

An Action Plan for Behavioral Health Workforce Development



Persons in Recovery
& Families
Community Capacity



Recruitment &
Retention
Training & Education



Leadership
Infrastructure
Research & Evaluation

A Framework for Discussion



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AN ACTION PLAN ON BEHAVIORAL HEALTH WORKFORCE DEVELOPMENT

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EXECUTIVE SUMMARY

INTRODUCTION AND OVERVIEW

A Workforce Crisis

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

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

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

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

An Action Plan with National Scope

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

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

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

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

Areas of Focus

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

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

Defining the Workforce

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

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

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

Issues of Language

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

A Common Agenda

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

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

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

THE PLANNING PROCESS

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

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

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

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

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

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

THE CURRENT WORKFORCE AND ITS ENVIRONMENT

The Mental Health Workforce

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

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

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

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

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

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

The Substance Use Disorders Treatment Workforce

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

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

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

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

The Substance Abuse Prevention Workforce

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

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

The Environment of Care

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

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

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

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

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

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

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

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

GENERAL FINDINGS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEVEN STRATEGIC GOALS: AN OVERVIEW

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

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

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

<p>TABLE 1 STRATEGIC GOALS AT A GLANCE</p>
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BROADENING THE CONCEPT OF WORKFORCE

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

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

STRENGTHENING THE WORKFORCE

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

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

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

STRUCTURES TO SUPPORT THE WORKFORCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[GOAL 7: Implement a national research and evaluation agenda on behavioral health workforce development.](#)

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

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

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

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

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

FOCUSED TOPICS & THE SEARCH FOR INNOVATION

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

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

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

NEXT STEPS: LEVERAGING CHANGE

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

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

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

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

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

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

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

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

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QUICK REFERENCE GUIDE TO STRATEGIC GOALS & OBJECTIVES

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

Objective 1: Provide information and education to individuals in care or recovery and their families to enable them to fully participate in or direct their own care and to assist and support each other.

Objective 2: Develop shared decision-making skills among individuals receiving care and their families and service providers.

Objective 3: Significantly expand peer and family-support services and routinely offer them in systems of care.

Objective 4: Increase the employment of individuals in recovery and family members as paid staff in provider organizations.

Objective 5: Formally engage persons in recovery and family members in substantive roles as educators for other members of the workforce in every provider training and education program.

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

Objective 1: Support communities in their development of the core competencies of assessment, capacity building, planning, implementation, and evaluation.

Objective 2: Increase the competency of the behavioral health workforce to build community capacity and collaborate with communities in strengthening the behavioral health system of care.

Objective 3: Strengthen existing connections between behavioral health organizations and their local communities.

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

Objective 1: Disseminate information and technical assistance in effective recruitment and retention strategies.

Objective 2: Select, implement, and evaluate recruitment and retention strategies tailored to the unique needs of each behavioral health organization.

Objective 3: Expand federal financial incentives, such as training stipends, tuition assistance, and loan forgiveness, to increase recruitment and retention.

Objective 4: Provide wages and benefits commensurate with education, experience, and levels of responsibility.

Objective 5: Implement a comprehensive public relations campaign to promote behavioral health as a career choice.

Objective 6: Develop career ladders.

Objective 7: Expand the use of “grow-your-own” recruitment and retention strategies focused on residents of rural areas, culturally diverse populations, and consumers and families.

Objective 8: Increase the cultural and linguistic competence of the behavioral health workforce.

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

Objective 1: Identify core competencies and focused competencies for behavioral health practice.

Objective 2: Develop and implement competency-based curricula.

Objective 3: Adopt evidence-based training methods that have been demonstrated as effective through research.

Objective 4: Use technology to increase access to and the effectiveness of training and education.

Objective 5: Launch a national initiative to ensure that every member of the behavioral health workforce develops basic competencies in the assessment and treatment of substance use disorders and co-occurring mental and addictive disorders.

Objective 6: Educate prospective students about best practices in training and education to inform their selection of a training program or training provider.

Objective 7: Identify and implement strategies to support and sustain the use of newly acquired skills in practice settings.

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

Objective 1: Identify leadership competencies tailored to the unique challenges of behavioral health care.

Objective 2: Identify effective leadership curricula and programs and develop new training resources to address existing gaps.

Objective 3: Increase support for formal continuous leadership development with current and emerging leaders in all segments of the workforce.

Objective 4: Formally evaluate leadership development programs based on defined criteria and revise the programs based on outcomes.

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

Objective 1: Create a National Technical Assistance Structure that coordinates and provides information, guidance, and support on workforce development to the behavioral health field and advises the federal government.

Objective 2: Create a federal Behavioral Health Workforce Partnership, led by a SAMHSA Workforce Team.

Objective 3: Finance workforce demonstrations through a National Workforce Development Fund and foundation-sponsored initiatives.

Objective 4: Change the economic market for services to create conditions that improve the quality of care and strengthen the workforce.

Objective 5: Increase the use of data to track, evaluate, and manage key workforce issues.

Objective 6: Strengthen the human resources and training functions, staffing, and levels of expertise in behavioral health organizations.

Objective 7: Promote the increased availability and use of information technology to support the workforce during training and service delivery.

Objective 8: Identify Magnet Centers in workforce best practices, drawing on the “Magnet Hospital” concept from the field of nursing.

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

Objective 1: Increase the quantity and quality of workforce-related research through creation of a federal interagency research collaborative.

Objective 2: Increase the quantity and quality of formal evaluations of workforce development practices by providing technical assistance to the field.



SECTION I

OVERVIEW



CHAPTER 1

INTRODUCTION

A Thousand Voices

On September 10-11, 2001, a diverse group gathered in Annapolis, Md., to address growing concerns about the behavioral health workforce. The group included persons in recovery, family advocates, educators, providers, policy makers, and students with expertise in the prevention, treatment, and lived experience of substance use disorders and mental illnesses. Their goal was to build consensus around the growing workforce crisis in the behavioral health field and to identify potential strategies to improve the quality of education and training (Hoge & Morris, 2002). From this initial meeting emerged The Annapolis Coalition on the Behavioral Health Workforce, an organization whose central mission is to improve workforce development in behavioral health throughout the nation.

The 2001 meeting opened with the voices of individuals¹ with mental and addictive disorders telling their personal stories of recovery and talking about the key roles that caregivers had played in these journeys. The voices of persons in recovery and their families have been prominent in all subsequent gatherings of the Coalition, and it is their varied perspectives that have served as a “true north” (Berwick, 2002), orienting and grounding the efforts of this group to strengthen the workforce.

Over the past 5 years, the Annapolis Coalition has functioned as a neutral convener of diverse individuals, groups, and organizations that recruit, train, employ, license, and receive services from the workforce. The resulting dialogue has given voice to many different perspectives and helped to define the complex web of forces that supports and, far too often, thwarts efforts to build and retain a workforce that delivers compassionate, safe, and effective care. In turn, the Coalition has given voice to the workforce agenda, advocating, at every opportunity, greater attention to this critical issue in policy and practice. It has conducted this advocacy role, for example, with the President’s New Freedom Commission on Mental Health (New Freedom Commission on Mental Health, 2003) and, most recently, with the Institute of Medicine (IOM, 2006).

¹ “Listening to the Voices of Recovery,” a videotape co-produced by the late Vicki Cousins, who was an advisor to the Coalition.

In 2005, the Substance Abuse and Mental Health Services Administration (SAMHSA) commissioned the Annapolis Coalition to develop a national strategic plan, or Action Plan, on workforce development. The Coalition engaged senior experts on workforce issues to lead the planning effort in diverse sectors of the behavioral health field. The senior experts, in turn, convened panels of experts to help guide the process. Advisors, panel members, and Coalition staff traversed the country, from Alaska to Florida and California to Massachusetts, meeting with a broad range of individuals in an effort to obtain information and recommendations on strategies to strengthen the workforce and to find innovative practices that might have lessons to offer the nation.

During one such meeting, an educator in the addiction counseling field commented, quite passionately, that she was bringing to the table “a thousand voices” representing the many students whom she had taught over the years – and all that they had taught her about the needs of individuals who make a commitment to work in the behavioral health field. Her comment serves as a metaphor for the planning process that governed the development of this Action Plan: The recommendations represent the wisdom offered by the thousands of people who were willing to give of their time, experience, vision for the future, and practical ideas for transforming current approaches to recruitment, retention, training, and education.

The behavioral health field has not historically spoken with one voice. As recommendations emerged, they were circulated for review and discussion among the senior advisors – and there often was controversy. But as the discussions progressed, as language differences were explained, and as assumptions were explored, it became apparent that there are many commonalities across sectors of the field regarding workforce issues. It became abundantly clear that the people working in these diverse sectors have much to learn from each other and much to gain by working together on the workforce agenda.

Many voices undoubtedly have not been heard in the planning process so far. Like any good strategic plan, this Action Plan is a work in progress that must continue to evolve as others add their voices, as the behavioral health care environment continues to change, as more experience is gained, and as better evidence is generated about effective strategies to strengthen the workforce.

