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Identifying Supervision and Training Needs Within a Native American Reservation Co-occurring Treatment Program

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2023

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Abstract

Native American rural communities are not without substance abuse treatment needs; however, highly skilled mental health providers are often limited on a reservation, which leaves this population with clinicians with less experience and education. This project is a case study of a substance abuse treatment program within a Native American tribe in the western portion of the United States. The practice-focused research questions directly related to the training, certification, and education of staff in the addiction field, and to the ways in which the program evaluated the efficiency and effectiveness of the staff members. The purpose of this study was to explore the educational requirements for certified addictions practitioners and to define the expectations for culturally appropriate education, training, and supervision to serve this population. The Baldrige Excellence Framework provided the conceptual framework of this study. A qualitative approach was used, in which analytical and descriptive data were compared from both internal and external sources, as well as structured and semi-structured interviews. The key findings include the need for specific training regimen using culturally appropriate and evidenced-based practices, which focus on intake and assessment, clinical treatment skills, treatment planning, supervision, and application of practice standards. The implications for positive social change could include a better understanding of training needs for staff working with Native American clients, and to better assist clinicians with limited education to better serve those that struggle with substance abuse difficulties.

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Dedication

This project is dedicated to Sadie and Rivers. They helped define my purpose and create the person I am today.

Acknowledgments

I would like to acknowledge my cohort, especially Silvia, as each member helped to propel me forward with this process. I would also like to thank Dr. Hendricks-Noble for her support in completing this project.

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Section 1a: The Behavioral Health Organization

This behavioral health organization (BHO) is a tribal recovery center on a Native American reservation in the Western portion of the United States. The approximate enrolled members of the tribe are over 10,000, with close to 8000 living within the reservation boundary, according to the Governor's Office of Indian Affairs. The state in which this tribe is located has a poverty rate of 12.4% for the population in its entirety (U.S. Census Bureau, n.d.). However, according to a university website which collects data on the state's tribes, this tribe had a poverty rate of 31.1%, which represents the highest rate for those under 18-years-old compared to all other reservations in their respective state. In 2018, national Native American/American Indian estimates of living in poverty was 23.7% (National Indian Health Board, 2021), which demonstrates that this tribe has an even higher rate than other tribes on average. In all populations, a high level of poverty lends itself to an increase in addiction and mental health concerns, and considering Native American reservations demonstrate on average the highest rates of poverty this population continues to represent with high acuity and severity.

Native American/Alaskan Indian represented the second highest population for overdoses in 2017 (Dickerson et al., 2021). The rate of deaths of despair, which are deaths related to suicide and drug and alcohol use, are also higher in the Native American population, compared to the national averages of the entire population. Nationally, the Native American communities' rates of death are 101.6 per 100,000, while non-Native communities represent 57 per 100,000. Of the 101.6 deaths, 44.2 are related directly to alcohol. Tribes in the western region of the United States demonstrate some of the

highest rates of death of despair (Suarez, 2021). According to Suarez (2021), one western region tribe has experienced 109 deaths related to despair from 2014 to 2018, where their entire state averaged 54 during the same period. Native Americans have double the substance abuse rates (Hilton et al. 2018), and this tribe in the western United States presents as no different.

Given the high acuity and concerns, this program works with all Native American tribal members, if they are enrolled and can demonstrate ancestry with a certain tribe based on Indian Health Service regulations. The mission and vision of the program lends itself to helping the Native population despite the enormity of the problem. The BHO has funding provided through Indian Health Services, with the primary supervisory location being off, but close to, the reservation.

Offerings and Services

The BHO is primarily an outpatient substance abuse program, although the new behavioral health leader (BHL), is working on creating more full access to mental health services as well. Currently they offer substance abuse evaluations, and outpatient substance abuse therapy. The program has one Intensive Outpatient group available; however, the BHL has indicated that in coming months the scheduling will change to include more group times and therapeutic activities being available. There are some individual mental health therapy and substance abuse sessions offered, although because of limited certification and licensure, the program is not fully equipped for the identified needs. This BHO offers crisis care, with at least one clinician being available for emergency sessions to be addressed at the facility.

Structure and Staffing

The BHL is not from this tribe but is an enrolled Native American in another western tribe. This BHL has identified her need for continued involvement in the community, as well as learning specific cultural traditions and values, and stated that she often defers back to her cultural counselor for tribe-specific questions and concerns. Dickerson et al. (2021) noted the importance of not only understanding the substance used by the population within the Native American community, but also be familiar with the cultural and spiritual importance within the tribe. Although each tribe is unique, having a BHL that is familiar with western Native culture was deemed important by the tribal council.

The BHL has a Master's in Education and a PhD in Counselor Education and Supervision. She supervises eight staff members (see Appendix A). The clinical supervisor has a Master's in Social Work and is a licensed addition counselor in the state. The second staff member has a Master's in Addiction and a Bachelor's in Biblical Studies. The cultural counselor has an Associates of Arts in tribal studies and a Bachelor of Arts in Human Services. The three other counselors are considered certified behavioral health peer support specialists and have Associates of Arts in Human Services from the tribal college. The case manager is currently working on becoming certified to bill for services in the state. The final staff member is an administrative assistant.

Clinical staff members, other than those who had master's degrees, all attended the local tribal college, from which the program of study requirements for the human services degree was reviewed. The college is accredited by the Northwest Commission

on Colleges and Universities (2022). The accreditation is the process by which an educational program can increase confidence in the integrity, quality, and performance of the institution. According to the handbook, there are several semester long classes aimed at addiction specific treatment and intervention. The other classes consist of psychology, counseling, ethical and legal issues, and classes specific to native culture. Finally, before the associate degree is confirmed, the student must complete a practicum at a behavioral health site.

According to the state's licensing requirements, which I obtained from the state's Department of Labor and Industry Boards, to become a licensed addiction counselor in this state, an individual must have an Associate of Arts degree in alcohol and drug studies, addictions, or substance abuse. Or, they must have a baccalaureate in a human services field such as community mental health or counseling. Along with this educational level, anyone pursuing a license must also have 330 hours of specific educational hours in areas such as biopsychological assessment, addictions, gambling, pharmacology, and alcohol and drug studies. The licensure applicant must also pass a national exam such as the National Association of Alcoholism and Drug Abuse Counselors Certification Commission (NCC) Level 1 or Level 2 exam, or similar, if not already licensed in another jurisdiction, according to the state's Department of Labor and Industry Board.

A certified behavioral health peer support specialist is much less demanding and requires limited education to obtain. A peer specialist must have had prior treatment, have a diagnosis of a behavioral disorder, and be in recovery for a minimum of 2 years

outside of hospitalization or incarceration. They must also work under the supervision of a licensed professional, who has been licensed for over 3 years. The individual seeking certification must also take a 40-hour training course with exam, according to the state's licensing board.

The tribal chairman is head of the organizational structure, to whom the BHL must answer. However, according to the BHL, Indian Health Services (n.d.) also has an integral role in program development and operation. Indian Health Services (n.d.) has a vision of developing healthy communities and working with health care systems through culturally appropriate practices and strong partnerships. Because of their intent as well as being the primary funding source, Indian Health Services expects to have some involvement to ensure proper application of resources.

Practice Problem

A tribal specific mental health and substance abuse program in a western region of the United States that works with all Native Americans on the reservation who struggle with substance abuse needs was used for this project. Clients for these services must be members of the tribe, or an enrolled member of any Native American tribe. The BHL was hired in the late summer of 2021 to help facilitate a more versed program, address staffing concerns, and apply for national accreditations. The BHL, over the course of several interviews, identified the concern that certified addictions practitioners lack the appropriate skill level for the high acuity population they serve, and that specific additional supervision and training is needed. She was unable to identify areas of specific need related to the effectiveness of staff, other than believing that they are struggling to

perform effective and efficient care and provide services needed. She also identified the struggle to lead, educate, and supervise staff, while adhering to the board's expectations. Her concerns as a leader were related to her ability to manage a workforce while simultaneously creating and implementing a plan for the organization. She reported the concern that her clinical supervisor also lacks full ability to effectively supervise and determine staff training and education needs, as well as fully evaluate the effectiveness of staff.

The Native American population has less access to treatment services for substance abuse disorders, yet greater substance abuse problems than the rest of the United States (Novins et al., 2016). The Substance Abuse and Mental Health Services Administration (SAMHSA, n.d.) reported that in 2020, Native Americans represented 24.9% of the treatment intakes in the state. Despite accessing treatment less, Native Americans have a 7.1% alcohol use disorder rate, while the national population average is 5.4% (American Addiction Centers, 2022). According to this Novins (2016), clinicians who work with the Native American substance abuse population are less likely to use culturally appropriate evidence-based practices. Clinicians with certification rather than full licensure may not be fully equipped to work in the Native American substance abuse and mental health field, given the high acuity and identified need for evidenced-based therapeutic education. The literature has significant information related to mental health addiction training and supervision programs within master's and doctoral level educational programs, and little information is found in relation to certification level clinicians. The information found thus far indicates that all programs should have

additional quality improvement and continuing education to perform at best practices standards.

The research questions for this doctoral study were as follows:

RQ1. Above and beyond the state requirements for certification and licensure, what additional educational and training needs are appropriate for staff to be better qualified to work at this agency?

RQ2. How is the effectiveness and efficiency of staff determined?

Purpose

The purpose of this study was to explore the educational requirements for certified addictions practitioners, as well as licensed clinical therapists and social workers. I sought to define the expectations for culturally appropriate education and training to serve this population. The purpose was also to assess the training and supervision provided for staff members to be more fully capable of serving culturally appropriate treatment. The purpose was to also determine how staff are being evaluated, and to what extent staff effectiveness and efficiency are determined. The expected outcome of this study was to help develop a plan of action for the BHL to ensure culturally appropriate training identification and follow through, as well as education and application of specific areas of supervision.

The current BHL has stated that she is working towards getting the program national accreditation, which has become the priority. She is also focusing on program development, funding, supervision, and education for staff. The BHL has identified not only lack of time to complete all necessary tasks, but also concern about the direction

needed for additional training, education, and supervision of her staff. The purpose of this study was to explore the current training and education of staff so that gaps related to ability and need to serve those with addiction concerns can be identified. I proposed to help develop a plan of action for the organizations leadership to ensure culturally appropriate training and supervision for this populations where the training and education prior to employment may be lacking for the specific clinical population of this tribe in the western United States. An additional purpose was to review the current training and supervision provided to assess how the organization's current workforce can become more fully capable of providing culturally appropriate treatment through supervision withing the agency. It offers specific insights needed for the supervising staff to better determine effectiveness and efficiency of clinicians and assist in areas identified as problematic.

This case study applied the Baldrige Excellence Framework (National Institute of Standards and Technology [NIST], 2021) which helps the organizations assess performance in the areas of leadership, strategy, customers, analysis workforce, operations, and results. The framework helps to identify the needs for an organization and identify solutions. The Baldrige Excellence Framework (NIST, 2021) supports this study to include validating management practices. This process helped to ensure that supervision and management are geared towards the identified gaps in educational and skill level for clinicians, who are working with the same clientele as master's level therapists. The requirements for state certification and education were reviewed, as were client outcomes, diagnosis, and factors such as age and therapeutic contacts. Additional

insight was gained from program staffing data. Baldrige also demands that it is important that an organization accomplish their mission and improve results. Knowing where the gaps in education and skills training are will improve outcome measures for the program and clients. Based on the conceptual framework of excellence, this topic will have meaning for others in the field of behavioral health.

Significance

This case study is significant in that it could help evaluate and determine very specific needs for additional training and education within this substance abuse treatment setting, where many of the staff have less than master's degrees in the field. Instead of using financial resources to pay for random trainings, this provider could identify targeted needs for their program and staff members. This could contribute to positive social change by helping the individuals who work in the behavioral health field, which has been identified as having a mental health and addiction professional shortage in all areas of the country (Johnson & Brookover, 2020). According to the Kaiser Family Foundation (2017), every state in the Northwest region has less than 50% availably of mental health care professionals. This project could help identify specific areas of need for education, experience, and supervision for staff that are less than licensed, or have less than master's degrees. The solution of additional targeted and specific continuing education courses could be created for this level of practitioner, as well as support for the supervisors often tasked with education and training, while maintaining workloads outside of the clinical expectations.

When considering positive social change, the helpers as the change agents must be considered as paramount to the process. If the behavioral health field wants to have qualified, emotionally well practitioners, it must consider how it values, treats, and supports the clinicians. This case study identified and defined additional supports and interventions that could help those that serve the client within the mental health and addiction field.

Summary and Transition

In summary, this BHO has a deep connection to the tribal community and an identified need for both mental health and substance abuse treatment. Although there is funding available for hiring, training, and supervision needs, there was an unknown direction towards which the process should engage. The need for qualified clinical staff has been identified, and this project helped answer what type of continuing education and training, as well as specific supervision, are needed. Although the BHL has been able to identify concerns with abilities, she has also made it clear that she was not fully aware where to begin and where to put the focus. This project assisted in identifying specific targets and goals to better support this tribal health program meets the needs of the people.

Section 1b provides an organizational profile that addresses key factors that are particular to this program. It identifies services rendered as well as the foundation for the mission and vision to which the program adheres. I discuss partners and collaborators as well as how the BHO operates within the current tribal system. The profile elaborates on the program structure as well as the funding and support given to the BHL.

Section 1b: Organizational Profile

This project is a case study of a tribal substance abuse and partial mental health program within the western region of the United States which is working towards national accreditation and improved services. Currently the tribal program serves all members of the tribe, or any other enrolled member of any other Native American tribe, who seek services. They offer some individual mental health services, and a continuum of substance abuse outpatient treatment. SAMHSA has identified that a continuum of care is important for clients to have access to the levels of care that are appropriate for their needs (Forman & Nagy, 2006). A continuum of care would include levels of care such as Level 0.5 driving under the influence (DUI) education, Level I outpatient (OP), and Level II.I Intensive Outpatient (IOP). For higher acuity, based on the evaluation, clients are referred to programs off the reservation for residential substance abuse treatment (Mee-Lee et al., 2013).

