions for Peer Recovery Specialists who typically: assist clients in crafting individual wellness plans (wellness plan); assist clients in expressing their goals and needs for recovery (recovery needs); work with treatment professionals to develop and implement person-directed individual recovery plans (implement plans); facilitate peer recovery support groups (support groups); assist clients with locating and accessing community support groups (community groups); and screening for the presence of co-occurring disorders (screen).

Overall, the SOP-defined tasks were well-aligned with the provider-reported job tasks for those providing peer recovery support services, with the exception of screening for the presence of co-occurring disorders, with 40% of respondents reporting they never do this. Tasks related to recovery needs were performed every day by 74% (31/41) of respondents, followed by implementing plans (57%; 24/41), connecting clients to community groups (48%; 20/41), facilitating support groups and crafting wellness plans (45%; 19/41 each), and screening for co-occurring disorders (24%; 10/41) (Figure 7).

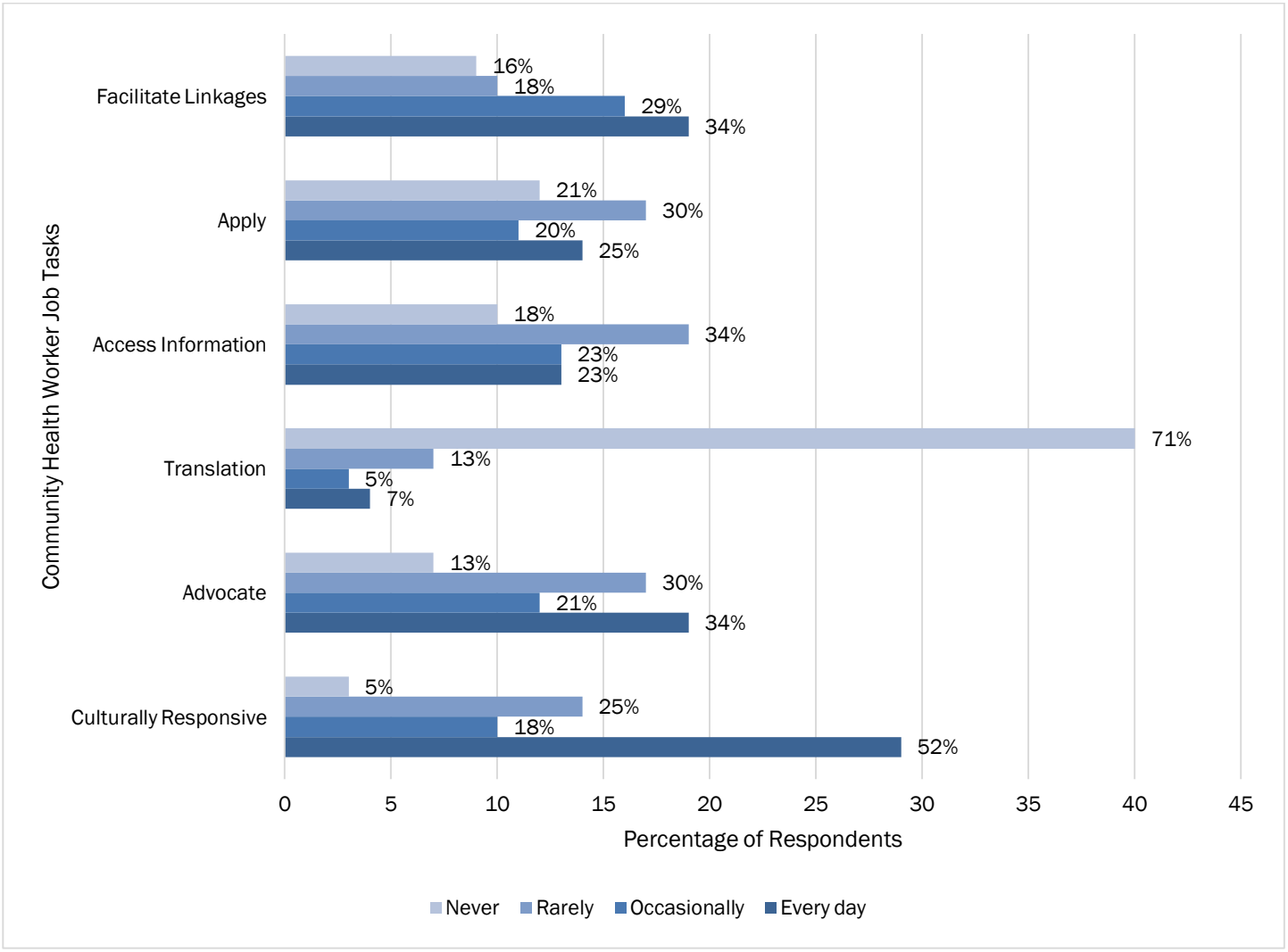
Figure 7. Frequency of Performing Peer Recovery Specialist Core Tasks (n=41)