Strategic Planning with National Scope

At its core, strategic planning is a disciplined effort to understand where a field or entity is, where it hopes to be, and how it might get there (Bryson, 2004). Applied to the issue at hand, it is an effort to identify the current weaknesses in efforts to develop and sustain a strong workforce in behavioral health; envision a

future in which a compassionate, effective, and efficient workforce exists; and identify practical strategies that can be implemented as the field strives to realize that vision.

The task of the Annapolis Coalition was to create an Action Plan that is national in scope. Over the past few decades the boundaries among the public, private, and nonprofit sectors have softened. Federal powers have shifted largely to state and local governments, and all governments are increasingly turning to private organizations as vehicles for action. The result is an environment in which "...no one organization or institution is fully in charge and yet many are involved, affected, or have a partial responsibility to act..." (Bryson, 2004, p. 6). In this context, a strategic plan is intended to demonstrate how the collective action of the public, private, and nonprofit sectors can positively influence, in a coordinated and concerted fashion, the strength of the workforce in behavioral health, and thereby dramatically improve the quality of care received by individuals and their families. In an environment of diffuse authority and responsibility, strategic planning is largely about fostering an ongoing, collaborative process of strategic "...*thinking, acting, and learning...*" (Bryson, 2004, p. 2)

Areas of Focus

Given the complexity of the field, considerable breadth is required to include all of the issues that need to be examined in this planning process. From a population perspective, the plan encompasses workforce issues relevant to people who have been identified as having mental illnesses, substance use disorders, and co-occurring mental and addictive disorders. A life-span perspective was adopted to ensure that advisors paid specific attention to workforce development issues as they pertain to children, youth, and parents, as well as older adults. Planning also was organized around the workforce needs related to cultural and linguistic competencies and to the needs in rural and frontier areas.

With respect to workforce activities, advisors examined health promotion, prevention, treatment, rehabilitation, and recovery. There was a heavy emphasis on resiliency for children and families, recovery and recovery-oriented services for adults and elders, and a special focus on self-help, peer support, and family support interventions.

A range of other activities and processes required and received attention, including recruitment and retention, training and education, licensure and certification, workforce financing, and the use of information technology in training and service delivery.

Defining the Workforce

A broad definition of workforce was adopted for this planning process. It includes the behavioral health workforce, which consists of individuals in training or employed to provide health promotion, prevention, and treatment services. This group comprises professionals with graduate training, as well as individuals with no degree or an associate's or bachelor's degree, who represent a large segment of the workforce.

Persons in recovery and their family members are explicitly recognized as members of the workforce, as they have critical roles in caring for themselves and each other, whether informally through self-help or more formally through organized peer- and family-support services. The amount of caring provided by the trained workforce simply pales in comparison to that provided by persons in recovery and their family members, who are the unsung heroes and heroines of the workforce and whose needs as a workforce are explicitly addressed in this Action Plan.

Given the time and resource constraints for developing this Action Plan, SAMHSA and the Coalition decided that the behavioral health workforce development needs of other health and human services personnel would not be addressed in this planning process. Clearly, primary care providers, hospital emergency room staff, correctional staff, teachers, and other providers of a range of services have major roles in responding to the needs of individuals with mental and addictive disorders, who more often than not seek help outside of the behavioral health system. Drawing on this first Action Plan, which is focused on the behavioral health workforce and on persons in recovery, children, and youth, and their families, a foundation has been laid from which a second wave of planning focused on other health and human services personnel could and should unfold.

Issues of Language

One of the special challenges in developing a broadly inclusive strategic plan has involved grappling with differences in the language used by different stakeholders in the diverse sectors of the field. The selection of language is an extremely important issue, one dimension of which is captured in the following quote: "Words have long been used to objectify and demonize people experiencing mental illness and substance use disorders. In recovery, alternative words become instruments of personal and collective liberation. Crafting language is about personal and social change, not political correctness" (White, Boyle, & Loveland, 2005, p. 241).

Language is critical in that it often conveys a set of underlying assumptions. However, the behavioral health field lacks consensus on a set of terms that is broadly applicable and acceptable to the diversity of people, interests, and issues within the field. Furthermore, there is considerable controversy about

appropriate language within specific sectors, a circumstance that is complicated by continuous change in preferred language as conceptual models evolve and the science base grows. Individuals with a personal or professional interest in a specific area often disagree on preferred language, due to differences in roles or the timing of their exposure to evolving conceptual models.

The authors of this report recognize that many of the terms used within these pages are imperfect. The need for further consensus-building around language issues is duly noted. Simultaneously, the reader is asked to recognize that compromises were made to ensure that the report is broadly applicable to the field, and that constantly referencing the diversity of language preferences would make the document ponderous to read.

A few explanations and caveats are offered about the language in the report. The term *behavioral health* was selected as a short and simple reference to encompass the sectors of the field that focus on persons with mental illnesses, addictions, and co-occurring mental and addictive disorders. The use of the term is not intended to imply that such illnesses are simply behavioral in nature, nor that these illnesses and related treatments are solely medical or biological in character.

The report refers to problems, illnesses, disorders, and conditions. The existence of a continuum, from mild problems to severe and persistent illnesses, is explicitly recognized by the authors and is the concern and focus of the workforce. None of the terms used in this report is intended to imply assumptions about etiology. Those issues were simply not addressed in the planning process.

Every effort has been made to employ person-centered or person-first language, with considerable reference to persons in recovery to denote individuals with problems or illnesses, including those seeking help or receiving services. The term *recovery* seems widely, though not universally, accepted across the mental health and addiction sectors of the field with respect to adults. The concept of resilience is acknowledged to have more relevance for children and youth (Benard, 2004), even though the term is mentioned less frequently within these pages. Similarly, a life-span focus, from early childhood to older adults, is fundamental to a comprehensive workforce approach and is implied throughout these documents, even if these diverse populations are not repeatedly mentioned.

Actions taken by the workforce are described using a range of terms, including *health promotion, prevention, early intervention, treatment, rehabilitation, and recovery supports*. The importance of these diverse approaches is clearly recognized, even though each may not be referenced when a workforce in action is described.

The report is presented in five sections. The first section provides an overview of the planning process, the current workforce, and the environment in which the workforce functions. Section II identifies and discusses the core findings and recommendations on workforce issues that are widely applicable to all sectors of the field, and that are common or cross-cutting in nature. Section III on focused topics uses language that is more tailored to address workforce issues specific to select populations or sectors. Section IV provides a conclusion, centered on next steps and the process of leveraging change. Section V contains appendices to the report, including a List of Contributors and Preliminary Implementation Tables which map action steps to recommended stakeholders.

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CHAPTER 2

PLANNING PROCESS

The Annapolis Coalition served as the vehicle for organizing and managing the strategic planning process. The Coalition's central mission is to improve workforce development in behavioral health throughout the nation. The Coalition has expertise in workforce development and functions routinely as a neutral convener of the many and varied stakeholders concerned about the future of the workforce. In this planning effort, as in all of its activities, the Coalition engaged recognized experts in workforce development for selected sectors of the field and relied on their wisdom in formulating workforce recommendations for the sectors. Many of the experts constitute the National Steering Committee of the Annapolis Coalition, which guides the direction of the Coalition on all substantive issues related to workforce policy and recommendations.

An Array of Planning Vehicles

Given the intended breadth of this Action Plan and the need for multiple methods of data collection, an array of planning vehicles was adopted, as outlined below.

- **Senior advisors and technical advisors.** Nationally recognized experts in workforce development from diverse sectors of the field were engaged to manage planning in their areas of focus, to serve as ambassadors in the process to their peers, and to serve on the National Steering Committee, which reviewed and vetted all recommendations and the final Action Plan. The senior advisors were complemented by a number of technical advisors who were engaged to provide additional expertise and consultation on selected topics. Senior and technical advisors are identified in the List of Contributors.
- **Expert panels and work groups.** Senior advisors convened and chaired expert panels on a range of topics. In concert with the senior advisors, panel members assumed responsibility for planning, selection of recommendations, and review and vetting of panel reports. Smaller work groups also were convened to develop recommendations and reports in additional areas. The

panels and work groups are in the following list. Participants in the panels and groups can be found in the List of Contributors.

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

- **Reviews of existing recommendations and reports.** The planning process was enriched by the workforce development efforts that have preceded it. Advisors and panels were charged with identifying, accessing, and reviewing previous workforce reports and recommendations and relevant published literature. Like any reasoned effort at strategic planning, this effort built on prior work, which has been substantial.
- **Planning sessions in existing meetings.** Senior and technical advisors and board members and staff of the Coalition participated in a substantial number of national, regional, and state meetings, where they presented an overview of the strategic planning charge and planning process. Feedback from participants on workforce concerns and recommendations was obtained through question-and-answer sessions, break-out groups, and special dialogue sessions convened by the conference organizers. The sessions were exceptionally diverse in character, focusing, for example, on mental health, substance use disorders treatment, substance abuse prevention, children and youth, persons in recovery and their families, and workforce needs in rural and frontier sections of the nation.
- **Specially convened planning sessions.** Expert panels convened special meetings dedicated exclusively to work on the strategic plan. Efforts were made to ensure that participants in the meetings represented diverse perspectives, with a special emphasis on inclusion in each gathering of persons in recovery and experts in treatment and prevention across the mental health

and addictions sectors of the field. These objectives were usually, although not universally, achieved.