The organization's BHL has identified the need for additional support related to education, supervision, and training for their current staff, as well as create a structured program for future employees. The purpose of this project was to not only to evaluate education and training needs, but also develop a structure supervision and continuing education program for the program based on identified gaps for both the program as well as the individual clinician. The research questions for this program are as follows:

RQ1. Above and beyond the state requirements for certification and licensure, what additional educational and training needs are appropriate for staff to be better qualified to work at this agency?

RQ2. How is the effectiveness and efficiency of staff determined?

Organizational Profile and Key Factors

Healthcare Service Offerings

The BHO offers individual mental health services which are limited in scope. Given that there are only two licensed clinicians with master's degrees working in this program, other than the BHL, the ability to work in the mental health arena is limited to low acuity or severity and lesser need. Primarily, this program offers outpatient substance abuse treatment services. These services include intensive outpatient and outpatient services.

SAMHSA refers to intensive outpatient as being at least 9 hours each week (Forman & Nagy, 2006). This BHO is currently offering this service; however, the BHL acknowledged the need to alter group times and offerings to be more flexible for the clientele and increase hours to fit the mandated weekly treatment services. Of the services noted by *Tip 47*, the clinical treatment manual provided by SAMHSA (Forman & Nagy, 2006), this BHO includes orientation, assessment, crisis care, individual and group therapy. They also offer individual treatment planning and psychoeducational planning as a part of their intensive outpatient services. The BHL discussed some struggles in the full understanding of her clinicians to evaluate level of care appropriateness and referrals through the comprehensive biopsychosocial evaluation as well as a lack of family counseling and case management. Because of the nature of staffing, this BHO is unable to provide medication management, medical treatment, and vocational services, which are recommended to be a fully comprehensive substance abuse treatment program.

The BHO's outpatient program is similar to their intensive outpatient program, as they offer less intensive, or fewer hours of, services based on a clinically determined need. This would include individual and group therapy, as well as case management and continuing care support which, per client, consists of less than nine hours of service weekly.

Mission, Vision, and Values

The mission, vision and values statements listed below were taken directly from the 2021 strategic plan provided by the BHL. These were reviewed within the last year due to application for national accreditation through Commission on Accreditation of Rehabilitation Facilities (CARF, 2022). CARF is used to gain public trust in the program, and as their website suggests, helps provide assurance that their providers are striving for a high quality of services. The BHL indicated that this BHO recognized the need to improve services, and work toward accreditation to follow through with their mission, vision, and values more actively.

- **Mission:** BHO is an Indian Health Services 638 contract organization that is dedicated to providing chemical dependency evaluations, education and clinical services to all those living on the reservation, or within the general area, in order for us to assist and facilitate their progress toward a healthier lifestyle for the client and their families; as well as community prevention/awareness services with focus on self-recovery from misuse or abuse from their drug of choice.
- **Vision:** The vision of this BHO shall provide quality counseling services to

the BHO and surrounding areas. This will be accomplished through the provision of education, prevention, positive coping skills, assessment, referral and treatment at an appropriate level. We will endeavor to build confidence, protect confidentiality and privacy, develop self-esteem, work with all stake holders and bring hope and healing to the BHO. To build a healthy lifestyle through the recovery from addiction we will assist and guide our clients through reliable and consistent services. When necessary, we will provide transportation. Our goal shall be to collaborate as a harmonious and healthy client focused environment.

- **Values:**
    - Respect for a client's background and culture
    - Appropriate level of treatment according to the client's need
    - Treatment should be available at the time the client requests it
    - Many clients need help with problems and issues outside of the substance use

Assets

Currently the BHO is working in an older building that the tribe owns. The building is small but provides some office and group space, although admittedly is too small for the need. The BHL also stated that a large crack was recently identified in the building, which could result in significant financial burden, or the need to move. The BHL has noted that groups must be kept to a minimum, and at times, clinicians must share space, which means that clients must be staggered, leaving limited time for

individual sessions. The BHL reported that they currently have enough computers and office equipment but needed additional programming materials for staff, which are considered evidenced based (SAMHSA, n.d.). A significant asset is the existing Indian Health 638 contract, which the BHO has held for several years.

Governance

This BHO is governed directly by the tribal government, according to the tribal website. In this tribal structure, there are four tribal executive officials. The tribal chairman, vice-chairman, secretary, and vice-secretary make up the board. These are all elected officials within the tribal executive branch. The BHL answers directly to the tribal chairman, although it is not often related to clinical programming but funding, and perception of the program by tribal members. The BHL attends schedule meetings, as well as has unscheduled contact with the chair. Because of the nature of the potential change in tribal government, this practice can change with any new administration. Staffing and program personnel can also change with minimal notice with any governmental change as well.

Along with the chair, the BHL will also answer directly to Indian Health Services, as they are the primary funder for the 638 contracts. A 638 contract is funding given directly to tribes for general services and budget. This budget could be anywhere from 1% to 91% of their total annual budgets. Because most of all funding comes from Indian Health Services, it is known that this is a portion of the checks and balances system, despite it not being a part of the written policy and procedure. The 638 contracts were

given to guide funding, but keep the oversight minimal, which is referred to as “self-governing” (Melvin Consulting PLLC, 2019).

Clients, Other Costumers, and Stakeholders

The clients are members of the tribe or be enrolled in any tribe, and most live within the tribal borders. Although the BHO will accept non-tribal members, these situations are determined appropriate by the BHL with some insight and support from the clinical team. If an individual needs services but are not a member of the tribe or an enrolled affiliated tribal member, there must be extenuating circumstances identified, such as being a relative of a tribal member and living on the reservation without access to off-reservation services. The clientele consists of both adult and adolescents.

Stakeholders in the community are first and foremost the tribal members. Within a tribal community, the entire population is expected to have value and a voice for programs such as this. According to Dellinger and Poupart (2021), the resiliency and wisdom of elders is vital for many North American tribes, and this tribe presents as no different. Dellinger and Poupart also noted that having multigenerational homes with long-standing cultural influences helps to direct tribal mentorship, which also applies to this tribe and involvement with the BHO.

Other stakeholders for this BHO are Indian Health Service, and the state in which they bill for additional funding via Medicaid. Medicaid is a federal medical funding program for adults, children, pregnant women, elderly, and people with disabilities that are below the poverty line (Medicaid, n.d.). According to the BHO, Medicaid contributes only 5% of the funding; however, with their attempt to gain CARF accreditation, the

BHO is hoping to improve upon that billing avenue. The BHL stated that it could open options to further federal funding, grants, and private donations. The BHL also identified the potential to approach private funders with the ability to demonstrate increased legitimacy with accreditation. Because this tribe does use Medicaid, the state in which they reside also are considered stakeholders, given that this is a taxpayer-funded program.

Stakeholders also include law enforcement and the court system. The elected tribal judge, county attorney, and elected tribal council officials would fall into this category. Another vital partnering program in the community would include the local tribal hospital, which offers detoxification services for tribal members. Churches, schools, and other community programs are also considered stakeholders, although they are not considered primary referral sources, but more support related for the clients in the program.

Suppliers, Partners, and Collaborators

Currently, clientele come from self-referral or from the tribal law enforcement and court system. Family members of the juveniles can refer; however, most of these children come from within the court system. Indian Health Services offers behavioral health treatment at a different location, and at times, they refer directly to the program BHL due to her level of education and expertise. Although the program itself focuses primarily on addiction services, the BHL is seen as an asset for the community's mental health concerns as well, especially if the client has a dual diagnosis of both mental health and an additive disorder.

Partners and collaborators are other treatment providers around the county. For all residential treatment recommendations, clients are sent out of the reservation to fulfill this level of care recommendation. The BHL has noted the intent to work with more of these referrals on an outpatient basis once her staff are better trained and equipped to not only evaluate appropriate level of care, but also increase the ability to work with higher acuity clientele.

The BHL explained that if a client presents as having only a mental health concern, with no substance abuse difficulties, they are referred to the behavioral health program at the nearby Indian Health Service behavioral health unit. This unit is directly owned and operated by Indian Health Services and serves more than this tribe at one location. Because "nearby" could still mean inaccessible for tribal members given the lack of transportation, the clinical team at this BHO can make the decision for the individual to be seen if the BHL deems it clinically appropriate. The BHL will often see these individuals, as she is licensed and educated to do so.

Competitive Environment

Currently, this program has minimal competition for substance abuse outpatient services. According to the BHL, the greatest competition and struggle to access clients comes from the lack of referral for high acuity detox clients who enter the tribal hospital for detoxification purposes. The BHL reported a current desire to work with all stakeholders in the community to have more immediate access to those individuals, in an attempt to treat and refer before the client leaves the detox unit at the tribal hospital. Within the outpatient mental health program at Indian Health Services, also located

within the hospital, many of the clients that present with substance abuse needs are referred to this BHO for outpatient care.

Strategic Context

The BHL completed a strategic plan shortly after coming into this BHO. The BHL identified using the organization's mission, values, and prior goals for a strategic plan which had to be developed within the first 3 months of her arrival for a CARF review. She reviewed available data collected from a needs assessment, consumer surveys and performance indicator data, which she reported was minimal and difficult to find. The BHL used a strengths, weaknesses, opportunities, and threats (SWOT) analysis for her program and had limited support in completion of this task, given the nature of the time and lack of information for its completion. A SWOT analysis can help the BHO identify critical success factors (Bryson, 2018). Bryson noted that analysis should identify distinct competencies which will help establish goals and outcomes. Bryson also discussed the importance of having background information to prepare, which given the BHL's time and limited sources was not feasible before the CARF accreditation was to take place.

The strategic plan was completed by the BHL in the autumn of 2021 (see Appendix B). Shortly after, the CARF accreditation did take place, and given not only the continued struggles identified in the SWOT analysis but also factors related to ability to conform to standards in such a short time, they were awarded only a 1-year accreditation. The BHL has made application for another accreditation process and has begun to implement corrections identified during the last review.

Performance Improvement System

According to Baldrige Excellence Framework (2021), the program will need to address action plan development and follow through while focusing on ongoing success and deployment. As the BHL has identified specific goals and objectives to the SWOT analysis, which is part of the overall strategic plan, she is currently at the phase of determining the action plan and implementation. Because of the nature of her current position of both adhering to the board and programs expectations, as well as supervision and program development, the performance improvement system is in its infancy stage. The BHL completed this analysis without stakeholder feedback, as well as having only a few months of insight into the program. As a result, the strength of the strategic plan had its limitations. For example, it does not include input from customers, which Brown (2012) indicated can offer insight into tangibles and intangibles or the "what and how" services are delivered.

Organizational Background and Context

This BHO needed support for this project due to several reasons. First, the BHL has identified the need for additional support for the program. In consideration of the full extent of weakness and threats to the program, as identified by the program's strategic plan, it was apparent that the ability to determine supervision and continuing education and training for staff will not likely be paramount for the program as the focus is on other arenas that are barriers to progress. Although addressing this struggle could assist with identified concerns, the BHL has little time or ability to aim focus in this direction given the constraints of the current job duties assigned.

A second reason for needing this project was that the acuity and severity of the drug and alcohol problem has been identified, with the Native American population having high risk and probability for continued struggles. Having qualified and well-trained professionals is necessary for addiction and mental health concerns within the behavioral health field. Given both internal and external factors that attribute to increased vulnerabilities, an increased access to services and qualified providers is necessary (Johnson & Brookover, 2020).

The institutional context of this program lends itself to success of this project. Currently the BHL has been given permission to do what is needed to not only address underlying concerns, but also improve upon the program and reach the goals identified. The tribal chairman has directed the BHL to lead, hire and manage as needed, with little interference as possible. The BHL believes that the staff are willing to learn, and they each have identified a desire to grow and work towards the goals identified within the strategic plan. Given that this tribe has a long history of wanting to support its people, using this cultural strength is evident within the staff and this BHO.

Definitions

The following operational definitions were used throughout this capstone study:

- *42 C.F.R.*: A law used to help ensure that substance abuse treatment does not result in adverse consequences related to legal proceedings, court, divorce, custody, or employment. (SAMHSA, n.d.).
- *Behavioral health leader (BHL)*: The current clinical director for this organization.

- *Behavioral health organization (BHO)*: An organization that works with individuals seeking treatment for substance abuse or mental health services.
- *Certification and Accreditation of Rehabilitation Facilities (CARF)*: A national accreditation program used by behavioral health programs to demonstrate continuous improvement to quality of care (CARF, 2022).
- *Client*: Individual seeking services for mental health or addiction treatment.
- *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*: A law which is used to attempt to protect sensitive personal and medical information of clients without permission from the individual (CDC, n.d.).
- *Intensive outpatient (IOP)*: Treatment that is 9 hours or more each week, per client. This can include mental health individual and group therapy, as well as case management or vocational support.
- *Outpatient (OP)*: Services that are provided that are less than 6 hours each week. This can include mental health individual and group therapy, as well as case management or vocational support.

Fiscal and Legal Management

Currently the BHO's financial management is the responsibility of the BHL. The BHL must budget accordingly, and follow all expectations outlined by the 638 contract. The BHL is also responsible for appropriate billing for Medicaid and consideration of grants. The BHL answers to both the Tribal Chairman, as well as Indian Health Services for budget requests and reports. Because this tribe has had struggles with finances, accountability and structure related to federal funding, they are currently ineligible for

additional funding until the tribe can demonstrate improvement based on federal law and expectations. This has hindered somewhat the ability for this BHO to secure funding via grants through the federal system (BHL, personal communication July 29, 2022).

Although the tribe is a sovereign nation, their program must adhere to the State's laws and regulations related to certification and licensure because of billing a taxpayer funded program or Medicaid. Laws such as HIPPA, and 42 C.F.R. as well as ethical codes of conduct from the American Counseling Association (ACA, 2022) and/or the National Association of Social Workers (NASW, 2022) are expected, as they are tied directly to licensure and certification. Because they want to also receive CARF accreditation, the laws, and ethics that CARF mandates are also expected to be followed.