A total of 56 respondents completed questions for Community Health Workers. These job tasks include: assist the organization in being culturally responsive to the service population (culturally responsive); advocate for local health needs (advocate); provide translation and interpretation services for clients and health care providers (translation); help clients access health information (access information); help clients complete applications and registration forms (apply); and facilitate client linkages to services (facilitate linkages).

Respondents most frequently reported performing tasks related to cultural responsiveness (52%; 29/56) every day, followed by advocating for local health needs and facilitating linkages (34%; 19/56 each), helping clients complete applications (25%; 14/56), helping clients access information (23%; 13/56), and providing translation services (7%; 4/56) (Figure 8).

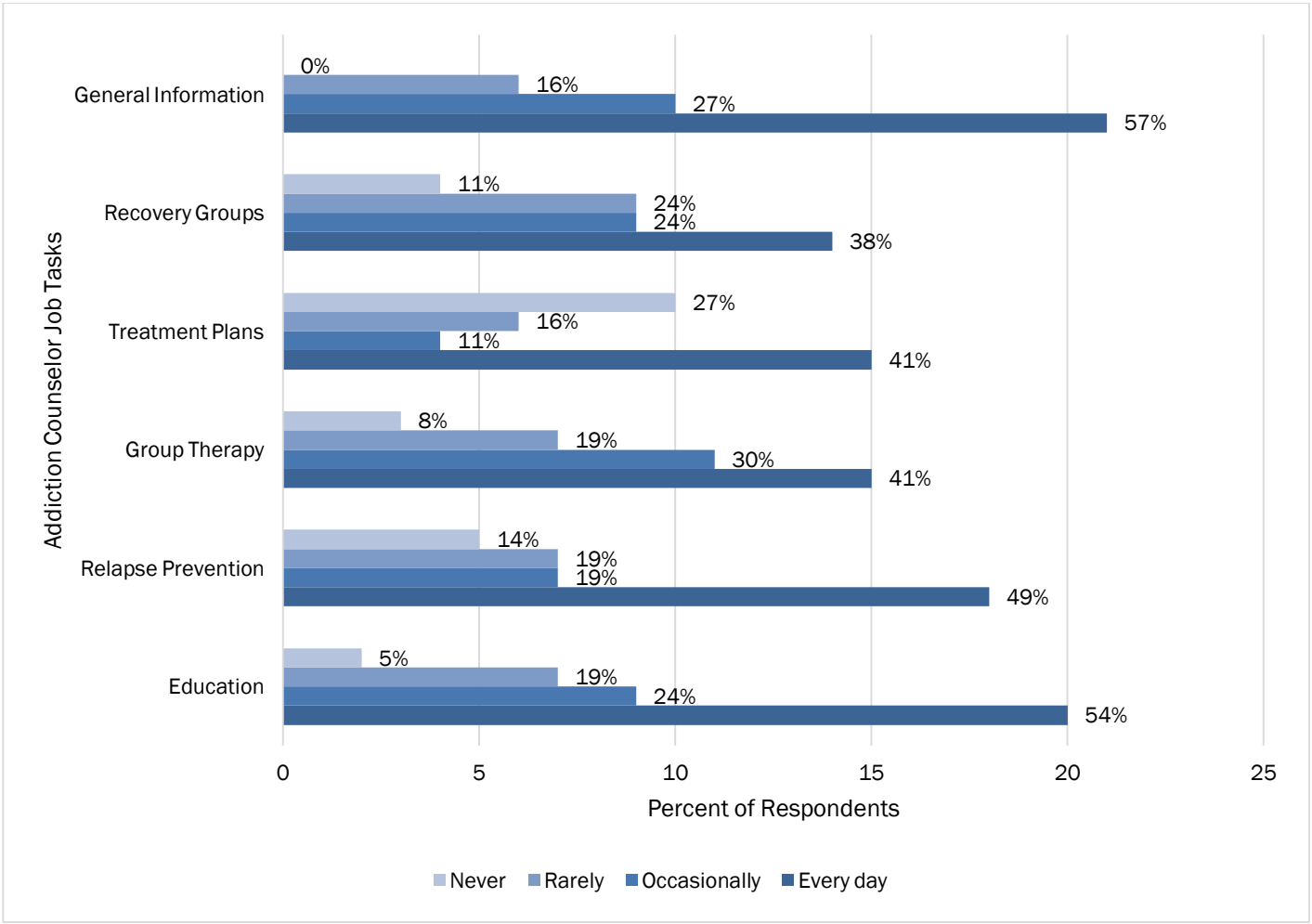
Figure 8. Frequency of Performing Community Health Worker Core Tasks (n=56)