- **Targeted calls for input.** Meetings, letters, and invitations to submit recommendations were used to reach out to key leaders and organizations in the field. Professional associations were engaged through individual meetings and a joint meeting held with the Alliance of Mental Health Professions.
- **Open calls for input.** The Coalition used its Web site as a gathering point for information and input. Individuals and organizations were invited to submit comments and information via this mechanism, and to direct others who might be interested in providing input to use the Web site or to contact members of the Coalition.

Development of Recommendations

Based on previous work and a preliminary review of the workforce literature, the Coalition released a draft set of strategic goals for senior advisors, expert panel members, and all other participants in the planning process to consider. Advisors, panels, and participants provided recommended changes to the draft goals, identified workforce needs, and offered specific recommendations to address those needs. Panels drafted and submitted reports containing their recommendations, which were systematically analyzed for content and organized according to the initial draft goals. Input received through other channels was reviewed at this juncture as well. The resulting product was a revised set of seven strategic goals. The National Steering Committee reviewed the goals, discussed them at length, and subsequently approved them.

Specific recommendations submitted through all sources were organized by goal area into detailed implementation tables, clustered around the specific objectives necessary to achieve each goal. The National Steering Committee reviewed and extensively discussed the implementation plans; they were substantively modified based on Committee feedback. Next, Coalition staff drafted the core sections of the report, with subsequent review by the Committee. Senior and technical advisors then drafted the focused sections of this report in their areas of expertise.

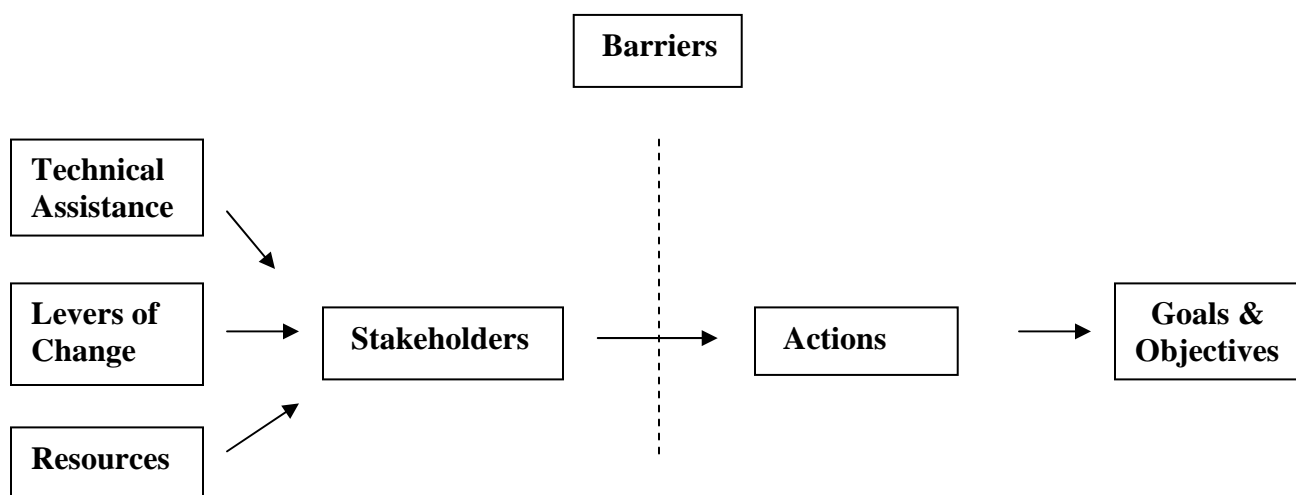
For a strategic plan that is national in scope to have credibility, it must attend to the critical issues of content and process. Within the time and resource constraints of this endeavor, achieving broad participation and diverse input, grounded in a thorough review of available reports and the published workforce literature, has been of paramount importance. A conservative estimate is that more than 5,000 individuals have been engaged in some element of the planning process, with every individual specifically

invited to provide verbal or written input. The credit for the thoroughness and quality of the final report belongs to the many individuals who contributed through this process. The Annapolis Coalition accepts responsibility for any limitations, errors, or omissions in the final product.

A Logic Model

In developing the Action Plan, the Coalition employed a logic model, which is represented by the graphic in Figure 2.1. In the model, various inputs (resources, technical assistance, and levers of change) influence and support the actions of stakeholders as they implement specific actions designed to achieve desired objectives and strategic goals. Identifying potential barriers to action was an important step as planners considered recommendations regarding potential actions, and especially the feasibility of each recommendation.

FIGURE 2.1: Logic Model for the Strategic Plan



Definitions

Goals:	Broadly defined strategic directions. These are limited in number and serve as cornerstones for the strategic plan.
Objectives:	The specific outcomes that are proposed as part of each broad goal.
Actions:	The means of accomplishing the objectives, with specific responsibilities proposed for key stakeholders.
Stakeholders:	Individuals, groups, organizations, and governments with a vested interest in and responsibility for the future of the workforce.
Technical Assistance:	The knowledge and hands-on assistance provided to stakeholders to facilitate actions.
Levers of Change:	The catalysts, mechanisms of influence, and incentives proposed to motivate stakeholders to achieve the proposed actions.
Resources:	The human, physical, and monetary capital required to implement the proposed actions.
Barriers:	The practical, technical, financial, or political obstacles to achieving the proposed actions, objectives, and goals.

The implementation tables that were developed as the plan emerged contain detail regarding many elements of the logic model. The tables added specificity and clarity to the proposed actions and served as a mechanism to quickly sort those actions by stakeholder (e.g., federal or state government, provider organization, professional association, etc.).

Key Stakeholders

Proposed actions vary in their relevance to the range of stakeholders that have a role in this plan. Key stakeholders include the following:

- **Federal Government.** While the federal government cannot carry the full burden of workforce improvement, Congress and federal agencies have a critical role in this agenda.
- **State, County, & Local Governments.** It can be argued that states have the largest influence on behavioral health care and, in turn, on the workforce that provides mental health and addiction services. In states where care is financed, organized, or delivered through county or local governments, these jurisdictions also have considerable impact on workforce development and practice.
- **Foundations.** Innovation in health care is frequently driven by the nation's private philanthropic and charitable foundations as they draw attention to unmet needs and fund efforts to address those needs.
- **Payers.** Through their purchasing activities, public and private payers exert enormous influence on services and related workforce practices. Medicare, Medicaid, and private health insurers largely create the financing context that drives the organization and delivery of services and the activities of the workforce.
- **Oversight Organizations.** Bodies that accredit training programs and provider organizations, and credential, certify, or license individuals and prevention and treatment programs, exert tremendous influence over training, education, and the activities of the workforce (Institute of Medicine [IOM], 2003). These organizations constitute critical *levers of change* for improving workforce development.
- **Advocates.** Another form of oversight and influence is provided by advocacy organizations, which shape the financing and delivery of prevention and treatment services. These organizations

are increasingly focusing on the training and education of the workforce as advocates seek to transform workforce practices.

- **Professional & Trade Associations.** A wide range of organizations exists that are designed to support a specific sector of the field, segment of the workforce, or category of provider. As they seek to strengthen the quality of care and federal, state, and local support for their areas of interest, associations also exert considerable influence on workforce development and practice.
- **Education & Training Programs.** Graduate programs at universities and professional schools have a major role in developing the workforce of the future. Similarly, a diverse array of training programs seeks to provide continuing education and development to people currently in the workforce.
- **Service Providers.** Agencies and systems that employ a workforce for the purpose of providing prevention and treatment services shape recruitment and retention practices, continuing education, staff development, the use of best practices, the provision of supervision and mentoring, and a host of other activities that have an impact on the size and effectiveness of the workforce.
- **Technical Assistance Organizations.** A broad range of organizations provides consultation and technical assistance to the behavioral health field on topics that affect workforce development and practice. The section of the report on infrastructure development recommends that existing technical assistance capacities be linked through a proposed National Workforce Technical Assistance Structure.
- **Communities.** As detailed in latter sections of the report, communities are central to identifying and addressing their behavioral health needs. They share responsibility for linking to local behavioral health systems and supporting the workforce within those systems.
- **Individuals.** Persons in recovery, family members, and practitioners can assume individual responsibility for elements of the agenda to strengthen the workforce. At a minimum, each person can ensure that he or she has a personal plan of development to strengthen knowledge and skills, and each can advocate for broader, system-level changes.

The Search for Workforce Innovation

Many of the recommendations in this plan are drawn from exemplary workforce practices identified by senior and technical advisors and the expert panels. Pockets of innovation in recruitment, retention, education, and training exist throughout the country and serve as models that demonstrate practical and affordable strategies for strengthening the workforce. Replicating a previous search for innovation (O'Connell, Morris, & Hoge, 2004), senior advisors and their expert panels were asked to identify up to three innovative practices for each focused area using criteria adopted from Harvard University's John F. Kennedy School of Government for the school's annual Innovations in Government award (Hassel & Steiner, 2000). The criteria focus on the novelty, significance, transferability, and effectiveness of a practice. The identified innovations are referenced and briefly described in various sections of the Action Plan as Innovation Highlights. More detailed descriptions of the innovations are available through the Coalition's Web site (<http://www.annapoliscoalition.org>).