Summary and Transition

This BHO has identified needs, as well as mission, vision and values that lends itself to accomplishment of its identified goals. The program has assets that have been consistent throughout the years, such as a large contract that assists with self-determination and improved services. The program has other strengths such as a culture which works towards improvement of its people, and staff that are all aligned with this value. It has a new BHL that has identified specific strengths, as well as needs and long-term goals. The program's weaknesses are also evident, but the desire to work towards addressing those struggles is apparent. This project will add to the BHL's ability to supervise and train, as well as add to the program in its entirety. It adds a solution to a continuing problem that they not only face, but the behavioral health field does as well.

Section 2 presents some background, approach-leadership strategy, and assessment. It explains how information was gathered, and from where. It discusses how the data collected was compared to the research to establish gaps in not only the research but within the BHO itself. It also covers key strategies and process and how they affect both clientele and the workforce.

Section 2: Background and Approach—Leadership Strategy and Assessment

This BHO serves the Native American population within the western region of the United States. The leadership is characterized by tribal leaders, Indian Health Service funding supervisors, and a newly hired BHL. The program is working towards national accreditation and has made significant changes in recent months. Because of the significant changes in leadership and programming, problems related to education and training have been identified. The BHL and funders have acknowledged the need for additional support and assistance in identifying a solution to what they determine to be a barrier to success and goal attainment.

Supporting Literature

To locate supporting literature for this study, I used Walden University's library databases, Google Scholar and internet searches within governmental websites. Search words related to supervision, education, training, substance abuse, mental health and addictions were used in all databases. Other words related to culture and evidenced based practices were also applied. References noted as being potentially valuable within scholarly articles were then searched when it was determined that additional information and consideration related to the practice problem could be identified. The search results revealed significant information related to substance abuse, mental health and addiction treatment; however, there was limited information about specific needs for appropriate educational levels to treat clientele within a Native American reservation treatment program. There was also limited information related to the certified level practitioner training or education expectations within any treatment program. Information related to

master's level programs was considered for best practices in education, and this was then compared to demands of lesser degree programs.

Because the problem of a lack of education was identified as a potential gap, I used published research to support the need for targeted and specific standards in an addiction training program. The primary training program for the certified staff members within the BHO is the local tribal college, where an individual can receive an Associates of Arts in Human Services Addictions Studies. When considering research related to educational needs, Klimas et al. (2017) identified how the lack of training of addictions within the medical school arena impacts the ability to work appropriately in this field. They noted that some reasons for lack of training are cost associated with additional medical school, lack of appropriate mentors, trainings, and recognition. Klimas et al. found a deficit in training in addictions and noted that offering a more involved program helped the physicians understand not only the medical but also socioeconomic concerns for the clientele.

Physicians have a high level of medical training by the time they reach fellowship, but even at this education level, education on addictions is lacking, according to Klimas et al. (2017). The outcome indicated that very specific training was lacking to fully address the substance abuse problem that plagues the nation. The certified staff at this BHO have some classes related to addiction and mental health; however, compared to physician education, instruction in these topics is limited as the program at the college has minimal credits that are specific to addiction training.

To further demonstrate the importance of targeted training and education, Martin et al. (2020) noted the importance of being trained in an evidence-based assessment tool such as the Screening Brief Intervention and Referral to Treatment (SBIRT) tool. Martin et al. observed that most mental health clinicians are not trained in this form of care, and that simply training on how to use a tool does not translate to practical application. Martin et al. identifies not only areas in which should be considered best practices, but also helps to identify typical struggles with the application of education. The individuals were from masters and doctoral programs, again demonstrating that even at higher educational levels gaps exist. Compared to the education training at the local college, there is minimal specific training on assessment or evaluation, and this, according to the BHL, has typically been learned once the staff member is at work and being trained on the job.

The local tribal college does offer one class that is specific to evaluation and assessment; however, the BHL indicated that there is concern that her clinicians are not well enough trained in this area and that the education was not sufficient. There is a need for better education for substance abuse treatment within the psychology field in general, especially in the areas of evaluation and assessment (Pederson & Sayette, 2020), so it is likely that the BHL is correct about this program as well. The importance of teaching how to use brief intervention and assessment tools, as well as encouraging students and staff to create relationships with referrals and other stakeholders in the substance abuse field, was identified. Again, much like Martin et al. (2020), Pederson and Sayette (2020) identified the need for prior and more extensive training in the arena of evaluation and

assessment, which would be consistent with what was reported by the BHL. This training need will be important for the consideration of solutions to the problem associated with lack of specialized training prior to entering the treatment provider field.

Although the local college demonstrated some classes related to addiction, McCarty et al. (2020), identified that at a minimum, those in the field should understand assessment and intervention, as well as have a full understanding of motivational interviewing skills. Based on the class lists for an Associate of Arts degree at the local college, these specific areas do not appear to be targeted nor specific.

The work that the University of New Mexico has done with training and education for substance use disorders (McCrady et al., 2020) has also indicated the need for specialized trainings in the area of addictions. McCrady et al. (2020) discussed the importance of many factors, including development of relationships to foster education as well as the need for willingness to mentor and train in the addiction field. McGrady et al. (2020), noted the specific fundamentals that could be used as a comparison for what could be considered best practices in education and identify a template or model for other graduate programs, but nothing related to associate degree only programs. This information is also helpful to determine potential gaps for this BHO, and possible new, specific trainings that should be completed prior to a clinician working with any client population.

Having skilled clinicians within the arena of evidence-based practices of motivational interview and cognitive behavioral therapy are vital for effective substance abuse treatment programs (Vaughen et al., 2021). Although Vaughen et al. (2021)

indicated that there is “no uniform model for training professionals,” there are many expectations that should be considered for any training and education program. According to the program requirements at the tribal college, they do offer some classes related to group fundamentals of counseling, as well as fundamentals and theory of counseling; however, the full extent of the specific training was not yet identified. Venner et al. (2016) also cited the importance of both cognitive behavioral and motivational interviewing therapy skills to be important to any program, including within Native American training programs. Venner et al. noted that cultural adaptations of evidenced based practices may be necessary to address the health disparities presented in the Native American population, given the cultural implications that could be present for any given tribe. Although tribes are varied and all present with unique strengths and challenges, Venner et al. acknowledged the need to appropriately train staff in rural, Native, communities. This BHL has similar concerns and discussed the need for education, training and cultural adherence or involvement to all programming. The BHL believed that her staff can communicate well with the clients, but that they lack specific tools such as cognitive behavioral therapy, and motivational interviewing.

Specific training and educational components of the local college classes demonstrated some education in cognitive behavioral treatment, assessment and intervention, and addiction therapy, although specifics in each class are not known. Given the few credit hours offered for each, the implication is that instruction in these topics is minimal and not intensive or adequate when compared to master level programs. The

certification process also appears to be lacking, in comparison to the research indicating the need for specialized education and further trainings.

Along with specific educational intervention, the spiritual and traditional interventions were also found to be important when treatment the Native American population. Dickerson et al. (2021) identified the disparity between Native American/American Indian individuals who struggle with mental health or addiction, compared to individuals that require interventions. They found the need to integrate spiritual and traditional practices to assist with increasing involvement and care for this population. They also noted the importance of traditional involvement as having a potential to decrease depression and anxiety symptoms. Because this BHO uses a cultural counselor, it is evident that they are attempting to incorporate traditional care into their treatment program. This, along with the BHL's decision to offer *sweats* at least monthly, indicates the program's desire to not only address the substance abuse needs, but also be mindful of spiritual practices. Native American sweats, or *sweat lodge ceremonies*, are the practice of using a tent-like space, heated water typically via heated stones, and prayer, for ritual purification. Although tribal ceremonies vary, the premise of healing and spiritual transformation is universal. This arena presents as sound, in looking at the educational demands specifically related to the cultural components of this tribe.

Currently this BHO has employed several staff members who have associate degrees in addiction from their local college. These individuals are considered "certified" rather than licensed, given their limited educational background. They can perform some clinical duties, under the supervision of a master's level clinician; however, they present

as more peer recovery support, according to the BHL. Kelley et al. (2017) discussed a non-clinical approach to recovery of peer recovery support. Kelly et al. identifies the primary interest as being those within the Native American recovery community and does so because this population demonstrate a higher need for substance abuse treatment, as well as a cultural component that often incorporates the community and traditional cultural concepts into the healing and recovery process. Kelly et al. (2017) noted the importance of including cultural aspects to recovery being helpful and created a positive outcome, which is present with the staff members despite not having as high of degrees as their colleagues.

Sources of Evidence

The sources of evidence of the specific struggles related to this practice problem were from many sources. First, the BHL was interviewed on several occasions. She discussed not only her background, but what concerns she has noted since entering this program. Another source of evidence was the interview with the clinical supervisor, which was semiformal to encourage a more communicative approach to exploring her perspective of the practice problem. The clinical supervisor was able to further elaborate on problems related to the staff having the lack of further education, beyond associates level certification and training.

Another source of evidence was the strategic plan from autumn 2021, which the BHL created just weeks before beginning the certification process known as CARF Accreditation. The strategic plan was helpful, as it allowed insight into where the program is hoping to direct, and to determine gaps in the ability to follow through with

those goals, if the BHL's belief that there is a lack of education and supervision is accurate. Although CARF demands that a strategic plan be in place for at least 6 months prior to the certification process, given the time from her being hired to the date of the review, a temporary plan was developed. Along with this document, the BHL also allowed the review of monthly reports that she provides to the tribal chairman. These reports shared information about clients such as numbers seen, primary diagnosis, wait times and lengths of stay. Resumes of staff were also used as sources of evidence to determine education and certification levels of staff.

Outside of the program, sources of evidence were also from the state's licensing board and certification rules. Within these rules, it lists training expectations, and educational requirements for all licensed and certified providers. This offered perspective about the differences not only between education and training levels, but also between job duties and expectations. Another source was information gained from the local college's requirements for graduation, and credits offered to obtain an Associates of Arts degree.

Leadership Strategy and Assessment

Leadership Governance

The BHL is currently left to determine all aspects of the program with minimal supervision. There is no governance board, nor formal governance to determine staffing or supervision structure. The BHL has been given a hands-off approach to create the program she deems fit, within the financial and ethical structures determined by her license as well as funding requirements. Most of her supervision and support comes

informally from the Tribal Health Director, who is an employee of Indian Health Services. The BHL reported that this individual has a Master's in Public Administration and has been working in the field for many years and is close to retirement. The BHL stated that her supervision, although not mandatory, has been helpful for offering direction and support in areas she is unfamiliar.

Programs can use governance and mandates associated accrediting bodies such as the Counsel on Accreditation (COA) or the Joint Commission (TJC). This program chose to use the CARF. All three programs require the use of data to determine client care; however, none mandate specifics related to therapeutic delivery (Lee, 2017). Lee (2017) found that the accreditation process can encouraged development and implementation of the improvement process and quality management. This BHO program specifically chose CARF because it is the most predominate accreditation program in the region, according to the BHL. She indicated that this program was chosen because not only her current grant funder requested the BHO to gain certification with this project, but also that Medicaid and Medicare indicated it being the most appropriate for the program. The program also must follow funding mandates related to the 638 contract via Indian Health Services.

The BHL is the trainer for all ethical concerns and trainings. Because the program is currently working towards CARF accreditation, the ethical codes for both staff as well as the program are being recreated and trained. The program currently uses CARF standards, as well as Indian Health Service funding and training requirements to anticipate legal, regulatory, and ethical concerns.

Strategy and Key Challenges

A strategic plan was developed over a short period in preparation for CARF accreditation. Since the creation of that plan, the BHL has made the decision to involve stakeholders such as community members, elders, Indian Health Service staff as well as her staff and some clientele and to consider the creation of a new strategic plan to help support program growth. The BHL identified wanting to increase prevention, early intervention, and severe addiction treatment, and to do so with the help of these stakeholders. She also identified the need to work more with the community and other providers to meet the goals identified in the primary strategic plan.

A key challenge to completion of the identified long-term goals has been the lack of formal structure and success the program has demonstrated in years prior. Because the changes the BHL is proposing are significant, and the program has not fully accessed its potential, she understands the need for systemic change. For example, the emergency room does not currently use any 72-hour hold for suicidal or addiction-related concerns. The BHL has identified changing policy at the tribal level with the tribal attorney, clinical supervisor at Indian Health Services behavioral health unit, and the tribal chairman. so that they can address high acuity, as well as the revolving door of addicts to the tribal hospital.

Determining Key Processes and Factors

The program collects data from the use of AccuCare (Orion Healthcare Technology, 2020). AccuCare is a practice-management system used by behavioral health programs for electronic records purposes and well as billing. The BHL creates

monthly reports and turns them into reports that she can shared with the tribal chairman. The BHL would like to use more of this information in further identifying goals and strategies for the strategic plan. The information gained from this has not yet been considered for "next steps," and there is consideration for how to change this and incorporate data into goals and planning.

The organization obtains information related to client care directly from their electronic health care data collection system. This system tracks client contact, diagnosis, hours of service and primary drug of choice. It also collects data related to income, race, gender, and suicidal ideation. This process begins at time of intake, where a case manager will input initial information and then a clinical staff member will complete an intake evaluation. From that point forward, all contact is to be recorded within the system so that long term tracking of treatment hours and client numbers can be completed.

Another way the program determines strategy is based on funding. Currently the tribe is considered high risk for any federal funding, and until this situation is resolved, this program cannot access additional grants or funding streams through the federal government. The BHO has a private funder, who donates 1% of her profits from a business she owns back to the program, which helps make up for some funding deficits. The BHL admitted that some of the changes currently have been, and still are, "trial and error." The BHL believes that by accomplishing a three-year CARF accreditation, rather than the one-year they received, will indicate that many of the problems she walked into are changing. This, along with instituting yearly evaluation and a new strategic plan, the BHL indicated, will help create a clearer path for determining key processes.