A total of 37 respondents completed job task questions for Addiction Counselors. These individuals: provide client and family education pertaining to substance use disorders (education); help create plans for client relapse prevention (relapse prevention); help clients identify group therapy session (group therapy); help develop individual treatment plans for individuals with substance use disorders (treatment plans); participate in recovery group discussions (recovery groups); provide general informal counseling; support and follow up for the clients (general information).

Tasks for individuals who self-reported being a Level 1 Addiction Counselor were fairly well-aligned with the tasks outlined in state SOPs. All six of the competencies were performed every day or occasionally by over one-third of respondents. Over half of respondents reported performing tasks related to providing general information (57%; 21/37) and providing client and family education (54%; 20/37) every day, followed by relapse prevention (49%; 18/37), group therapy and treatment plans (41%; 15/37 each), and recovery groups (38%; 14/37) (Figure 9.)

Figure 9. Frequency of Performing Level 1 NAADAC Addiction Counselor Core Tasks (n=37)



Scope of Practice Awareness and Alignment with Job Responsibilities

At the end of the survey, respondents were asked to report whether they were aware that an SOP existed for their profession and whether they believed the SOP elements were an accurate reflection of their daily job tasks. Over three-quarters of respondents (77%; 43/56) were aware that an SOP outlined their job responsibilities. When asked who defined the SOP for their job tasks, almost half responded that their employer defined their SOP (47%; 20/43), followed by national/state licensing or certification board (28%; 12/43), a national or state authority (14%; 6/43), and funding agencies (5%; 2/43). Nearly all respondents 93% (27/29) agreed or strongly agreed their daily job tasks were aligned with the duties outlined in their occupation's SOP, while the remainder strongly disagreed (7%; 2/29).

CONCLUSIONS AND POLICY CONSIDERATIONS

Paraprofessionals, peers, and Level I Addiction Counselors continue to represent an under-researched segment of the behavioral health workforce. This study found that paraprofessional SOPs: 1) typically do not exist at the state level, 2) if they do exist, they are prescribed by an employer or funder, and 3) they are ill-defined. This may be explained by the fact that the term "paraprofessional" itself is difficult to define; a uniform definition does not exist, particularly in the health care fields. Further, the five occupations selected for study may be common in the field of behavioral health; however, as the gray literature search demonstrated, many states and individual organizations have adopted alternate occupational classifications or job titles. For example, the study focused on SOPs for Peer Recovery Specialists, but similar SOPs for Recovery Coach, Peer Specialist, and Rehabilitation Specialist were also identified. Further, some states require the use of specific job titles that may not accurately describe function, adding to the challenge of distinguishing between occupation, function, and role (e.g. the use of a Community Health Worker title to hire all peers regardless of job duties and lived experience). The lack of standardized definitions and job categories for this segment of the behavioral health workforce not only makes research efforts challenging, but may contribute to the misalignment of SOP authority and job tasks.

The findings of this study show that Addiction Counselors and Peer Recovery Specialists typically have a well-defined SOP. For this reason, there was greater alignment reported between SOP-defined tasks and reported daily job tasks for individuals who identified with one of these occupations. For Health Navigators/Case Managers, the tasks outlined in the survey based on SOP information were not as well-aligned with daily job tasks. This may be explained by the low number of respondents who identified as Case Managers/Health Navigators; the poor definition of these occupations and varying job titles within them; and/or the lack of

standardized SOPs for these occupations. Overall, there was substantial overlap of job tasks reported among the Case Manager, Health Navigator, and Community Health Worker occupations.