Looking Back and Looking Forward

Extensive efforts have been made to ensure broad participation in the development of the Action Plan, with opportunities for input from a wide spectrum of perspectives. Panels of experts drawn from diverse sectors had a critical role in formulating the recommendations. Nationally recognized experts in workforce development, serving as a National Steering Committee, reviewed and refined the core recommendations in order to maximize the relevance of the report to the field as a whole. These same experts, with assistance from their panels, crafted sections of the report on focused sectors of behavioral health in order to ensure that the unique workforce needs within each sector received attention. The sections that involve focused topics, such as substance abuse prevention and treatment, children's mental health, and rural mental health, are not intended to be comprehensive strategic plans, but rather are meant to highlight the unique needs and potential next steps for strengthening the workforce within those areas.

During the year in which the Action Plan was being prepared, innovation in workforce development has continued to occur across the country. As the field gains increased knowledge and experience with workforce development, the Action Plan must continue to evolve and the search to identify and disseminate innovative practices must continue.

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CHAPTER 3

CURRENT WORKFORCE AND ITS ENVIRONMENT

Since its inception, the Coalition has conceptualized the behavioral health workforce quite broadly, expanding the traditional definition, which includes professionals and paraprofessionals, to include individuals in recovery and, when appropriate, their families. It is widely recognized that people who have mental and substance use conditions seek help from a broader workforce based in primary care settings, schools, emergency departments, and faith-based organizations. However, time and resource constraints precluded addressing these health and human service providers in the Action Plan. Ideally these segments of the workforce will be the focus of a subsequent workforce improvement effort.

The following pages offer observations and information about the workforce and the environment in which it provides prevention and treatment services. This topic has been dealt with more extensively in other publications, such as *Mental Health, United States, 2002* (Manderscheid & Henderson, 2004), *Strengthening Professional Identity: Challenges of the Addiction Treatment Workforce* (DHHS, 2005), and in a paper prepared for the Institute of Medicine (IOM) by Morris, Goplerud, and Hoge (2004) as background for the recent report *Improving the Quality of Health Care for Mental and Substance Use Conditions* (IOM, 2006). The brief review that follows is intended to provide a context for the Action Plan and the recommendations that it outlines.

The Mental Health Workforce

The single most comprehensive source of data on the mental health workforce is contained in monographs published by SAMHSA. Data from the latest available edition of the SAMHSA document, *Mental Health, United States, 2002* (Manderscheid & Henderson, 2004), inform this Action Plan. The SAMHSA document has been produced biannually by representatives of multiple professional associations working as a group known as the Alliance of Mental Health Professions. Historically, the various professional associations have not collected workforce information using a standardized data set nor on a common survey schedule. Thus, it has been difficult to assemble a unified picture of the mental

health workforce or to compare the various disciplines. As discussed in this Action Plan in the section on infrastructure, the Alliance of Mental Health Professions has been developing a standardized data set and working to generate comparable data across disciplines. Further progress on this agenda is sorely needed.

Table 3.1 identifies the major mental health disciplines, the number of professionals in the disciplines, and their rate per 100,000 U.S. residents. The information is adapted from Table 3 in *Mental Health, United States, 2002* (Manderscheid & Henderson, 2004, p. 332). The interested reader should consult the original source material to better understand the limitations of the data.

Table 3.1: Clinically Active and Clinically Trained Mental Health Personnel by Discipline

Discipline	Number	Rate per 100,000
Psychiatry	38,436	13.7
Psychology	88,491	31.1
Social Work	99,341	35.3
Psychiatric Nursing	18,269	6.5
Counseling	111,931	49.4
Marriage & Family Therapy	47,111	16.7
Psychosocial Rehabilitation	100,000	37.7
School Psychology	31,278	11.4

There are widely differing trends in the growth of the various mental health disciplines, as reported by Duffy et al. (2004). The annual rate of increase in the number of clinically trained psychiatrists fell from 41% in 1982 to only .3% in 2002. In contrast, psychologists prepared at the doctoral level doubled in number during this period. Clinically trained social workers increased in number by 20% between 1989 and 2000. While the number of clinically trained psychiatric nurses with graduate degrees grew by 40% from 1988 to 2000, this trend was offset by an increase in the number of these nurses who were not clinically active in the workforce and by sharp reductions in the number of students enrolled in graduate-level psychiatric nursing programs.

Mental Health, United States, 2002 (Manderscheid & Henderson, 2004) describes the relative homogeneity of the current workforce in terms of race and ethnicity. The vast majority of professionals in the traditional mental health disciplines are non-Hispanic Whites, with the specific percentage by discipline as follows: 75.7% of psychiatrists; 94.7% of psychologists; 85.1% of social workers; 80% of counselors; 91.5% of marriage and family therapists; 69.8% of psychosocial rehabilitation providers; 95.1% of school psychologists; and 83.8% of pastoral counselors (Duffy et al., 2004). These figures stand in contrast to the diversity of the current U.S. population, in which 74.7% of residents are non-Hispanic Whites; 14.5% are Latino; 12.1% are African American; and 4.3% are Asian (U.S. Census Bureau, 2005). Several recent reports have identified the negative impact on care quality and access that

results from a lack of diversity and cultural competence in networks of service providers (DHHS, 2000; IOM, 2003; New Freedom Commission on Mental Health, 2003). The problem will be exacerbated; the U.S. growth rate among Latinos from 2002 to 2005, at 46.2%, was more than double the 21.6% growth rate among non-Hispanic Whites (Wilk et al., 2004).

The mental health professions also are aging. For example, the percentage of clinically trained professionals over the age of 50 is quite high, estimated at 65.2% of psychiatrists, 65.9% of psychologists, and 58.2% of social workers (Duffy et al., 2004). This raises serious concerns about whether the pipeline of young professionals will be adequate to compensate for the growing demand for services at the same time that significant segments of the workforce are approaching retirement.

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

A large portion of the mental health workforce does not have graduate-level professional training. Morris and Stuart (2002) described the portion of the workforce with a bachelor's degree or lesser qualifications as follows:

In 1994 there were over 145,000 of such mental health workers employed, accounting for 25% of the total mental health workforce. Registered nurses were the next largest group at 82,620 or 14.3% of the workforce, followed by social workers at 41,326 or 7.2%. Most interesting is the site of employment of these individuals. In private psychiatric hospitals other mental health workers constitute 8.7% of the total staff, as compared with state and county mental hospitals where they constitute 40.9% of the total staff.... Thus, it is readily apparent that the public sector employs the vast majority of this group of providers. (p. 380)

This direct care workforce poses special challenges. The Coalition agrees with a recent Robert Wood Johnson Foundation report that "the frontline workforce is a vital, but little understood component of the healthcare community. In general, we know that this critical part of the healthcare delivery system is the most at risk component of health employment and encompasses occupations with the least amount of visibility" (Robert Wood Johnson Foundation, 2005, p.1). Because many people in recovery enter the mental health workforce at this direct care or frontline level, concern is heightened about the vulnerability of this sector of the field.

The Addictions Workforce: Treatment & Prevention

Nationally, nearly 22 million persons ages 12 and older, or 9.4% of the total U.S. population, are dependent on or abuse alcohol or illicit drugs (Wright, 2004). Federal epidemiological surveys estimated in 2002 that 7.7% of the population ages 12 and older met diagnostic criteria for alcohol dependence or alcohol abuse disorders, and about 3% of persons ages 12 and older met the criteria in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (4th ed.)* [DSM-IV] for illicit drug dependence or abuse disorder (Wright, 2004). Yet only 1 person in 10 who had a drug use disorder and 1 person in 20 who had an alcohol use disorder received treatment for the condition (Wright, 2004). The workforce implications of these statistics are simply staggering.

The workforce that is specifically trained and credentialed in addictions services is small in comparison to the identified need. Current data indicate that approximately 67,000 licensed and unlicensed counselors provide substance use disorder treatment and related services (Harwood, 2002). Data from Keller and Dermatis (1999), which are contained in Table 3.2, indicate that an additional 40,000 professionals are involved in providing such care. Note that the data on workforce size reported by these authors vary somewhat from the data reported in Table 3.1, due to the use of different definitions and methodologies.

Table 3.2: Health Care Professionals Licensed or Credentialed in Substance Use Disorder Treatment

(Source: Keller & Dermatis, 1999)

Discipline	Workforce Size	# of Certified Addiction Specialists*
General and specialty medicine	700,000	2,790 ASAM certified
Psychiatry	30,000	1,067 addiction psychiatrists
Clinical psychology	69,800	950 APA substance-abuse certified
Social work	300,000	29,400 ^o
Nursing	2,200,000	4,100 ^o
Physician assistant	27,500	185 ^o
Marriage/family therapy	50,000	2,500 ^o

*as noted in Harwood (2002), the licensed and unlicensed addictions workforce numbers 67,000

^o self-described addictions specialist

The substance use disorders treatment workforce is primarily female, older, and White. Most studies find that women account for the majority of the clinical workforce in specialty substance use treatment facilities (Harwood, 2002; Knudsen, Johnson, & Roman, 2003; Mulvey, Hubbard, & Hayashi, 2003; RMC, 2003). For example, among new counselors entering the field, 70% are female (NAADAC, 2003). The average age of treatment staff is midforties to early fifties (NAADAC, 2003; RMC, 2003). Studies indicate that from 70% to 90% of substance use disorder treatment personnel are Caucasian (Harwood, 2002;

Knudsen et al., 2003; Mulvey et al., 2003; RMC, 2003). The characteristics of staff working in this sector of the field frequently differ from their predominantly young, male, and minority clientele.