Clients/Population Served

The program serves all tribal members, as well as any other individual that is enrolled in a Native American tribe in the United States. The BHO serves all Native American tribal members; however, their main objective is to work with those living on the reservation at the time. They work with both adolescents and adults and gain referrals from the court system, family members, community members, and other stakeholders in the community. Other stakeholders can and do include schools, a local hospital, and church organizations.

Their primary services are aimed at adults, although they are hoping to increase juvenile services. Individuals that seek services must present with a primary concern related to alcohol or other drug use disorders and have life difficulty as a result. If a client has a mental health concern, they may still receive services; however, referrals are made as necessary to the behavioral health clinic at Indian Health Services.

The BHO currently has no formal information gathering process to gain access on client satisfaction. The BHL reported that clients do have access to staff, supervisors and can speak directly to the Tribal Chair if needed. For example, clients can text the BHL as well as the Clinical Director, and the phone numbers are posted in the facility for ease of access. The BHL has instituted a group process where the client is able to document at the end of the session how they felt the process has been going, and any concerns they may have. The BHO is in the process of developing a plan to obtain information from clients post discharge. The BHL reported that none of the satisfaction data collection has been consistent, and there is an understanding that this would need to change. According

to CARF (2022), input from persons served and stakeholders is a fundamental standard, and one in which the BHO was cited as lacking. The BHL has indicated the need to create not only a satisfaction survey, but also to formalize the process in order to adhere to policy and procedure as well as CARF mandates for this requirement.

Because some of the staff are in recovery, the BHO believes that this offers a different form of communication and interaction with the clientele. The BHL indicated that there is informal communication occurring within the recovery community and staff, and this form of communication cannot be quantified. Some of the staff members speak the Native American language from this tribe, which also indicates a connection to the culture and an increase in responsivity to staff from client. Food, and a general welcoming area as well as a website for improved communication are in the current short-term plans. The staff are often involved in community events, and traditional offerings. They hand out t-shirts at health fairs, do clean-up of communities and are involved in helping clients participate in Native Powwows and traditional ceremonies.

Workforce and Operations

There is no current way the BHL formally assesses staff capability and capacity, although she currently does do informal evaluations during the day-to-day operations. The BHL reported that typically she will look at how many clients are being referred to residential, for example, and then will look at the evaluations to determine why the staff member chose this recommendation. She will then review the process with that evaluating staff member. She identified it being laborious and inconsistent. This is consistent with the identified problem related to what additional training and supervision

are needed. The BHL leader also supervises all other staff members and explained the attempt to "hand-off" this duty solely to the clinical supervisor. This leader is working with the clinical supervisor to increase her full understanding of the need for specific supervision, as well as a more formal evaluation process. Again, this speaks directly to the practice problem of identifying specific supervision and training needs. The BHL is currently considering additional support, such as with an outside consultant to add more trainings as well as become compliant with CARF standards related to staff trainings.

To support the staff members, the BHL instituted a significant raise for all within her first few months at the program. There are no benefits; however, the BHL will allow flex time and has also instituted a four-day work week, which now all staff use. Prior to this BHL's hiring, any on-call time process was not effectively managed, so now four hours of time off is given for every weekend of being on-call, even if no calls occur. The BHL will approve trainings to be completed on the clock if the staff member can prove it would support the job duties, or if it has a direct impact on certification or licensure (BHL, personal communication, April 29, 2022).

Analytical Strategy

This case study was designed to examine the impact of education and supervision of staff within a tribal substance abuse treatment program. A qualitative approach can be both analytic and descriptive (Ravitch & Karl, 2021), and may be varied given the epistemological view of the subjects. This case study entailed data collection from external sources, internal information and both structured and informal interviews, to

"paint a comprehensive picture" (Burkholder et al., 2020) around the bounded unit, or substance abuse program and the phenomenon related to the research questions.

External Data Collection

Data for this study was collected from relevant websites and Walden University databases. Data was also collected from the state's mental health licensing board. This entailed a complete listing of expectations of all licensure requirements for those with master's level clinical degrees, as well as associates level educations. The licensure laws indicated specific clinical training post education, and clinical hours needed to obtain license. Data was collected from educational institutions from which staff received clinical degrees. This information listed class titles and credits associated. The Tribal Chairman and Tribal Health Director were contacted, and attempts were made to interview both.

Internal Data Collection

Internal data was collected from the BHL via emails, calls, and face to face communication. Information obtained was the policy and procedures, monthly staffing reports, resumes and the strategic plan. The staff chosen represented those that could offer relevance to the research questions (Burkholder et al., 2020). Staff chosen were the BHL and the clinical supervisor. The interviews were recorded and coded according to Saldana's (2021) thematic analysis that attributes meaning to the data through recognition of patterns. Grounded theory (Burkholder et al., 2020) was applied to the interviews because the questions, although developed prior to the first interviews, did evolve during the process so that more information could be collected based on new areas of

exploration being identified in the process. Also, additional interviews occurred because of new information and additional questions occurring. The qualitative process was used to interpret the meanings that the BHL and clinical supervisor gave to the problem through open-ended interview format, and then be compared to the data collected from other sources such as internal documents generated by the BHL, as well as the external sources related to education and licensure. (Appendix C).

Trustworthiness

To demonstrate more rigor and validity, Ravitch and Carl (2021) noted the importance of triangulation which is defined as including multiple data sources. The information, once all gathered from all sources, was compared to determine if there are patterns and themes present, and if the information is comparable. The goal was to ensure credibility of the research by being complete with both the interview process, data collection and interpretation process. The researcher looked for transferability between the staff members, and potentially the strategic partners, to determine if each member has a similar experience related to the problem. The researcher established conformability for this problem, such that other researchers can derive the same outcome from the data (Ravitch & Karl, 2021).

Summary and Transition

The BHO is the primary recovery center for a tribe in the western region of the United States. This program works with all individuals who are considered enrolled for any Native American tribe, but primarily work with those that live within the reservation boundaries. They work with both adolescents and adults whose primary diagnosis and

concern is substance abuse related. Although they have the capacity to work with individuals with mental health needs, this is not their primary function. The current BHL has been employed by this program less than one year and is currently seeking to secure national accreditation to increase funding as well as program legitimacy. Because of this, the BHL has recognized the need to further evaluate the training and supervision needs, as well as to change the program and increase stakeholder involvement.

Section 3 covers the measurement, analysis, and knowledge management components of the organization using the Baldrige Excellence Framework (NIST, 2021) to discuss the culture and performance of the program. It presents information gained from the BHL and clinical supervisor to further elaborate on the practice problems. It will discuss performance as it ties directly to supervision, as well as how information management supports or detracts from the BHO.

Section 3: Measurement, Analysis, and Knowledge Management Components of the Organization

A tribal specific substance abuse and partial mental health program in a western region of the United States that works with all Native Americans on the reservation who struggle with substance abuse needs is being used for this project. Clients for these services must be members of the tribe or an enrolled member of a recognized tribe. The purpose of this study was to explore the educational requirements for certified addictions practitioners, as well as licensed clinical therapists and social workers. I sought to define the expectations for culturally appropriate education and training to serve this population. The purpose was also to assess the training and supervision provided, as well as additional needed, for staff members to be more fully capable of serving culturally appropriate treatment. The expected outcome of this study was to resolve the training and supervision needs of the program and help develop a plan of action for the BHL to ensure culturally appropriate training identification and follow through, as well as specific areas of supervision needed.

The research questions for this study are as follows:

RQ1. Above and beyond the state requirements for certification and licensure, what additional educational and training needs are appropriate for staff to be better qualified to work at this agency?

RQ2. How is the effectiveness and efficiency of staff determined?

The first source of evidence for this project was the BHL. As I interviewed her, she shared not only her background but also the concerns she has identified since entering

this program. This first interview was used to determine the practice problem and research questions. Another source of evidence was the interview with the clinical supervisor, which was semi-structured to encourage a more communicative approach to her opinion of the practice problem. The BHL was able to further elaborate on problems related to the staff having the lack of further education, beyond associates level certification and training. She was also able to identify her own struggles related to supervision and education since beginning her professional career. She was also able to elaborate on how she struggles to determine what areas of need her staff have, and how to evaluate their effectiveness. The clinical supervisor was able to identify her own struggles in not only approaching staff but also motivating and evaluating them. The initial interview questions for both the BHL and clinical supervisor are listed in Appendix C.

I also attempted to interview the tribal health director, as she has been identified as a valuable stakeholder with additional insight into not only the mental health field, but also this program in particular. The tribal chairman was also contacted for an interview to gain insight into how the leadership of the tribe itself has been determining success of the program. Neither individual confirmed the interviews, which resulted in them not occurring.

The strategic plan, which the BHL created just weeks before beginning the certification process known as CARF Accreditation, was used to gather specific insights related to the strengths as challenges of the program. Along with this document, the BHL also allowed the review of monthly reports that she provides to the tribal chairman. These

reports shared information about clients such as numbers seen, primary drug of choice, age, and gender. I used resumes of staff as sources of evidence to determine education and certification levels of staff.

Outside of the program, sources of evidence were also from the state's licensing board and certification rules. Within these rules, training expectations and educational requirements for all licensed and certified providers was identified. This offered perspective about the differences between not only education and training levels, but also on job duties and expectations. Another source was information gained from the local college about the educational trainings offered related to the human services degree in addictions.

Analysis of the Organization

According to the Baldrige Excellence Framework (NIST, 2021), organizational culture should include an engaged workforce, open communication, and high performance. The program has an engaged workforce, which is evidenced by weekly staff meetings where staff can note concerns, bring up new ideas, and ask for support. The BHL identified that staff also have the capacity to move positions, with additional training or education, and this is fostered by paying for education or training for the staff members. Staff are also allowed to work on continuing education credits while on the job if it applies directly to additional certifications or is related to the mental health or addiction field. The BHL has plans to use a consultant to complete a strategic plan this year and invite all her staff to participate in a retreat to engage them in the process.

The area that presented as being problematic was related to high performance, which aligns directly to the practice problem of the lack of education and supervision as well as identification of effectiveness and efficiency of staff. The BHO instituted four 10-hour days to support more client contact in the evenings as well as time for paperwork to be completed in the morning work hours. However, the BHO and clinical supervisor have noted a lack of work being done in a timely manner and a lack of understanding of clinical expectations, such as appropriate assessment process, progress notes, treatment plans. Staff are not to take time off on Fridays if paperwork is not completed; however, staff do not follow this expectation and typically do not have work done in an ethical or timely manner and yet do not work on Fridays. Despite this concern, the clinical supervisor does not direct staff to change behaviors or attend work as needed. Currently, there is no formal process for chart review or supervision of staff within the program itself, such as witnessing group interaction. There has also been no formal staff evaluation completed in recent years by any clinical supervisor or BHL.

Currently there is no formal assessment of engagement as defined by Baldrige (NIST, 2021). As the BHL had been there less than a year at the time of this study, she had yet to complete any staff yearly reviews and had not yet reviewed job descriptions. The informal process she employs has been to use indicators such as staff retention and productivity of client staffing numbers, which she would review during weekly meetings with staff, but not document. The BHO has identified the need to contract with a consultant to assist with performance management related to client healthcare. This

position will assist with identification of CARF requirements that were lacking and a solution to the recommendations proposed, all related to client care and program policy.

Baldrige framework notes the importance of core competencies, personal development of the workforce, new knowledge and skills and organizational performance and improvement (NIST, 2021). This area also relates directly to the practice problem, as there is limited understanding of what core competencies of staff are lacking. Once that has been better determined, goals related to the specific needs will be created, as well as a plan to better achieve those goals. As the BHO has taken on the challenge of gaining a 3-year accreditation by CARF, many of the factors related to the formal process of staff and client satisfaction and client outcomes will need to be defined. However, the actions and specifics of that process will likely be created through the process of addressing this practice problem.

Knowledge Management

The organization currently has limited ability to manage organizational knowledge. The program is considering using external storage systems to create a better system of management. For program information such as policy and procedures or intake paperwork, all information is currently stored on USB hard drives that have been lost and taken by disgruntle personnel in recent years. Because of this, consultants have been used to help recreate information as well as the BHL spending what she reported as "significant time" each week on this process. All staff information is maintained in paper files in a locked filing cabinet; however, all staff have access if they should so choose.

The BHO uses AccuCare (Orion Healthcare Technology, 2020) for all client data, such as intake information, length of stay, diagnosis, and progress notes. The reports generated can create information needed for funding purposes related to hours and length of stay. The reports are only generated by the BHL, given her access and clearance into the system. The BHL then provides this report monthly to the tribal chairman. AccuCare is protected by their own firewall and information management systems and is accessed via the internet from the agency computers. The tribal information technology department, which is in another location on the reservation, is responsible for all technology management for the tribe.

Summary and Transition

For this practice problem, I used information for analysis from both internal and external sources. Internal sources included the BHL and clinical supervisor as well as personnel files, policy and procedures, and the most recent strategic plan. External information was gained from the state's licensing board and local tribal college. Currently there is no formal process for staff evaluation, although the BHL has reported a goal to complete this before the next accreditation attempt in coming months. Although the BHO uses an external data collection program for client care, the program has identified the need to create a more formal, secured policy related to internal data collection and program information that can be better accessed despite staff turnover or difficulties.

Section 4 provides the analysis, findings, and preparation of findings to further elaborate on how information was used to establish themes from within the BHO. The

section includes discussion of the process and flow of the data, and how identified themes were noted within the areas of client care, workforce, and leadership. It demonstrates that the themes, which tie back to the practice problem, can be addressed to lead to social change.

Section 4: Results—Analysis, Implications, and Preparation of Findings

This project is a case study of a tribal substance abuse and partial mental health program within the western region of the United States that is working towards national accreditation and improved services. This tribal program serves all members of this tribe, or any enrolled member of any other Native American tribe, who seek services. The purpose of this study was to explore the educational requirements for certified addictions practitioners, as well as licensed clinical therapists and social workers, and to define the expectations for culturally appropriate education and training to serve this population. The purpose was to assess the training and supervision provided, as well as additional needed, for staff members to be more fully capable of serving culturally appropriate treatment. I also looked to determine how staff are being evaluated, and to what extent is their effectiveness and efficiency determined.