There are several limitations to this study. First, the lack of SOPs for paraprofessional occupations made it difficult to generate a survey instrument that adequately described job tasks. In addition, it was difficult to accurately identify respondents who met the survey inclusion criteria both because we chose a degree-based definition for "paraprofessional" and because some workers who meet the study's inclusion criteria may not self-identify as a paraprofessional. In an effort to avoid screening out potential respondents for whom the term "paraprofessional" may not resonate, the survey was structured so that all participants, regardless of education level or job title, self-selected into the survey based upon whether they self-identified as direct service providers, peer workers, or paraprofessionals. We recognize that many of these workers are highly trained and function at or above their professional SOP regardless of whether their educational background is related to their daily work. Hence, future research in this area may consider modifying the inclusion criteria to consider more than, or something different from, degree attainment as a key differentiating code.

Suggestion bias is a potential limitation of this study; however, an attempt to mitigate against this was made by ensuring that the association between occupations and tasks was "blind" to the respondent throughout the survey. Additionally, the screening questions prior to each question block were drawn from a small sample of available SOPs. It is possible that the definition used for "peer recovery specialist" may have resulted in respondents choosing alternate job titles. For example, the definition indicated that Peer Recovery Specialists may provide "treatment", which may only apply to few, if any, workers in this job title, and did not emphasize the role of peers in case management and health navigation. The findings of this study help distinguish the activities of those self-identifying as peer providers and may help with further refinement of a Peer Recovery Specialist definition.

Finally, caution should be taken in generalizing findings of this survey to a larger group of paraprofessionals and Addiction Counselors due to the low number of total respondents. In addition, responses were not evenly distributed across states, with a majority of the respondents coming from Illinois, Maryland, and Washington; this resulted in over-representation of the Community Health Worker respondents within our sample. The overall response rate is uncertain due to the survey dissemination methods used, as we do not know how many eligible respondents each participating organization employs or how many eligible respondents received the survey from their employer. Future research would benefit from a more direct method for surveying employees if a sampling frame could be obtained. This research did not cover reimbursement for

services provided by paraprofessionals, however anecdotal evidence demonstrates that it is sometimes difficult for paraprofessionals to be fully reimbursed for services provided. More research is needed into the reimbursement structure for these providers.

Overall, the study findings show that Addiction Counselors and paraprofessionals are a segment of the behavioral healthcare field that provide services in varied settings to varied client populations. Additionally, as many of these individuals work full time at their employing organization, they are a critical extension of the behavioral health workforce, and support the efforts of organizations to provide a range of behavioral health services. The following strategies are recommended to enhance understanding of job functions and ultimately improve behavioral health workforce capacity: 1) states should develop and adopt standardized SOPs, and occupational definitions for paraprofessionals; 2) national and state certification/licensing bodies should adopt standardized educational and training guidelines to ensure individuals are providing services outlined by their specific SOP; and 3) the training structure and job functions developed for the various levels of Addiction Counselors should be reviewed, as they may serve as a model for other occupations given that job tasks appear to be highly standardized and align well with the designated SOP.

Acknowledgments

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NATIONAL COUNCIL FOR BEHAVIORAL HEALTH
STATE ASSOCIATIONS OF ADDICTION SERVICES
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Appendix

Screening Questions:

1. Health Navigation/ Case Management: Do you perform any activities that people in your organization would consider health navigation or case management? (health navigation or case management could include insurance navigation, client service coordination, or care coordination)
2. Addiction Counselor: Do you perform any activities that people in your organization would consider addiction services? (Addiction services can include substance use education, treatment planning, or facilitating group/individual therapy)
3. Peer Recovery Specialist: Do you perform any activities that people in your organization would consider peer recovery services? (Peer recovery services can include treatment and client goal planning, facilitating support groups, or client screening)
4. Community Health Worker: Do you perform any activities that people in your organization would consider community health services? (Community health services can include advocating for local health needs, being responsive to the service community, or assisting clients in accessing health services)