The reported proportion of treatment staff that meets state credentialing standards for substance abuse counselors ranges from a low of 45% (DHHS, 2003a) to a high of 72% (Mulvey et al., 2003). Harwood (2002) found that about 53% of treatment staff members were certified as substance abuse counselors and that 56% of certified counselors had a master's degree. Outpatient nonmethadone facilities tend to have the highest percentage of certified staff, and methadone programs tend to have the lowest (DHHS, 2003b).

The content and intensity of preprofessional training received by certified counselors vary widely, as there are no uniform standards accepted across the country regarding curricula. Edmundson (2002) studied the 260 training programs listed by NAADAC, which is the professional counselors' association. Fifty-five percent were at the community-college or 2-year level, 13% at the bachelor's level, and 32% at the graduate level. The course credit requirements for undergraduate and 2-year programs were found to vary considerably. There is no accreditation or oversight body for undergraduate or continuing education programs to ensure consistency of acquired knowledge or competencies.

It has been estimated that by 2010, "the need for addiction professionals and licensed treatment staff with graduate-level degrees is expected to increase by 35 percent" (NASADAD, 2003). However, addressing the 90% to 95% of persons with substance use disorders who need but do not receive treatment will require changing the way that the country organizes, finances, and manages substance use disorders treatment. It will be important, for example, to examine not only the current substance use disorders treatment system, but also strategic opportunities to intervene where people with substance use disorders intersect with the broader health care system, such as in primary care settings and emergency departments. This will require a more expansive analysis of workforce options that is beyond the scope of this initial effort to design a workforce plan.

The workforce for substance abuse prevention is discussed in detail in Chapter 19 of this report. The prevention workforce has been estimated to number approximately a half million. However, there is no standard inventory or methodology for defining and counting this sector of the workforce. It is extremely diverse in character, composed of professionals from the fields of social work, education, psychology, criminal justice, health care, counseling, and the clergy. This workforce also includes parents, teachers, youth leaders, indigenous workers, law enforcement officers, school personnel, and civic and volunteer groups. As depicted graphically in Chapter 19, the substance abuse prevention workforce typically falls into three distinct, yet overlapping, segments: (1) tribal, state, territory, or substate managers of prevention funding and delivery systems; (2) direct implementers of prevention programs and activities;

and (3) community or coalition members engaged in promoting the behavioral health and wellness of communities. Some members of the prevention workforce have pursued and obtained state credentialing in addictions, while many others have not pursued or are ineligible for credentialing due to educational eligibility requirements.

The Environment of Care

Each day, environmental forces shape, support, challenge, block, or defeat the activities of the workforce, and thus determine how well the behavioral health needs of individuals, families, and communities are met. A well-prepared workforce has little meaning in an environment that does not actively promote the values, competencies, and skills of that workforce or pay competitive wages to persons with those skills and competencies. Geary Rummier, an expert in the field of human performance, has noted that “When you pit a bad system against a good performer, the system almost always wins” (Rummier, 2004).

In providing treatment, organizational characteristics are at least as influential as individual education or training (IOM, 2001, 2004). While numerous reports and studies have focused on improving behavioral health care, substantive attention too seldom has been given to the environment in which care is provided or the impact that a “toxic” environment can have on both persons in recovery and service providers. The sections that follow review major trends in the environment that are having an impact on the behavioral health workforce. The sections also consider the competing demands of stakeholders in the field, discuss the concept of toxic environments, and highlight the notion of a workforce at risk.

Trends Influencing the Workforce

In recent reports on the addiction treatment workforce, the Center for Substance Abuse Treatment (CSAT) identified trends that are affecting the people who work in the field (DHHS, 2003a, 2005). The trends generally have broad relevance to all of behavioral health and are briefly summarized as follows:

- *Insufficient workforce/treatment capacity to meet demand.* The gap between the need or demand for service and the availability of treatment puts enormous pressures on the current workforce.
- *The changing profile of the people needing services.* The workforce is challenged to keep pace with changing patterns of drug use, co-occurring mental illnesses and substance use disorders, medical comorbidity, and criminal justice involvement among individuals being served. Population growth within racially and ethnically diverse groups brings increased demands for delivering culturally and linguistically competent care.

- *Shift to increased public financing of treatment.* Declining private insurance coverage for behavioral health care, budgetary constraints in publicly funded systems, managed care policies and practices, and the large number of persons who lack health insurance create hurdles for the workforce as it seeks to provide access to quality care.
- *Use of best practices.* The recent emphasis on evidence-based practices and treatment guidelines has challenged the workforce to rapidly and substantially alter its practice patterns in the treatment of persons with substance use disorders, mental illnesses, and co-occurring mental and substance use conditions.
- *Increased utilization of medications in treatment.* Pharmacological agents, in combination with psychosocial treatments, increasingly are used throughout all sectors of behavioral health. The workforce needs to be knowledgeable about this rapidly changing aspect of care.
- *Movement toward a recovery management model of care.* Major shifts have occurred from episodic, acute, facility-based treatment approaches to approaches that emphasize community-based care and concepts such as disease management, illness self-management, and recovery. These are fundamental paradigm shifts that require members of the workforce to significantly alter their work setting, assumptions, strategies for delivering care, and basic approach to collaborating with persons in recovery and their families.
- *Provision of treatment and related services in nonspecialty settings.* The behavioral health workforce increasingly is asked to work in nontraditional settings, such as the correctional system and primary care settings, or to collaborate with health care in these settings around screening, brief treatment, and referral.
- *Use of performance and patient outcome measures.* Increasing payer demands for accountability place burdens on the workforce to provide more data and to produce demonstrated outcomes.
- *Discrimination or stigma.* Persons with mental and substance use conditions face discrimination on many fronts, including in employment, housing, and insurance. These obstacles complicate the demands on the workforce and are associated with a general stigma related to being part of the substance use disorder treatment workforce.

Conflicting Stakeholder Demands on the Workforce

The interface between behavioral health care and its environment has become increasingly complex. In the past, the mental health delivery system was conceptualized as having only two visible parts: providers

and patients. However, the system has grown to include multiple stakeholder groups, all of which have an impact on the workforce and must be taken into account as it provides prevention and treatment services. These groups have related, but slightly different, interests.

Consumers of care/people in recovery want appropriate services to be available when and where they are needed, and expect to be involved in establishing treatment plans. Families want what is best for their members and are concerned about issues related to quality of life, social supports, education, and empowerment. Lawmakers and other regulators want citizens to have high-quality care at the lowest cost and want providers to be accountable for their care. Payers and insurers are concerned about paying for covered services by competent, licensed, and credentialed professionals, and ensuring their own financial viability. Finally, law enforcement and the courts want to ensure public safety and protect patients' constitutional rights regarding access to care and treatment received. The behavioral health workforce operates at the intersection of the changing and often conflicting priorities and interests of these stakeholder groups in an environment of scarce resources.

Toxic Environments

Much of behavioral health care is provided within organizational settings, with the workforce as employees of these organizations. In his book *The Four Pillars of Excellence* (2005), Paul Light identifies the following aspects of robust organizations:

- Alertness – Spotting fluctuations as they emerge, not after their effects have already been felt.
- Agility – Empowering employees with the authority to make routine decisions, reducing barriers between units, encouraging participatory management, and fostering open communication.
- Adaptability – Changing the circumstances and taking advantage of new opportunities as they arise.
- Alignment – Saturating the organization with information and providing effective information technology.

These four qualities stand in sharp contrast to the qualities documented in recent reports about behavioral health. Throughout the process of obtaining stakeholder input for this report, the Coalition heard repeatedly that the environments in which behavioral health care is both given and received are toxic for persons in recovery, family members, and the workforce.

For example, providers are increasingly aware of their responsibility to provide cost-effective care in an environment of shrinking behavioral health resources. Dilemmas arise for clinicians who must balance a responsibility to both an individual service recipient and a population in need. Financing mechanisms and

organizational constraints create conflict for the provider who feels the need to serve the bottom line of the organization but, in so doing, may be jeopardizing the interests of the individual in need of care (Wolff & Schlesinger, 2002). All too often, staffing levels are reduced as a cost-cutting measure, while patient caseloads and acuity levels increase.

People in the workforce routinely struggle with the ambiguity of many of the rules, regulations, and expectations of the current health care environment. Workers must deal with the over reliance in some organizations on simplified treatment protocols that may limit professional judgment, limit tailoring of intervention to individual need, or may not be evidence based. They cite a reduction in their clinical productivity because of administrative burdens, excessive documentation, and assigned responsibility for nonclinical tasks. They report low morale and organizational commitment because of low pay, the absence of a career ladder, the severity of patient problems, excessive workloads, tenuous job security, lack of qualified and available supervision, and an inability to influence the service system (Blankertz & Robinson, 1997; Center for Health Workforce Studies, 2006; Gellis & Kim, 2004; Hanrahan & Gerolamo, 2004; IOM, 2003, 2004; Zurn, Dal Poz, Stilwell, & Adams, 2004).