The research questions for this program were as follows:

RQ1. Above and beyond the state requirements for certification and licensure, what additional educational and training needs are appropriate for staff to be better qualified to work at this agency?

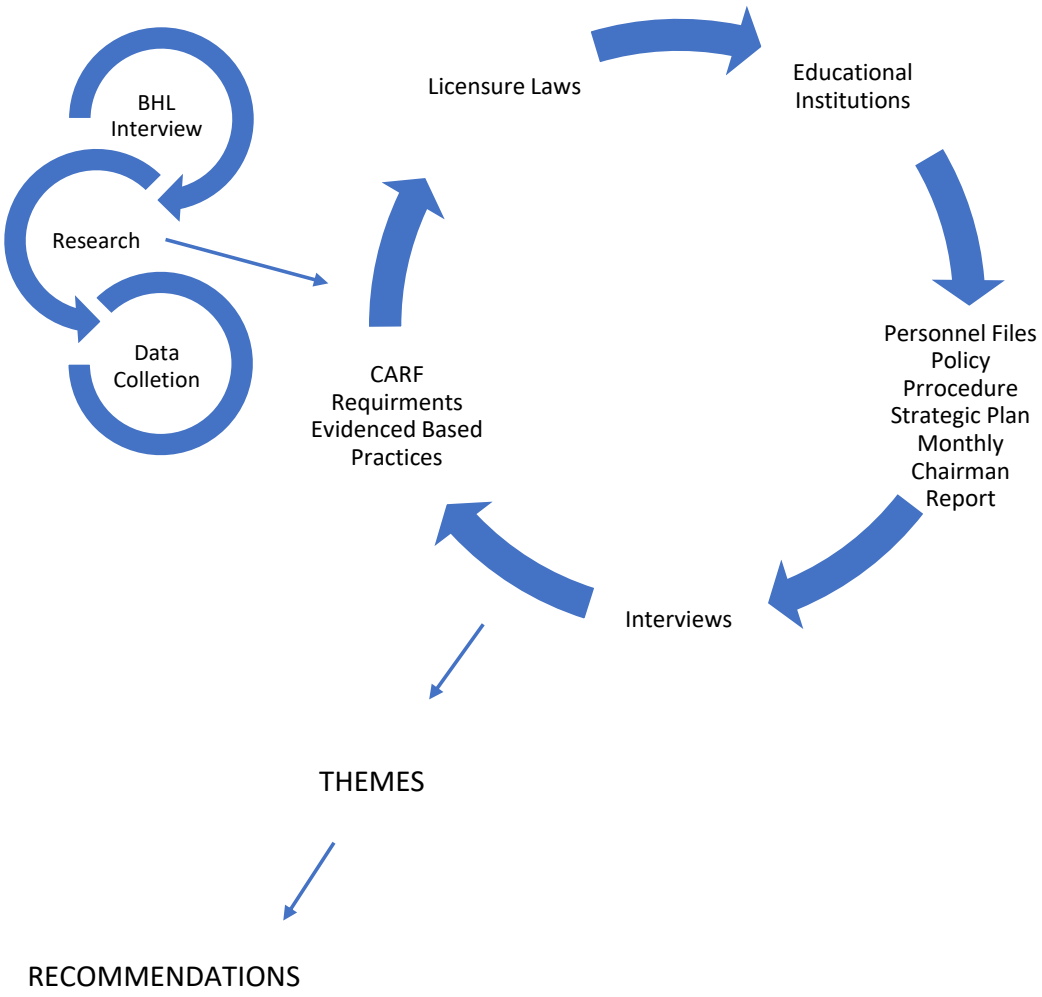
RQ2. How is the effectiveness and efficiency of staff determined?

As shown in Figure 1, the following themes were identified from the data: (a) there has been limited structure for staff and program requirements, which has presented leadership challenges for the new BHL; (b) program and clinical standards are somewhat being performed, but not in accordance with state or national accreditation mandates; and

(c) appropriate supervision could address most staffing concerns, and program needs. These themes will be discussed in this section.

Figure 1

Process and Flow



Note. This figure depicts the process of data collection, to identify themes and determine recommendations.

Sources of Evidence

The sources of evidence began with the interview with the BHL and the clinical supervisor (see Appendix C). I also examined the strategic plan from autumn 2021, created by the BHL shortly after her hire date. Monthly tribal reports dating back to October 2021, were also used, with the first report being completed by the clinical supervisor. Other sources of evidence included resumes of staff, used to determine education and certification levels of staff, as well as policy and procedure documents, which I collected and compared to CARF (2022) requirements.

Outside of the program, sources of evidence were also collected from the state's licensing board and certification rules. Within these rules training expectations, and educational requirements for all licensed and certified providers were identified. Another source of data was information gained from the local college about the educational trainings offered and credits given related to the human services degree in addictions. I also reviewed degree requirements from a state university where the clinical supervisor obtained a Master of Social Work. Attempts were made to interview both the tribal health director and tribal president; however, these interviews did not occur. I sent several emails to both, and only the tribal health director responded. However, that meeting was not followed through with due to her noting a prior obligation, with no follow-up meeting taking place.

The strategic plan, created in the autumn of 2021 by the BHL, indicated the need to obtain CARF accreditation, state certification and to improve performance in several clinical and staffing arenas. The plan also identified the need for a quality improvement

manager. The plan recognized the strengths related to cultural involvement, having no waiting list and being in operation since 2003. The monthly reports given to the tribal president were compared, including data related to assessment for juvenile and adults, primary drugs of choice and group and individual hours offered.

For the purposes of this project, certified staff members' tribal college's handbook from 2019-2021 was used, as it is the most up to date based on the website. The tribal college is accredited by the Northwest Commission on Colleges and Universities (2022), a federally recognized higher education accrediting agency. According to the 2019-2021 handbook, the college had 235 full-time students in 2016, with 96% being American Indian. The focus is on the tribe in which the college is located; however, the student body also consisted of students from three countries, four states, and nine different tribes. The college has nine full-time and 15 part-time employees. The program, as well as the facility, are based on tribal traditions and values, which would include the intentional placement of all tribal buildings in a circle, around a ceremonial dance arbor as the center of the school.

According to the handbook, for the Associates of Arts in Human Services Addiction Studies, there are 21 credits offered that directly educate on psychology and sociology. Classes include Introduction to Psychology, Fundamentals, and Theory of Group Counseling, and Group Counseling Models and Dynamics. The class schedule also included Abnormal Psychology and Legal, Ehical, and Professional Ethics and Introduction to Sociology.

Classes that directly relate to addiction studies include Drugs and Society, Pharmacology, Addiction Assessment, Treatment, and Addiction Counseling. These credits are nine in total over a 2-year period. Classes that directly tie to the tribal and multicultural needs are American Indian Psychology, Tribal Language, Multicultural Competency, and a Tribal Study. These credits are a total of 12.

The expected outcomes, based on the handbook, include that a graduate should be able to conduct interviews, assessments, evaluation, and treatment planning as well as follow up. There is also an expectation for students to be able to present issues of concern to their communities and address cultural needs. Besides being able to pass the state's exam to become a certified licensed addictions counselor, the goal is also to be able to demonstrate knowledge and counseling in the addiction field. The tribal college's handbook indicates that the program assists students with studying and passing the NCC exam.

Information from the clinical supervisor's Master of Social Work program was also collected via email, as the website did not offer specific information. I used this information to determine level of supervision training, as well as addiction training within that educational program. According to the class lists for the Master of Social Work, there is one class specific to evaluation; however, it does not denote the type of evaluations or the purpose. There are seven therapy classes related to individual and group approaches, totaling 25 credits. There are three classes specific to addictions within the electives category, totaling nine credits. There were no supervision-specific classes within the class schedule.

The state's licensing board requirements were used to determine standards to become a certified licensed addiction therapist with an associate only degree. According to the board of health's website, the clinician must have an associate of arts degree or a certificate from an accredited institution in one of the following areas: alcohol and drug studies, addiction, or substance abuse. In addition to, or included with the degree, the clinician must have at least 330 contact hours specifically related to addiction in several areas, with every college credit equating to 15 hours. The following is taken directly from the State's licensing board website.

- 60 hours – chemical dependency assessment and patient placement (must include chemical dependency assessment, biopsychosocial testing, diagnosis, referrals, and patient placement
- 90 hours – counseling
- 30 hours – pharmacology (must include drug classification, effects, detoxification, and withdrawal)
- 10 hours – ethics
- 30 hours – alcohol and drug studies
- 30 hours – treatment planning and documentation
- 20 hours – multicultural competency - knowledge of and sensitive to the cultural factors and needs of diverse populations and demonstrate competency in applying culturally relevant skills
- 30 hours – co-occurring disorders
- 30 hours – gambling/gaming disorder assessment and counseling.

Also, the clinician must have 1000 hours of supervised training within a qualified substance abuse program. And finally, along with the degree, the addiction-specific continuing education units, and supervised hours, the clinician must pass one of the four following tests, also taken from the licensing board website:

- Option 1 – National Association of Alcoholism and Drug Abuse Counselors Certification Commission (NCC) Level 1 or Level 2 exam.
- Option 2 – Northwest Certified II or III exam;
- Option 3 – Southwest Certification II exam; or
- Option 4 – International Certification and Reciprocity Consortium (IC&RC) Alcohol and Drug Counselor (ADC) examination or Advanced Alcohol and Drug Counselor (AADC) exam.

The clinical supervisor's interview data were coded for patterns. Saldana (2021) described using coding to identify rules, roles, routines, rituals, and relationships for the purpose of discerning trends to define meaning. I coded the data from the supervisor's interview into three categories aimed at roles and relationships between the supervisor and staff: (a) strengths of staff and self; (b) supervision needs; and (c) staff training needs. The pattern identified within the strengths of staff and self-indicated the continued desire to helping both the client and the community. Words such as "all in this together" and "help change" were noted. The common theme within her own identified supervision needs indicated her struggles with time management, structure, motivation of staff, and not doing the staff members' jobs when the work is not being done in a timely manner. She expressed her concerns that she was "not happy" with her training in supervision thus

far and noted that she has “had to figure it out” on her own through minimal, specific supervision training. The third category related to staff training needs identified several areas of concern. She noted that although staff may understand how to do evaluation and placement, the time management for this is poor which creates problems with intake and follow through from the clients. She noted the need for adolescent treatment training, behavioral health therapies and other evidence-based practices. She also noted the need for staff to understand chart completion and treatment planning.

Analysis, Results, and Implications

Client Program, Services, and Initiative Effectiveness

All themes were demonstrated within this topic arena: (a) there has been limited structure for staff and program requirements, which has presented leadership challenges for the new BHL; (b) program and clinical standards are somewhat being performed, but not in accordance with state or national accreditation mandates; and (c) appropriate supervision could address most staffing concerns, and program needs are evident in this area.

According to the Baldrige Excellence Framework (NIST, 2021), when creating data-driven action planning and strategic development, the data should be collected, aligned, and integrated. When comparing the strategic plan to the monthly BHL’s reports and concerns identified by the BHL and Clinical Director, there are some consistent problems identified between all these data sources. For example, the strategic plan noted the need for CARF accreditation. This program, prior to the BHL being hired, received a 1-year accreditation which indicated significant problems in all clinical program and

administrative areas. However, given the prior leadership concerns, programming and clinical standards were not deemed sufficient, and there was limited supervision to support this process. Obtaining accreditation would demonstrate that problems related to client services, programs, and initiatives would have to be improved and corrected. A 3-year accreditation would indicate that many problems surrounding client care and program needs had been addressed and changes implemented to receive a satisfactory outcome. It would also indicate that leadership has supported clinical work, and supervision is appropriate.

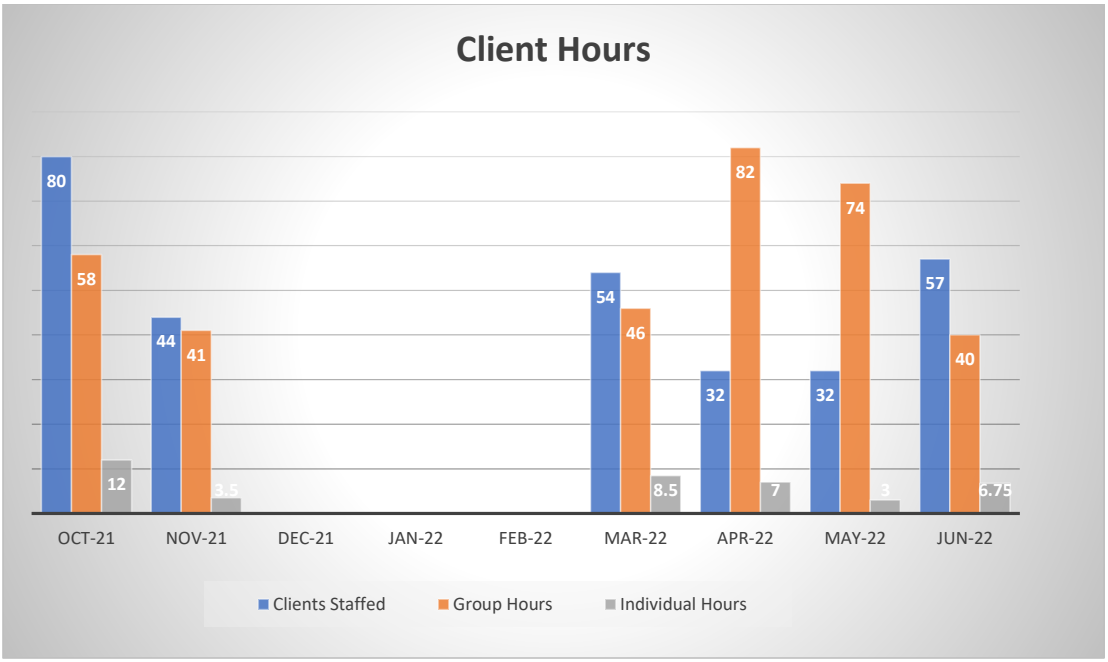
Examples of CARF accreditation obtainment which would demonstrate improving client program and services would also be as follows. Using the electronic healthcare information obtained from the monthly report, noting client and group hours, CARF would mandate more hours weekly for both, as requirements for group, individual sessions and case management hours have mandatory weekly minimums. Based on the service hours provided, and follow-up questioning from the clinical supervisor, intensive outpatient hours being provided were only 6 each week, rather than the clinically indicated 9 each week by both CARF (2022) and the American Society for Addiction Medicine (Mee-Lee et al., 2013). Also, individual, family, and group therapy must be offered; however, according to the information obtained for this study, no family sessions were noted. The clinical supervisor was unaware of this mandate, and the BHL was unaware that these services, nor appropriate hours, were not occurring.