Further frustration stems from lack of agreement on the appropriate utilization of the existing behavioral health workforce (Stuart, Worley, Morris, & Bevilacqua, 2000). The roles and functions of providers can be confusing, as seen in the example of mental health case managers. From one setting to another, the activities, preparation, and expertise of case managers vary greatly. Case managers may fulfill a cost-containment function, a coordination function, or a direct care function. Some case managers have college or professional degrees, while others enter the workforce with more basic educational preparation.

The characteristics of the current toxic environment serve to increase dissatisfaction among people in the workforce. The environment also encourages conflict among providers, rather than enhancing teamwork and interdisciplinary collaboration. Tensions heighten when economic resources are reduced and the disciplines or sectors of the field struggle to protect their work and ensure their survival. In the face of these dilemmas, it should come as no surprise that it is difficult to recruit into the field, and that many professionals and staff members currently in the workforce decide to leave.

A Workforce at Risk

A final, but critically important environmental issue affecting the workforce is related to personal safety. It is telling that little has been written about the physical injuries, emotional exhaustion, and burnout experienced by behavioral health providers, particularly frontline staff (American Nurses Association, 2006). The IOM report *Improving the Quality of Health Care for Mental and Substance-Use Conditions*

(2006) discusses unsafe care, restraint and seclusion, and the need to strengthen the quality-improvement infrastructure. It is critical that this focus be expanded to include the often unsafe working environment of behavioral health staff and to address the environmental and organizational factors that can contribute to this problem, such as limited reimbursement, inadequate staffing levels, lack of staff training in crisis management, increasing levels of patient acuity, shortened lengths of stay, and reduced staffing patterns. The fact that data are relatively limited on the physical and emotional injuries experienced by workers in the field is one example of how environmental and organizational characteristics can both create and mask problems that directly place the behavioral health workforce at risk. A workforce that frequently experiences a sense of vulnerability and threat is unlikely to provide the sense of hope and personal engagement that is at the core of the therapeutic alliance.

Summary

No change has as much potential to influence the workforce as the emerging redefinition of the role of the consumer in making health care decisions. This is as true in behavioral health as in general medicine. Trends such as illness self-management, peer-support approaches, and increased access to information via the Internet are remodeling the relationships among practitioners, patients, and families and posing new challenges for the workforce (Morris & Stuart, 2002).

Members of the workforce, no matter how well prepared, competent, and compassionate, must function within systems and environments of care. A competent individual placed in a toxic environment cannot function efficiently and effectively and is far less likely to be retained. Strengthening the behavioral health workforce requires creating environments that support the health and well-being, not only of persons with mental and substance use conditions, but of the workforce as well.

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SECTION II

CORE FINDINGS
&
RECOMMENDATIONS



CHAPTER 4

GENERAL FINDINGS

During the strategic planning process, a series of major themes emerged. The themes constitute a set of general findings about the state of the workforce and provide a context for understanding the specific goals, objectives, and actions that are offered as recommendations in the latter sections of this report.

Widespread Concern about a Workforce Crisis

Across the nation there is a high degree of concern about the state of the current workforce and pessimism about its future. The varied problems and issues are outlined in detail in the Special Topics section of this report. Below is a sampling of issues designed to highlight some of the most troubling concerns.

- There is a critical shortage of individuals trained to meet the needs of children and youth, and their families. As just one example, the federal government has projected the need for 12,624 child and adolescent psychiatrists by 2020, which far exceeds the projected supply of 8,312. There currently are only 6,300 child and adolescent psychiatrists nationwide, with relatively few located in rural and low-income areas (American Academy of Child and Adolescent Psychiatry [AACAP] Task Force, 2001). There is an even more severe shortage of practitioners trained and credentialed to treat adolescents with substance use disorders, and only five states require adolescent-specific knowledge for licensure (Pollio, 2002). There is a significant shortage of behavioral health professionals who have been trained to work in the nation's schools. This particular shortage is critical because, as noted by the President's New Freedom Commission, the majority of children who would benefit from behavioral health interventions do not become engaged adequately with traditional community-based treatment settings, and schools offer unparalleled access as points of engagement with children to address their behavioral health needs. By and large, training programs that focus on prevention and treatment within this age group have not kept pace with current trends in the field. The trends have been shifting toward strengths-based and resiliency-oriented approaches, systems of care, and evidence-based

practices (Curie, Brounstein, & Davis, 2004; McLellan & Meyers, 2004; Meyers, Kaufman, & Goldman, 1999).

- There is a pronounced shortfall in the current workforce of providers with expertise in geriatrics. This deficit is expected to worsen. Nationwide, only 700 practicing psychologists view older adults as their principal population of focus, well short of the estimated 5,000 to 7,500 geropsychologists necessary to meet current needs (Jeste et al., 1999). Similarly, only 640 members of the American Psychiatric Nurses Association (2002) have a subspecialization in geriatrics. In 2001, there were only 81 geriatric psychiatry fellows in training in the nation, and 39% of the available fellowships went unfilled (Warshaw, Bragg, Shaull, & Lindsell, 2002). These figures indicate that simply adding training opportunities is not enough. In order to address the dramatic shortfall in trained providers with specialized competencies (many of whom have substantial student loans to repay), there needs to be a fundamental change in the way that services are organized and reimbursed.
- Each year, only 20% of the individuals in the United States who need treatment for substance use disorders receive it. This is due, in part, to severe difficulties in recruiting and retaining qualified staff in sufficient numbers (Gallon, Gabriel, & Knudsen, 2003; Hall & Hall, 2002; Northeast Addiction Technology Transfer Center, 2005). In the most compelling study of this issue, McLellan, Carise, and Kleber (2003) found a 50% turnover in frontline staff *and* directors of substance use disorder treatment agencies in a single year. Furthermore, 70% of frontline staff members in these agencies did not have access to basic information technology to support their daily work.
- The substance abuse prevention sector faces critical workforce issues, which center on the lack of clear educational and career pathways for workers. This hampers recruitment and contributes to turnover, as many skilled prevention workers leave the sector in the search for upward career mobility.
- In rural America, the workforce crisis is particularly acute. More than 85% of the 1,669 federally designed mental health professional shortage areas are rural (Bird, Dempsey, & Hartley, 2001). There are 3,075 counties in the country; 55% have no practicing psychiatrists, psychologists, or social workers, and all of these counties are rural. It has been extraordinarily difficult to recruit, train, and retain professionals in rural areas. Few training programs for providing behavioral health in rural areas exist.

- Figures from the 2000 U.S. Census indicated that 30% of the nation's population is drawn from the four major ethnic groups; Latinos, African Americans, Asian American/Pacific Islanders, and Native Americans. In contrast, the behavioral health workforce lacks such cultural diversity, particularly in mental health. For example, non-Hispanic Whites currently account for 75.7% of all psychiatrists, 94.7% of psychologists, 85.1% of social workers, 80% of counselors, 91.5% of marriage and family therapists, 69.8% of psychosocial rehabilitation practitioners, 95.1% of school psychologists, 83.8% of pastoral counselors, and 90.2% of female psychiatric nurses (Duffy et al., 2004). While cross-cultural training has the potential to improve quality of care and service use among people of color (Fortier & Bishop, 2003), the workforce at large cannot be characterized as culturally or linguistically competent.

High Levels of Dissatisfaction among Persons in Recovery and Families

Workforce issues are a personal matter for individuals with mental health problems and illnesses and substance use disorders. While the experiences of the people who receive care obviously vary greatly, the individuals whose voices were heard during the process of developing this plan expressed strong dissatisfaction with the workforce.

Many of the complaints carried an air of sympathy for members of the workforce. Individuals receiving care acknowledged the heavy workloads, large paperwork burden, comparatively low wages, lack of access to training in state-of-the-art practices, and absence of administrative and technological support that confront the staff. But they also expressed considerable anger for what many described as the stigmatizing attitudes within the workforce about persons with mental and addictive disorders. There is frank concern that many of the professionals and staff members in the field have negative attitudes toward the very persons they are to serve, and that these attitudes impede the ability of workers to be respectful of the people receiving care. At times, a more benevolent but still negative interpretation was offered. It centered on the notion that the workforce is uninformed about recovery-oriented approaches to care and unreceptive to shared decision-making with persons in recovery, children, youth, and family members by virtue of having been trained in a model that emphasizes traditional doctor-patient relationships in which patients are viewed as the passive recipients of the experts' services.

Perhaps of most concern is the perspective of many persons in recovery, children, youth, and family members that the emphasis on compassionate and caring therapeutic relationships has been significantly eroded in behavioral health care. The angriest voices argue that compassion and caring are not eroding because they weren't there to begin with in the mental health community. Advocates continue to report demeaning and dismissive attitudes on the part of treatment professionals as occurring altogether too often. The IOM (2006) has highlighted the central importance of "continuous healing relationships" in all

aspects of health care, and such a tradition has deep roots in the treatment of persons with mental illnesses and substance use disorders. In mental health, for example, training has historically centered on the development of empathic relationships and working alliances. Whether due to a shift in training approaches, the multiple burdens on staff, or the emphasis on evidence-based or manualized therapies, there is considerable concern that the basic human connections between the people providing and the people receiving care are being lost.

Employer Dissatisfaction with the Preservice Education of Professionals

Another group that has voiced strong concerns comprises managers within organizations that employ the workforce. Their constant lament is that recent graduates of professional training programs are unprepared for the realities of practice in real-world settings, or worse, have to unlearn an array of attitudes, assumptions, and practices developed during graduate training that hinder their ability to function. University-based training programs and professional schools, despite their academic base, are largely viewed as out of touch with the realities of contemporary practice and as failing to provide substantive training in evidence-based practices. These concerns exist regardless of the professional discipline. It is simply difficult to overstate the level of concern among workforce employers about the current relevance of professional education in the behavioral health disciplines.

Change Occurs with the Generations

There is general recognition in health care of the long delay between the emergence of evidence for the effectiveness of prevention or intervention strategies and their widespread adoption. This phenomenon exists in behavioral health and may be due, in part, to the fact that change in practice patterns is tied to the changing generations of practitioners within the field. Change occurs with the generations, which accounts for the 20-year lag that characterizes the transition from “science to services.”

Underlying this dynamic is the fact that educational systems in behavioral health, as in most of health care, emphasize the teaching of specific practices. The teaching is focused on content rather than on the process of continuous learning. Students learn certain skills and seem to practice them throughout their career, rather than “learning to learn” as a foundation for a lifelong process in which the evidence on effective interventions is continually re-examined, with personal practice patterns shifting in response to the changing evidence.

Multiple Silos and an Absence of Coordination

The recent report from the IOM (2006) particularly noted the myriad disciplines, differing levels of training, and variability across states in licensing and credentialing the diverse groups that constitute the behavioral health workforce. A labyrinth of organizations, associations, councils, and committees also shapes the training and oversight processes for various segments of the workforce. Diversity can be an asset, but the disciplinary “silos” that are firmly in place appear to impede interdisciplinary training and experience, despite the heavy emphasis on interdisciplinary, team-based practice in systems of care. Furthermore, there is little cooperative or coordinated effort among the disciplines on workforce efforts, such as the development and assessment of competencies, despite the fact that there are many shared competencies across the diverse sectors of the workforce.

Another version of the fragmentation in the field consists of the divide and tensions between the mental health and addiction sectors, with a similar gulf between the areas of behavioral health treatment and prevention. These rifts have major negative consequences. It is difficult to promote change in any large-scale measure throughout the nation’s behavioral health care system because of the multiple divisions and the tendency of each discipline or sector to work in isolation. But perhaps more tragic is that no discipline or sector has adequate resources to pursue on its own a robust agenda for quality improvement, including workforce development. The ultimate negative consequence of the legacy of these silos is that pioneering work by one discipline or sector remains largely unknown to the rest of the field; given the missed opportunities to collaborate and build on each other’s work, there is little synergy of effort.

A Narrow Focus on Urban White Adults

A comprehensive review of workforce issues and needs in the diverse sectors of the behavioral health field brings into stark relief the narrow focus that pervades the field and, in turn, its workforce. Prevention and intervention strategies have been developed and tested principally through research by individuals who are Caucasian residents of America’s metropolitan centers. The vast majority of intervention strategies have been designed principally for young and middle-age adults, and have excluded children and older Americans. Similarly, the participants in effectiveness and efficacy studies largely have been non-Hispanic, White adults residing in the nation’s urban and suburban cores. The vast majority of individuals who provide prevention and treatment services similarly are non-Hispanic Whites and are clustered in the major population centers.

A life-span approach is markedly missing throughout this field and manifests itself in workforce development, as relatively few individuals are trained to meet the needs of America’s children, youth, and

elders. The unique needs of the country's rapidly growing ethnically and racially diverse populations also receive sparse attention, with parallels in a behavioral health workforce that lacks cultural and linguistic diversity and cultural competence. Similarly ignored are the unique circumstances of Americans in rural and frontier areas, where traditional approaches to workforce development, centered on "programs and professionals," simply fail to address local needs.

A Scarcity of Data on the Workforce and its Development

While estimates vary, it appears that as much as 80% of behavioral health expenditures are in human resources. Given the core role of the workforce in prevention and treatment, there is a striking lack of data about the workforce and about workforce development practices. The scattered information that does exist has no uniformity, which hinders cross comparison or aggregation of the data to examine trends. Furthermore, the reliability of much of these data is open to question. There is little consensus about key workforce variables, and there are few benchmarks that organizations can use as a reference point in assessing the magnitude of their workforce problems or the success in addressing the problems.

As the Annapolis Coalition and advisors managing the planning process sought evidence on effective workforce development practices, it became abundantly clear that the workforce is seldom the focus of research. There certainly have been a range of scholarly articles and reviews on the workforce topic; most, however, contain no data or data that are simply descriptive in nature. Even on critical topics such as the retention of staff, there is little data drawn from carefully executed research or evaluation on which to identify effective practices.

A Propensity to do What is Affordable, Not What is Effective

Most behavioral health organizations feel under siege, given the multiple demands for improved access to and quality of treatment and prevention services amid worsening economics surrounding the provision of those services. In such an environment, the need to train and support the workforce is generally recognized, but not made a priority. A peculiar dynamic has emerged in many settings that involves token efforts to develop the workforce, even though managers recognize that the efforts are inadequate and unlikely to have significant effects. The most glaring example is the provision of, didactic, in-services or workshops. These constitute the most common approach to staff training and development, even though there is clear evidence that such sessions are ineffective in changing the practice of the workers who participate. In a parallel fashion, many organizations have introduced training in evidence-based practices to frontline staff without being able to educate or train supervisors and managers in the practices, and without being able to provide the ongoing training, consultation, and staff development that would be required to accomplish and sustain adoption of the practices within the organization.

The Field is Hungry for Workforce Tools

With broad recognition of a workforce crisis, there is a palpable demand in the field for practical models, strategies, and tools to address the myriad problems. Employers of the behavioral health workforce, by and large, are interested in moving rapidly to improve recruitment, training, and retention, but are finding relatively few interventions or models that are well described, portable, and easily adaptable to different settings.

Pockets of Workforce Innovation that are Difficult to Sustain or Disseminate

Across the nation, selected states and organizations are creatively addressing workforce problems. These initiatives can best be described as pockets of innovation, as systematic and substantive efforts to bolster the workforce remain the exception rather than the rule. Many of the workforce efforts detected during the planning process appeared to be sorely underfinanced because there are few sources of dedicated funding for workforce development. Thus, workforce initiatives are difficult to sustain in a single organization or jurisdiction, let alone to disseminate and replicate in other jurisdictions. Most innovations simply remain unknown to colleagues in the field who are grappling with similar issues.

The Workforce Crisis Extends Throughout Health and Human Services

While there are aspects of the workforce crisis in behavioral health care that are unique, the existence of such a crisis is common to multiple areas of health and human services. Recruiting and retaining capable frontline staff has been a crippling problem in the developmental disabilities field (Larson & Hewitt, 2005). The workforce crisis in the field of child welfare, where staff with minimal training is asked to help families burdened by multiple medical, social, and financial problems, has been described in graphic and sobering detail by the Annie E. Casey Foundation (2003). The recruitment and retention of nurses in all areas of health have received national attention and federal- and state-level intervention. Recent national reports have highlighted the growing crisis in recruiting individuals to pursue careers as pharmacists (DHHS, 2000) and in public health (Association of State and Territorial Health Officials [ASTHO], 2004). The national crisis of confidence regarding the safety and quality of health care (IOM, 2000, 2001) is largely responsible for the recent efforts in medicine, across all disciplines, to identify core competencies and demonstrate the competency of those within their ranks.

Hope for the Future

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

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CHAPTER 5

SEVEN STRATEGIC GOALS: AN OVERVIEW

As described in Chapter 2 on the planning process, the distillation of the reports and recommendations of the multiple expert panels and work groups yielded a set of seven final strategic goals. Table 5.1 outlines the final goals. Table 5.2 presents a quick reference guide to the strategic goals and their related objectives and actions. Each goal is presented and discussed in detail in subsequent chapters.

Goals 1 and 2 focus on broadening the concept of workforce. Persons in recovery, children, youth, families, and communities are not simply recipients of prevention and treatment services. They are active in promoting and maintaining health and wellness, defining their unique needs, and caring for themselves and supporting each other. Their roles as formal and informal members of the behavioral health workforce must be greatly expanded.

Goals 3, 4, and 5 focus on strengthening the workforce. The recommended objectives and actions identified for these goals reflect activities related to best practices in recruitment and retention, training and education, and leadership development for the workforce.

Goals 6 and 7 involve creating improved structural supports for the workforce. The structural improvements include a system for providing technical assistance in workforce practices, more effective human resource departments within service organizations, greater information technology to assist the workforce, and a national research and evaluation agenda producing improved information on effective workforce practices.