As shown in Figure 2, client hours for the program are demonstrated, this data is from the monthly tribal reports provided to the tribal president. Clients staffed indicate

how many clients were discussed each week at staffing meetings. These numbers do not reflect how many separate clients were seen, but rather how many were discussed each week, which includes some clients that could be staffed multiple times over the course of a month. December 2021, January 2022, and February 2022 reports were not obtained. In June 2022, for example, there were 57 clients staffed, but only 6.75 individual sessions offered in a 1-month period. In a 4-week period, if every client was staffed once each week, making it 14 clients seen per week, that is still less than 30 minutes on average that each client is seen over a 1-month period. When the BHL was asked about the hours that were demonstrated, she shared that it appeared that group hours and individual hours were not documented consistently, although she believes that that they were offered. She noted that this was a concern related to the lack of structure prior to her arrival, and had not known to look at these numbers to evaluate appropriate clinical contact hours. Again, all three themes presented in this problem as leadership did not mandate appropriate and ethical clinical work and documentation, and the clinical supervisor, who was there prior did not know it to be problematic.

Figure 2

Client Contact Hours



Note. Client contact hours taken directly from monthly reports to the Tribal Chairman.

Group and individual therapy hours are not consistent compared to the amount of clients staffed. For example, despite a significant drop in clients staffed in April 2022, group hours were much higher, which is the opposite documented in October 2021. This would indicate that staff suddenly chose to do more group hours, or rather it is more likely that they happened to document more of the hours they were completing.

Obtaining CARF would mandate an increase in group and individual sessions. It would also mandate the appropriate and timely documentation of every clinical service offered. If Intensive Outpatient group and individual hours increase, it could better compare to how many clients are staffed compared to how many hours are offered. CARF accreditation would then align more with strategic plans goals and demonstrate

program improvement. This also would have potential to increase the clinical supervisor's ability to better gauge the efficiency and effectiveness of the staff as it would offer baseline measurement tools related to hours of client care being offered.

The interviews conducted with the BHL, and clinical supervisor demonstrated consistency related to the project problems, as well as themes. The BHL noted concerns the lack of training related to group facilitation, therapy and basic counseling skills, program development and assessments and similar paperwork. The clinical supervisor shared that during her education at the university's Master of Social Work program, there were no trainings on supervision, and she has had only one training during her tenure since 2017, whereby she was promoted due to the prior supervisor's death. Again, using the numbers associated with the monthly reports and comparing it to her interview, it is apparent that the clinical supervisor was unaware of how basic program requirements were not being met related to client care. Although she was aware of struggles, she was not using data collected to help identify supervision needs. The not knowing that group and individual therapeutic hours were not being documented is an example of the lack of appropriate supervision training and expectations that the clinical supervisor demonstrates.

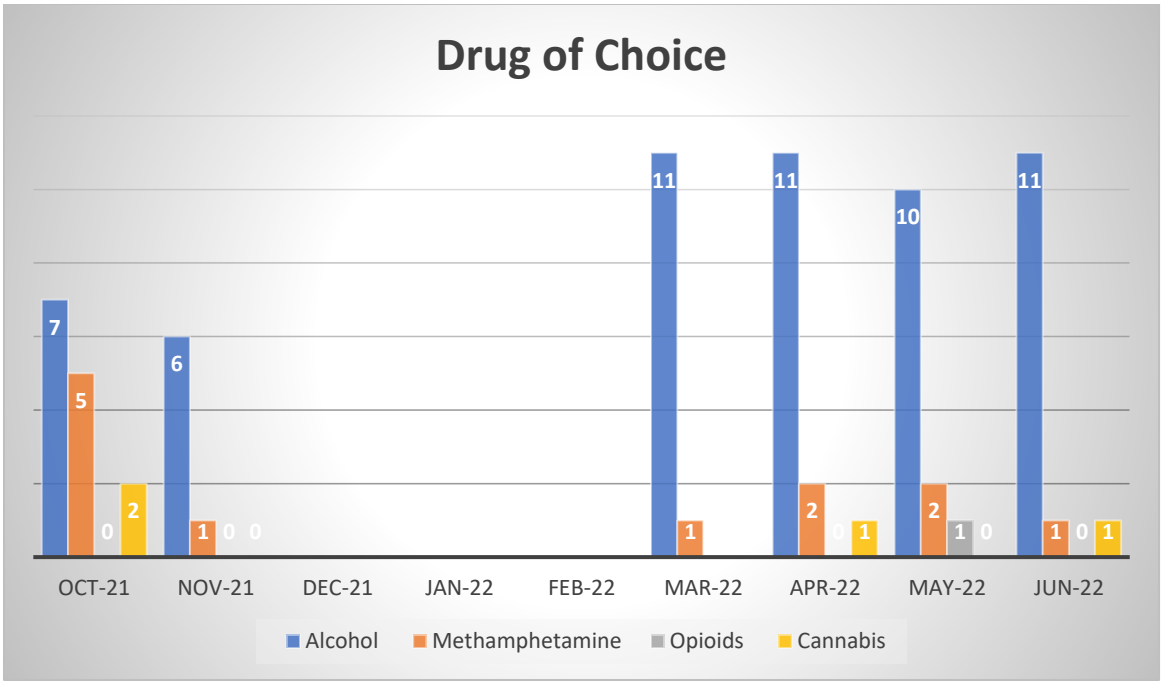
Client-Focused Results

Client outcome results could not fully be identified within all the information obtained, as this program has yet to implement follow-up procedures, and outcome measures other than chart completion using the AccuCare (Orion Healthcare Technology, 2020) system identified within the BHL's monthly reports. Using these reports, the

program is working on utilizing a Tribal Opioid Response grant, which is a program aimed addressing the increase overdose deaths of Native Americans dues to opioid use. According to the Department of Health and Human Services (DHHS, n.d.), in 2016 Native American populations have the second highest rate of overdose deaths in the country. Although the need is likely consistent on this reservation, there were minimal opioid difficulties noted within the monthly client information, as it denoted that alcohol and amphetamine were the main identified substances as a concern. With all the information shared, there was only one intake evaluation completed in May 2022 (see Figure 3) that identifying opiate use being a primary concern. If the research related to opioid use is correct, and that the grant is necessary, this could indicate that staff are not completing the intakes and assessments properly or considering the impact of opioids with clientele. This would lend itself to the BHL's belief that assessment and intake needs additional training. It would also indicate that Martin et al. (2020), was also correct that education on not only how to assess, but also practical application of how to interpret and use evaluation tools is necessary.

Figure 3

Drug of Choice



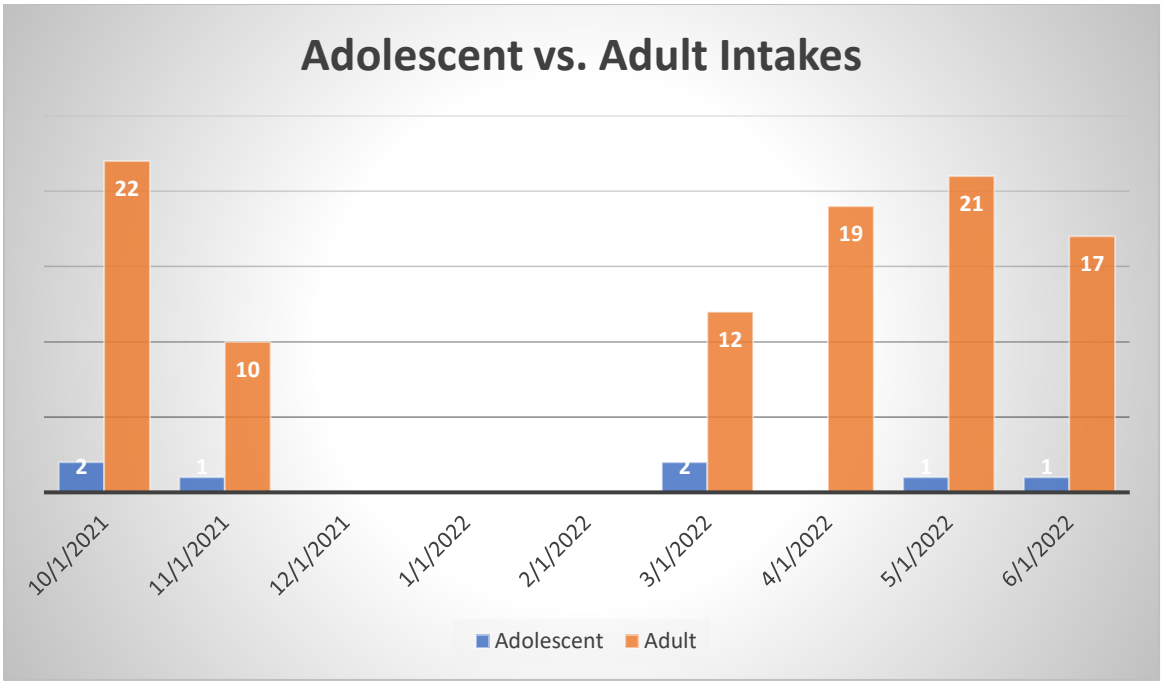
Note. Top four drugs of choice identified at intake. This information is taken directly from the monthly reports to the Tribal Chairman.

According to SAMHSA (2021) substance abuse screening training should include identification of concurrent substance use. The need to look for not only alcohol use, but also opioid and other drug use is vital to identify the appropriate evidence-based treatment protocol for each client. By learning to assess, refer and treat accordingly, client care could improve, as well as the application of grant monies, thus creating a potential repetitive funding stream. This would also demonstrate that client need is being more fully focused and addressed. Again, this problem ties directly to clinical standards being completed, but not likely in an appropriate and ethical manner.

Another example of a theme being presented is related to the numbers of adults vs. the numbers of adolescents being met with. Figure 4, which was created from the monthly tribal reports, indicates that over the course of the six months of information obtained, only seven adolescent intakes were completed. During that same time frame, 101 adults were met with for an evaluation.

Figure 4

Adolescent vs. Adult Intakes



Note. Adult and adolescent intake numbers completed at time of intake as reported within the monthly reports to the Tribal Chairman.

This chart demonstrates the significant difference in intakes completed for adults compared to the minimal intakes completed for adolescents. The BHL identified wanting her adolescent staff member to work more with adolescents, but that clinician is often pulled to work with the adult program because she takes on any work assigned by the

administrative staff that take walk-in clients. As a result, the hours put towards adolescent care have remained stagnant. The BHL has directed the clinical supervisor to change this process; however, the clinical supervisor expressed her concern that staff "do not listen to her" when she asks for that clinician to no take on additional intakes during the course of the week. (BHL, personal communication July 29, 2022).

According to both the BHL and clinical supervisor, the staff lack appropriate evidence-based training in clinical areas such motivational interviewing, adolescent therapy needs and group treatment that employs specific cognitive behavioral approaches. Jhanjee (2014) found that motivational interviewing, cognitive behavioral and relapse prevention are all necessary to illicit sustained change and recovery and better treatment outcomes. The leaders' concerns were echoed in the lack of training in the associates degree training in any of these areas. The clinical supervisor reported that no documentation could be found within the progress notes, which identified the use of any evidence-based practices within group or individual sessions.

Workforce

Baldrige Excellence Framework (NIST, 2021) indicates that workforce environment should address competency, staffing levels, skills, and certifications. In determining the needs for this component, personnel charts were reviewed, as were the educational and licensure requirements. Several of the charts were missing resumes, and the clinical supervisor was unaware of this until it was pointed out for the purposes of this case study. Although the BHL reported that staff are sent to trainings, which was also

noted within the monthly BHL's report, there was no documentation of additional training or certification within any staff member's file.

Both the BHL and the clinical supervisor noted that yearly evaluations were to be completed, and there was no formal process in place to do so. This applies directly to the second research question to determine how effectiveness and efficiency are determined. The clinical supervisor admitted that her greatest struggle related to supervision is not fully understanding how to do so, nor how to determine the needs of staff. Although she could verbalize generalities of what individuals needed to improve upon, as well as strengths, there was not documentation or formal process of evaluation. The theme that there is a need for more appropriate supervision is not only noted within clinical documentation and programming, but also the clinical supervisor has admitted to this as well.

The workforce capacity ties directly to the ability to determine effectiveness and efficiency. The clinical supervisor discussed staff strengths, and which staff excel and struggle in which areas; however, staff capacity was not tied to these markers. For example, as noted in Figure 4, she indicated one staff member does well with juveniles; however, the program also has her working on several tasks throughout the day while the adolescent program has not improved capacity nor increased in intakes. This goal was verbalized by the BHL and also within the strategic plan, yet no progress is being made towards implementation due to inefficient use of staff time and strengths.

Baldrige Excellence Framework (NIST, 2021) indicated that the workforce should address trends and climate. The BHL, within the monthly report, indicate the attempt to

hire four new staff members for the opioid task force grant, which has been identified as a need and funding trend nationally for tribes. However, during the interview with this leader, she reported the difficulty of finding qualified staff within this rural area. Workforce development and engagement are informally addressed by the BHL and clinical supervisor by allowing staff to attend trainings, including work on them while at work, if approved and if the training falls under some form of clinical arena; however, staff dictate which trainings are attended. There were no data identified indicating that any of the current staff have attended opioid treatment or intervention training. Given the lack of documentation, this could be a lack of data collection, or a lack of congruency for the workforce to address the trends and substance abuse treatment climate.

Leadership and Governance

The BHL and the clinical supervisor were both interviewed and presented as the primary individuals responsible for leadership. Although the Tribal President has some input, it is limited to monthly meetings and informal communication that is completed on an as-needed basis. The Tribal Health Leader has a financial supervisory role; however, has little involvement related to program supervision or creation. The leadership primarily falls directly to the BHL. The clinical supervisor does take on day to day tasks, but often refers to the BHL for staffing concerns. The BHL has significant autonomy for both program management as well as staffing.

Financial Results

This tribal program falls under the umbrella of the tribe itself and is currently unable to receive additional monies from federal funding until the tribal finances are

improved. Any funding that this program currently has is from existing grants, and donations. The BHL believes that the achievement of obtaining CARF accreditation will improve upon the ability to apply for program to access behavioral health funding within other streams such as Medicaid or Medicare, which would be tied to the program not the tribe itself (BHL, personal communication May 11, 2022). Also, CARF accreditation would put the program in line with become a state certified program, whereas they could offer services such as DUI education and charge for this class. Currently all clients that received DUI charges must obtain and pay for a class off the reservation. Because of the nature of the financial struggles that the tribe has had, the Tribal Health Director must approve all additional spending prior to authorization from the BHL. This is an increased measure to improve upon deficits from prior tribal administration and offers another level of governance accountability as encouraged by Baldrige criterion (NIST, 2021). The funding of this program is not tied to client outcomes or numbers, and there is no formal competition within the tribe itself for substance abuse clients.

Organizations, Communities and Systems

The monthly tribal report from March 2022, indicated that the BHL had begun the process of reaching out to other programs in the tribe. The programs identified could create additional referring sources for the treatment program. The strategic plan identified both short and long-term goals; however, without the involvement of stakeholders within other organizations the community, many of the goals may not be viable. The BHL acknowledged the need to integrate the community and stakeholders to improve upon the

program, as well as have access to other services in the community that could improve upon case management services the program offers.

Implications for Social Change

There are several implications for positive social change. First, using data driven solutions could improve the services provided to the tribal community members. Improving the clinical work of the current staff members, more informed care could be offered. By using evidence-based practices, staff could potentially improve upon the relapse prevention and recovery efforts of the clients and help the community with the consequences of addiction. A secondary beneficial outcome would be the increase in service hours, as well as increase in the numbers of clients accessing services due to the improved quality and perception of the program. Third, by improving both training and supervision the efficiency and effectiveness of staff could be better identified with more focused goals be created for each clinician. And finally, a social change outside of this program and tribe, could help identify which trainings would likely suit other tribal programs, or other programs using certified associate level staff. Being more focused on specific training based on not only education already possessed, but also tribal specific needs, is vital for improved programming.

Strengths and Limitations

There were several strengths of this project. First and foremost, the immediate and continued access, as well as involvement of the primary BHLs gave greater insight to data from the program, as well as the leadership perspective. This offered a much greater understanding into the problems within the program, but also in identification of

strengths and solutions. Also, there is extensive research and data available surround evidence-based practices within substance abuse treatment. This information was triangulated against the broad data collected from outside the program such as colleges, and the licensing board, as triangulation offers greater rigor and validity to a study (Ravitch and Carl, 2021). And finally, The Baldrige Excellence Framework (NIST, 2021) offered an organizational structure, from which to gauge and evaluate the program based on specific metrics and measures.

A limitation of this study is that there was limited client data available. Because there was such limited data collected, information that was gathered had to be assumed as being status quo for how the program has operated for an extensive period. As this is a qualitative case study, which is described as the interaction of a bounded unit in relation to some phenomenon (Burkholder et al., 2020), it is assumed that this process would have been similar prior to the new BHL, although not exact. Some information had to be assumed based on the information provided, as well as information lacking. Another limitation is not knowing what specific curriculum was offered within each of the classes at both educational institutions used for this study. Although a class may have a specific title of what is being taught, for the purposes of this project, the researcher has no way of knowing the extent being taught of each subject, nor the specific subject matter.

Summary and Transition

There were three themes that continued to present in the analysis of the findings: (a) there has been limited structure for staff and program requirements, which has presented leadership challenges for the new BHL; (b) Program and clinical standards are

somewhat being performed, but not in accordance with state or national accreditation mandates; and (c) appropriate supervision could address most staffing concerns, and program needs. These themes presented in areas of client program services, client results, and workforce. By identifying the themes, implications and solutions can be considered, in the context of the program strengths and Baldrige framework metrics.

In Section 5, I discuss the results and recommendations of this project. I identify how the program can specifically address the research questions, and how the BHO can implement changes in a practical and structure manner. I tie evidence-based practices, research, and Baldrige Excellence Framework (NIST, 2021) criteria to solutions that can have lasting results. Also discussed is how social change both within and without the program can occur.

Section 5: Recommendations and Conclusions

The results and recommendations presented in this section are based on the case study of a Native American substance abuse treatment program, which also provides some mental health services. This program serves both adults and adolescents and works with those that are affiliated with any tribe across the United States, although primarily only those living within the reservation boundaries. The results and recommendations were the result of the process of researching two questions related to the program's staff education and training, as well as effectiveness and efficiency of staff. The Baldrige Excellence Framework (NIST, 2021) has a purpose to organize health care organizations and assess performance in the areas of operations, leadership, strategy, customers, analysis workforce, operations, and results. It looks to establish if the organization is operating at its potential. Then, it assesses how organizational health and performances is measured. And finally, it defines ways in which the organization should change. The results and recommendations will be discussed within the Baldrige framework as well as within their convergence with previous literature. Implementations considerations are discussed and finally, suggestions for future research will be made.

Recommendations

Recommendations Related to RQ1

RQ1: Above and beyond the state requirements for certification and licensure, what additional educational and training needs are appropriate for staff to be better qualified to work at this agency?

The Baldrige Excellence Framework (NIST, 2021) identifies the importance of workforce engagement, and suggests specific recommendations to assist with the workforce to achieve high performance and work environment. Identifying strategic challenges, core competencies and both long- and short-term action plans to improve the learning and development system is fundamental to the framework, which encourages strong workforce engagement. There are several areas in which the framework related to reinforcement of new skills and knowledge can be applied to core competencies as well as action plans and strategic challenges. Being able to define specific education and training for staff applies directly to these competencies.

Data collected from research related to substance abuse treatment standards based on evidence-based practices, and the education of staff members, which consisted of one university and one tribal college, were compared. Several examples of gaps in care were identified when compared to the research. Vaughen et al. (2021) discussed the importance of motivational interviewing, along with cognitive behavioral therapy for substance abuse treatment, yet it demonstrated as lacking within either educational program. Venner et al. (2016) identified the need for motivational interviewing to have a strong cultural component, yet the leaders continued to identify staff struggles with application of this evidence-based practice, and information specific to this form of education was not found in either program. SAMHSA (2021) indicated the importance of all clinicians being able to screen as well as thoroughly evaluate substance abuse and to do so for the use of several substances. The tribal college identified two credits related to

evaluation, and the university that the clinical supervisor had attended had no specific classes aimed at this topic.

This study then used research to compare to what leadership in the BHO indicated. The BHL stated “it’s like we’re throwing money out the window to send people off” in reference to staff not understanding the kind of treatment that could be offered, as well as how to evaluate appropriateness for outpatient substance abuse therapy. Along with this, both the BHL and clinical supervisor expressed frustration with staff not doing appropriate clinical work. Neither leader could identify any group or individual session note that indicated any specific form of cognitive behavioral work was being completed, or what kind of evidence-based programming was being used. The clinical supervisor, as well as all staff members, had no demonstration of any participation in motivational interviewing training, which both Venner et al. (2016) and Vaughen et al. (2021) identified as being vital to substance abuse treatment.

The state’s requirement for counseling training indicated that there are no specific demands for the type of training or education needed within the category of “counseling.” This leaves any form open for approval from the state, even if it is not deemed evidenced-based or demonstrated through research as being sufficient. Both leaders indicated that staff are sent to trainings at staff request, which often is based on what a staff member determines to be important at the time. The BHL indicated that often trainings seem to be chosen based on location of the event as the primary reason, rather than the type of training being offered.

The outcome of this process indicated that core competencies related to specific clinical training are deficient and that staff should be better trained in cognitive behavioral and motivational interviewing therapy for both individual and group settings, which are both considered evidence-based best practices for substance abuse by SAMHSA (2021), as well as McCrady et al. (2020). Clinical staff also need better training in assessment protocols and procedures, as well as practical application of assessment outcomes.

Workforce Learning and Development

The state's licensing board mandates 90 continuing education requirements, or 6 credits in college, in counseling but no mandates as to specific type of counseling or educational components, such as using evidence-based practices. The associate level class, based on the college associate level class list, offers two classes, or six credits in group therapy; however, both the clinical supervisor and BHO identified this as a needed growth area for staff which could indicate that the classes are not specific to research and evidence-based practices. The lack of specific evidence-based education related to group and individual therapy indicate that an associate degree only with non-specific supervision is not sufficient. By tying the evidenced-based practice findings to program requirements, the BHO could use Baldrige framework to improve workforce engagement and development. Therefore, to address this the following recommendations is made: Supplement learning for clinicians with in-service training days that showcase evidence-based practices.

The state's path to licensure attainment mandates 90 hours, or six continuing education units, above and beyond the education if not obtained in college. According to the college's class schedule, only two credits are directly related to addiction assessment. Both factors, including the BHL's belief that evaluations are not completed fully, nor timely, indicates that this is identified need that has not been met with the education component. Therefore, a second recommendations is made: Supplement learning for clinicians which consists of in-depth and focused skills on how to perform intakes and assessments which assist direct level of care placement, diagnosis, and treatment plan development. This training should educate not only on identifying diagnostic criteria, but also doing so in an ethical and timely manner. Implementing evidenced-based practices tools such as American Society of Addiction Medicine (Mee-Lee et. al., 2013) standards of care is encouraged.

According to the associate level class schedule, treatment planning and documentation is worth one credit, while state licensure indicates that 30 hours, or two college credits, are needed. Both the BHO and clinical supervisor identified this as an area of concern. Along with this, the supervisor noted that clinical documentation could also include time management, as much of the documentation is not being done in a timely, or what she referred to as ethical, manner. A third recommendation, which would address the Baldrige (NIST, 2021) criterion identifying the need to improve the focus on the patient, as well as improve ethical business practices is as follows: All clinicians should participate in additional training on not only how to do appropriate treatment

planning, but the ethical and legal nature of clinical documentation. This could improve client care along with validate ethical business practices.

CARF (2022) requirements mandate the understanding of treatment planning, progress notes, program expectation and how to document work being done and clinical skills being used. A final recommendation related to learning and development systems within the Baldrige Excellence Framework (NIST, 2021) aspect of managing and performing for the criteria of workforce is this: All staff will have yearly in-services on CARF mandates, including information which emphasizes the importance of documentation of all clinical hours offered and received by clients.

All these trainings can be completed by the BHL, given this BHL's licensure and education. They can also be completed by consultants, with online trainings, at workshops or other state-approved continuing education sites. Each staff member should have each of these fields documented within his or her staff chart, with not only continuing education units given, but also the syllabus or class explanation as offered by the trainer or training program. If the education was offered on site by a clinical supervisor, the name and date of the training should be noted (see Appendix D). However, given this clinical supervisor's admitted difficulty and lack of training within these areas, this should not be done until she has demonstrated efficiency and effectiveness in these areas. An appropriate timeframe for completion of these hours should be no greater than the first 2 years, as the first 1000 hours is also mandated for certification. Both the hours and additional continuing education units (CEUs) can be obtained simultaneously. It is also recommended to continue with this mandate every two

years, for every clinical staff member, as Baldrige (NIST, 2021) recommends continued reinforcement of skills and knowledge for staff members. Because this program demonstrates a strong cultural commitment, trainings that are tailored to Native American is also recommended.

Recommendations Related to RQ2

RQ2. How is the effectiveness and efficiency of staff determined?

The results of this study indicate that there is no formal process for determining staff efficiency or effectiveness, there would be several recommendations made which would directly tie to the Baldrige Excellence Framework (NIST, 2021). According to the framework, workforce performance management should support workforce engagement and high performance. The process should be used to assess workforce engagement through both formal and informal methods, which could include factors related to the program itself and how well it is doing, as well as the individual staff member. In this section, the findings and recommendations related to RQ2 are discussed.

Workforce Engagement and High Performance

The first recommendation for the second research question is aimed directly at assisting the clinical supervisor with her supervision education and efforts: Create goals with and for the clinical supervisor. Because the clinical supervisor identified struggles with her own supervision, her goals should be created prior to addressing supervision needs of staff. Park et al., (2019) identified that there is a strong correlation between supervisee satisfaction and supervision working alliance, such that appropriate implementation of supervision process be implemented prior to the beginning process of

a more formal staff supervision process. Using a tool such as the supervision guide, devised by Tangen et al. (2019), the clinical supervisor could also have a roadmap for her supervision process. This supervision guide indicates the need for the supervisor to be aware of her own theoretical approach such as behaviorism or person-centered theory.

From this position, the clinical supervisor can then create objectives, consider theory and counseling contexts and structure supervision based on the supervisee's characteristics. The clinical supervisor could be continually monitoring and offering feedback, as well as structuring the learning and process for the clinical staff members. By encouraging performance improvement of the supervisor, as suggested by Baldrige (2021), her skills are given the opportunity to improve which could support her career progression as well as those she supervises.

Once the clinical supervisor is grounded and supported with her own process, then the first phase of staff evaluation should proceed. McNamara (2005) indicated the need to adopt a Performance Management Process, which aligns with the Baldrige Excellence Framework (NIST, 2021). McNamar suggested the need to clarify overall goals of the organization, which would include a strategic plan and the ability for that plan to align with the system. The process also aligns with the Baldrige (NIST, 2021) process category directly related to measurement, analysis, and improvement of organizational performance. The BHL admitted to developing the strategic plan for the purposes of a CARF review but did so without input from stakeholders and without long-term prior knowledge of the program. The process also did not use comparative data as suggested by Baldridge, as none existed. By recreating a strategic plan with the

involvement of stakeholders, and using comparative data from the prior year, measurable objectives and action plans can be crated. The second recommendation is the following: Recreate the strategic plan, and do so with the involvement of the stakeholders.

The strategic plan offers a starting point, from which the staff and program goals can be created and aligned, which is referred to as performance measurement by Baldrige (NIST, 2021). It can also offer the additional ability for the program to review the organizations performance and capabilities, by creating short and long-term goals and performance measures. Once this is created, McNamara (2005) suggests entering phase one, or performance planning. This step should be where the BHL and clinical supervisor identify and prioritize goals and desired outcomes of staff to help achieve the goals identified within the strategic plan.

The second phase for staff is performance assessment (McNamara, 2005), or performance analysis and review, according to Baldrige Excellence Framework (NIST, 2021). The following third recommendation is made: Create goals with staff. When the goals are initially created for staff, a specific time frame should be given so that each staff member knows benchmarks for progress and to determine of objectives are being met and action plans are being followed. During the performance assessment, the BHL and/or clinical supervisor should track and measure indicators to determine if progress is being made. Feedback should be exchanged, and any result that indicates success should be reinforced. This process can initially be informal, with a more formal process occurring at specified intervals.

The third phase for the process management process is to continually work on performance improvement planning, which leads to the fourth recommendation: Continually monitor all staff goals, which should tie to the strategic plan. McNamara (2005) indicated that the any unacceptable performance should be addressed frequently, with action plans being created. Baldridge (NIST, 2021) performance improvement suggests similarly the use of performance reviews to develop priorities for improvement and innovation. The clinical supervisor is recommended to do this regularly, as she identified struggles with many of the staff. Because she identified her own difficulties with confrontation, a more formal process of review could assist with her doubts as it implements the need for changes based on program and policy, rather than her personal bias. If staff performance is deemed acceptable, then that behavior should be rewarded and supported, again with more consistency and intention.

The Office of Personnel Management (n.d.) suggested using an evaluation tool that ensures that the staff are complying and one where staff can be monitored, and goals implemented and evaluated. An evaluation tool should be used consistently with every staff member and have measurable and identifiable goals that tie back the strategic plan. This tool should be used by the clinical supervisor in an ongoing manner, so that she can also identify specific areas of need for both staff and clients. This will help her to not only ensure that staff are meeting identified goals, but also that she is learning how to recognize both strengths and challenges for her staff members. KPMG (2022) noted that to implement and continue with an improvement culture, staff need to have buy-in to the changes and be able to measure and demonstrate impact. Along with this, staff must be

empowered, and the process must be seen as needing time, rather than being a quick fix solution. Any goal setting tool, and evaluation process, must be measurable, attainable and empower the staff member.

Any evaluation tool used by the BHL should be created following the development of the new strategic plan so that it can not only address program goals, but also help create individual goals for staff. The plan should include cultural considerations, as well as be appropriate for the staff based on education and clinical level. To tie this solution to the first research question, when staff reach goals related to additional training mandates, rewards should be given to encourage empowerment and be measured. By fully implement Baldrige Excellence Framework (NIST, 2021) workforce engagement, as well as measurement and analysis protocols, the BHO can not only assess engagement of staff, but also measure and reward performance management.

Implementation and Considerations

Included in the revised policy and procedure manual, new training process and formal staff documentation recommendations (i.e., continuing education hours) is recommended. Using Appreciative Inquiry, as described by Rothwell (2015), what is working well should be leveraged with staff, such that there can be further development of the positive aspects of the personnel, as well as the program. Because the program has a strong cultural connection, and staff present as wanting to help others in their tribe, these are significant strengths that should be valued. These strengths, along with the openness to change demonstrated by leadership, can be used as catalysts for change implementation. By asking questions which encourage change and input, leadership can

inspire and motivate staff. Leadership can further identify incentives, and as noted by Rothwell (2015), identify what makes the system most effective. Incorporating staff and organization strengths, along with the recommendations identified in this case study is urged. The BHO is encouraged to hire a consultant versed in organizational development to begin the process of policy change, as well as staff development. Organizational development practitioners understand whole systems transformational change (Rothwell, 2015) can could support the change from outside of the current leadership structure.

Implications for Future Studies

The data related to substance abuse treatment is vast, although there is limited information about what exactly would be appropriate training for clinicians with less than a master's degree in the field. Implications for future studies could focus on not only the training needed, but what type of supervision should be given based on the level of treatment being offered, as well as need and culture of the clientele. Given the rural nature of this program, and many like it, the availability of clinicians with formal higher education and degrees is limited; however, the desire to help others is abundant. There is an opportunity to continue to study the gaps in training and education, so that more people, and especially Native Americans, who struggle with addictive disorders may be helped.

Summary

The purpose of this qualitative case study was to explore the educational requirements for certified addictions practitioners, as well as licensed clinical therapists, and social workers. It looked to define the expectations for culturally appropriate

education and training to serve this population. The purpose was to assess the training and supervision provided, as well as additional needed, for staff members to be more fully capable of serving culturally appropriate treatment. It also looked to determine how staff are being evaluated, and to what extent is their effectiveness and efficiency determined.

The outcome of this project determined appropriate, additional training that should be provided to certified staff, and to do so within an appropriate time frame with achievable goals. The outcome also identified the need for a formal, measurable evaluation tool for all staff members, including the clinical supervisor. With both processes being implemented, both the program and staff can provide measurable and attainable goals, likely to improve upon service delivery and client care. This process could also improve the organization's performance and better achieve its potential.

There are social change implications with this project. First, this tribal program could improve the treatment offered to the community members of the tribe, and support client recovery efforts. This could have a ripple effect into the entire community by helping sustained sobriety efforts, which would impact the socio, economic and family systems within the community. By offering data informed care and by using evidence-based practices, staff could support and improve upon the relapse prevention and recovery efforts of the clients and help the community with the consequences of addiction. Another social change implication is that it could support other small, rural programs with identifying targeting clinical training needed by staff that are not versed in specific evidence-based practices within educational institutions. As it is likely that this

program reflects a common theme in rural communities, by using clinicians with varied degrees as well as experience, having a targeting training program could support better clinical practice as well as supervision efforts. This could offer a road map of structured training as well as supervision to guide evidence-based practices as well as support workforce development.

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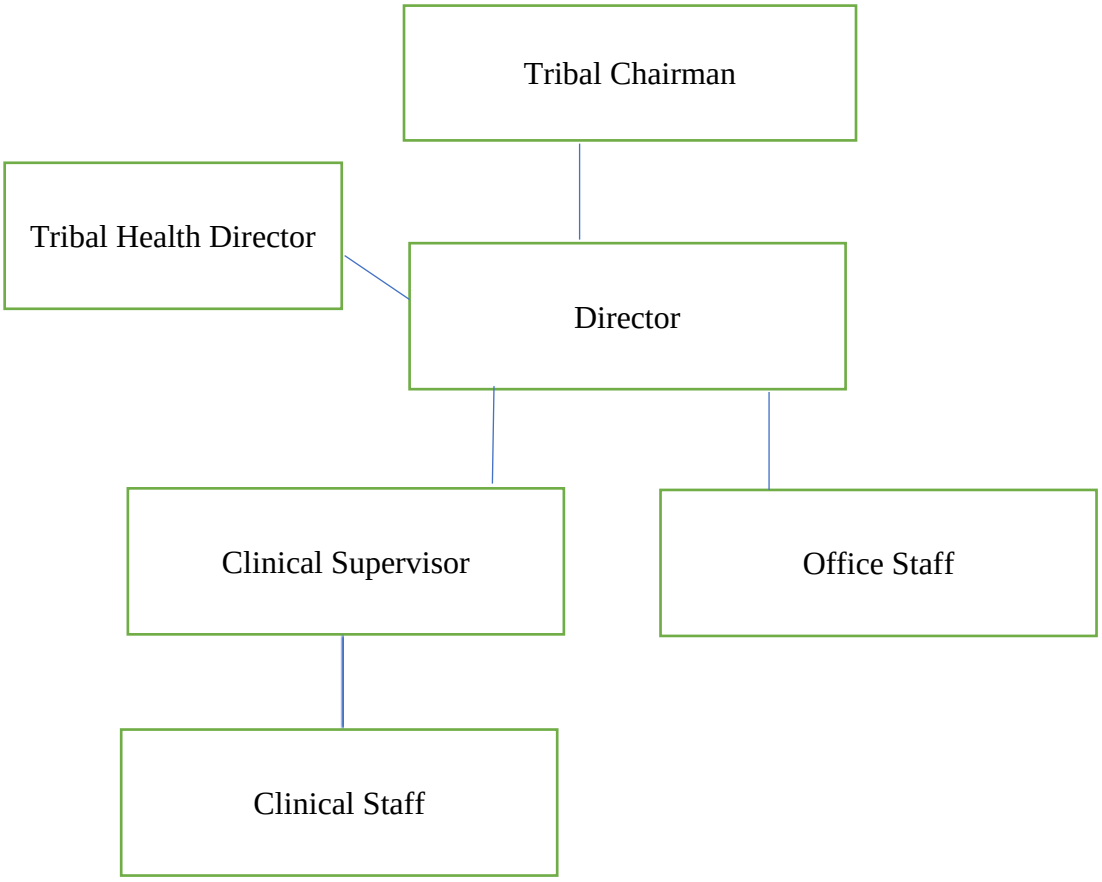
Appendix A: Organizational Chart



Appendix B: SWOT Analysis

Program Strengths

- *Central and accessible location.*
- *Expertise in providing substance abuse treatment services.*
- *Caring and experienced staff.*
- *Close working relationships with local criminal justice agencies and schools.*
- *Utilizes Medicaid reimbursement for eligible clients.*
- *Diverse funding base.*
- *Good reputation.*
- *Part of Crow reservation community services since 2003.*
- *Stable, interested, long-serving Business Council.*
- *Excellent treatment methods, utilizing evidence-based practices.*
- *No waiting list for treatment.*

Program Weakness

- *Only has one-year international accreditation (CARF), whereas a three-year accreditation is considered the only appropriate outcome. CARF will assist with legitimizing the program as well as access additional funding.*
- *Perceived as a program only for those clients with a need for residential treatment.*
- *Not State certified. State certification would enable provision our own DUI classes.*
- *Needs additional office space; staff are sharing offices which can be a hazard.*

- *No Quality Assurance manager to manage all of CARF information to keep the company on top of meeting certification standards at all times.*
- *No Safety Officer to carry out CARF safety inspections, drills, and provide trainings.*
- *Hire and train a Quality Assurance Manager who will work in compliance with established personnel policies and procedures, and CARF Standards.*
- *Assign a Safety Officer within the staff team to oversee all safety requirements of the CARF standards; polices & procedures, safety manual, and safety drills/inspections/reports.*
- *Establish an internal CARF committee who will oversee the review of all policies and procedures for CARF recertification reviews and ensure that all required trainings are completed annually.*
- *Give each staff member their part of the CARF manual standards so that they are knowledgeable with their requirements to follow and to meet standards for reviews.*
- *We need a larger office space to accommodate the needs of the program.*

Potential Threat

- *Current CARF certification for one year expires on November 30, 2021.*
- *Tribal court not understanding that not all referrals need residential treatment.*
- *Lack of adequate office space to meet growing/expansion needs.*
- *Declining oil and coal production resulting in less State income and potential budget cuts.*

Opportunity

- *Improve Medicaid reimbursement from clients based on their ability to qualify.*
- *Explore opportunities for optimizing functional office space.*
- *Educate community that CNRC is not just for residential treatment placement.*
- *New collaboration with Big Horn & Yellowstone County Court.*
- *State Medicaid is going to give CNRC funds from medicinal marijuana revenue to assist our program with expenses not covered by Medicaid.*
- *The Department of Public Health is offering to provide funding for our agency to hire a substance abuse prevention worker.*
- *Other federal grants are available that are treatment oriented that will be applied for.*

Objectives

- *Research and purchase a new electronic client record management system.*
- *Increase the amount of Medicaid reimbursement revenue for program needs not covered under our 638 contract (e.g., food for graduations, incentives for treatment participants, supplies for traditional cultural activities, new up-to-date evidence-based curricula, new computer equipment, staff training, counseling supplies, etc.).*
- *Design and implement an advertising campaign to attract more adult and adolescent clients.*
- *Relocate services to a more spacious and ideal location resulting in increased comfort and more groups offered that will be utilized for other program needs.*

Appendix C: Interview Questions

The following are the initial interview questions, for which the BHL was able to elaborate and discuss her concerns.

- What current issues do you see within the behavioral health field?
- What current struggles does your organization face?
- What practice issues are you trying to manage?
- Do you have a "wish list" of things that you would want to make better?
- How may a consultant be able to help with concerns you may have?

The questions for the clinical supervisor were:

- What is your experience at this program and in the field?
- On what areas did your master's program focus that would help with this position?
- What do you see as strengths of the program?
- How would you want to improve the program?
- What areas do you notice where clinicians struggle?
    - Are any patterns present?
- What areas in the program do you think need to change?
- If you could ask for any consistent trainings, what would they be in?
- What is your supervision style, and what trainings have you had that helped you with this?

Appendix D: Clinical Staffing Hours

Additional training for all clinical staff, above and beyond the 1000 supervision hours.

Staff Name: _____ Hire

Date:_____

6 Hours	Date	Hours	Is class information And CEU cert. in personnel file
Cognitive Behavioral			
Motivational Interviewing			

6 Hours	Date	Hours	Is class information And CEU cert. in personnel file
Intake/Evaluation			

2 Hours	Date	Hours	Training Staff Member
Treatment Planning/ Documentation			

2 Hours	Date	Hours	Training Staff Member
CARF and program requirements			