TABLE 5.1: STRATEGIC GOALS AT A GLANCE

BROADENING THE CONCEPT OF WORKFORCE

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

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

STRENGTHENING THE WORKFORCE

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

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

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

STRUCTURES TO SUPPORT THE WORKFORCE

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

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

TABLE 5.2: QUICK REFERENCE GUIDE TO STRATEGIC GOALS, OBJECTIVES, AND ACTIONS

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

Objective 1: Provide information and education to individuals in care or recovery and their families to enable them to fully participate in or direct their own care and to assist and support each other.

Action 1: Identify and make available to people in care and their families a body of peer-reviewed, scientifically sound, culturally and linguistically relevant materials in a variety of formats (text, video) and languages, and make these materials accessible to people with different educational levels.

Action 2: Routinely provide families and other natural caregivers and supporters information about optimal ways to help and support loved ones with behavioral health conditions; this information is developed and provided by consumers, family members, educators, researchers, and providers working in partnership(s) and reflects the range of cultural and linguistic differences of the country.

Action 3: Routinely engage persons in recovery and family members in teaching providers how best to work with persons seeking recovery from the perspective of the lived experience of mental or substance use conditions.

Objective 2: Develop shared decision-making skills among individuals receiving care and their families and service providers.

Action 1: Expand the knowledge base about shared decision-making.

Action 2: Make person-centered (or family-focused or youth-guided) treatment planning the norm in behavioral health interventions.

Action 3: Make consumer, family, and provider education a part of every provider interaction – no matter how often the provider has seen the consumer or family.

Objective 3: Significantly expand peer- and family-support services and routinely offer them in systems of care.

Action 1: Implement certified peer specialist (CPS) services as Medicaid reimbursable in all states by 2010.

Action 2: Expand the use of volunteer and grant-funded peer-support programs where indicated.

Action 3: Expand family support services (such as the NAMI Family to Family program and similar programs) in all provider settings, and adapt these programs to meet the needs of diverse communities (based on race, class, sexual orientation, geographic isolation, and language).

Action 4: Continue to build the evidence base on peer-support practices.

Action 5: Create opportunities for providers to support each other emotionally. (The emotional demands of their jobs are intense, and support among providers would be an excellent way to build resilience.)

Objective 4: Increase the employment of individuals in recovery and family members as paid staff in provider organizations.

Action 1: Develop mandates and standardized reporting mechanisms for self-identified consumers and family members employed as providers in non-peer-support positions, as well as in peer-support positions.

Action 2: Advocate for CMS endorsement of the use of appropriately trained individuals in recovery or family members as providers under state Medicaid plans.

Objective 5: Formally engage persons in recovery and family members in substantive roles as educators for other members of the workforce in every provider training and education program.

Action 1: Propose that national oversight bodies for each of the major behavioral health disciplines endorse inclusion of individuals in recovery and family members on the faculties of their preprofessional training programs.

Action 2: Propose that national educational oversight organizations that accredit residencies and practica endorse the use of individuals in recovery and family members as preceptors or consultants to preceptors.

Action 3: Include individuals in recovery and family members in the design, oversight, delivery, and evaluation of all state-sponsored training.

Action 4: Include individuals in recovery and family members in the design, oversight, delivery, and evaluation of all federally sponsored training.

Action 5: Include a course led by consumers and family members regarding recovery from the consumer and family member perspective in all provider-sponsored continuing education programs.

Action 6: Encourage providers, states, and organizations to use teams of consumers and providers to offer continuing education.

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

Objective 1: Support communities in their development of the core competencies of assessment, capacity building, planning, implementation, and evaluation.

Action 1: Increase the level of consensus and support for using SAMHSA's Strategic Prevention Framework and CADCA's related competencies as the basis for competency development with communities.

Action 2: Identify and further develop competency-based curricula, training models, and technical assistance toolkits for use in building community capacities.

Action 3: Implement training and deliver technical assistance to communities.

Action 4: Evaluate the efficacy of the competencies, curricula, training models, and toolkits in increasing community capacity.

Objective 2: Increase the competency of the behavioral health workforce to build community capacity and collaborate with communities in strengthening the behavioral health system of care.

Action 1: Identify the core competencies needed by the behavioral health workforce to build community capacity and collaborate with communities.

Action 2: Develop competency-based curricula and training models.

Action 3: Provide training and staff development to the behavioral health workforce in community capacity-building and collaboration.

Action 4: Evaluate the efficacy of the training approaches in developing the competency of the behavioral health workforce to support and collaborate with communities.

Objective 3: Strengthen existing connections between behavioral health organizations and their local communities.

Action 1: Provide technical assistance to behavioral health organizations in assessing and strengthening community ties.

Action 2: Encourage behavioral health organizations to develop and implement plans to strengthen their connections to local community coalitions, organizations, groups, governments, and agencies.

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

Objective 1: Disseminate information and technical assistance in effective recruitment and retention strategies.

Action 1: Collect, analyze, and summarize descriptive information and outcome data on recruitment and retention strategies on a routine basis.

Action 2: Provide information and technical assistance in recruitment and retention to behavioral health organizations.

Objective 2: Select, implement, and evaluate recruitment and retention strategies tailored to the unique needs of each behavioral health organization.

Action 1: Identify the recruitment and retention needs of each behavioral health organization.

Action 2: Implement and evaluate interventions designed to address the unique recruitment and retention needs of each organization.

Objective 3: Expand federal financial incentives, such as training stipends, tuition assistance, and loan forgiveness, to increase recruitment and retention.

Action 1: Convene an expert panel to propose the sources, priority areas, and target recipients of increased federal financial incentives.

Action 2: Increase federal financial incentives and evaluate their effectiveness.

Objective 4: Provide wages and benefits commensurate with education, experience, and levels of responsibility.

Action 1: Develop partnerships with the federal and state departments of labor focused on employment, wage, and benefit issues.

Action 2: Use data generated through collaborations with departments of labor to adjust wages and benefits.

Objective 5: Implement a comprehensive public relations campaign to promote behavioral health as a career choice.

Action 1: Engage a national marketing firm to develop the campaign.

Action 2: Develop and implement comprehensive marketing campaigns at the national, state, and local levels.

Action 3: Create a Web portal that is a comprehensive resource for people recruiting for or seeking positions and careers in behavioral health.

Objective 6: Develop career ladders.

Action 1: Conduct a review of career pathways through educational, certification, and licensing systems.

Action 2: Develop additional curricula, training programs, and certification or licensure procedures to address gaps in the career ladders.

Objective 7: Expand the use of “grow-your-own” recruitment and retention strategies focused on residents of rural areas, culturally diverse populations, and consumers and families.

Action 1: Develop and distribute technical assistance in existing initiatives to recruit these priority populations into entry-level positions and foster their continued professional development through a career ladder.

Action 2: Increase the use of this recruitment and retention strategy with these priority populations.

Objective 8: Increase the cultural and linguistic competence of the behavioral health workforce.

Action 1: Initiate broad dissemination of standards and tools for culturally competent practice.

Action 2: Increase the cultural competence of interpreters used in delivering services through the development of standards, training models, and reimbursement strategies.

Action 3: Create workplace environments that are conducive to a diverse workforce.

Action 4: Expand the pipeline of culturally and linguistically competent professionals who are entering the behavioral health field.

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

Objective 1: Identify core competencies and focused competencies for behavioral health practice.

Action 1: Establish a Competency Collaborative that links organizations developing behavioral health competencies and provides technical assistance.

Action 2: Develop a model set of core mental health competencies.

Action 3: Identify and further develop focused competencies relevant to specific areas of behavioral health practice.

Action 4: Identify and further develop competencies in critical practices that include (a) person-centered planning, (b) culturally competent care, (c) development of therapeutic alliances, (d) shared decision-making, (e) evidence-based practice, (e) recovery- and resilience-oriented care, (f) rehabilitation, (g) interdisciplinary and team-based practice, (h) advocacy, (i) use of informatics, and (j) continuous quality improvement.

Objective 2: Develop and implement competency-based curricula.

Action 1: Develop model, portable curricula for entry-level, direct care staff based on the core competencies.

Action 2: Develop a set of consensus standards for evaluating curricula on relevance and effectiveness.

Action 3: Identify or further develop competency-based specialized curricula, relevant to specific areas of behavioral health practice.

Action 4: Require training and education organizations routinely to review and update their curricula and conduct self-evaluations using the consensus standards.

Objective 3: Adopt evidence-based training methods that have been demonstrated as effective through research.

Action 1: Identify effective teaching methods through a systematic review of available research.

Action 2: Employ evidence-based teaching methods in training and education organizations.

Action 3: Require (through accreditation standards for preservice and continuing education) the use of evidence-based teaching methods.

Action 4: Identify and adopt conference and meeting models that have demonstrated impact on participant learning and behavior.

Objective 4: Use technology to increase access to and the effectiveness of training and education.

Action 1: Provide technical assistance to training and education organizations in best practices in the use of technology for learning.

Action 2: Employ best practices in the use of technology-assisted instruction.

Action 3: Fund demonstration initiatives in technology-assisted instruction.

Objective 5: Launch a national initiative to ensure that every member of the behavioral health workforce develops basic competencies in the assessment and treatment of substance use disorders and co-occurring mental and addictive disorders.

Action 1: Incorporate addiction and co-occurring competencies into all competency models, preservice and continuing education curricula, training accreditation and program accreditation standards, and certification and licensure requirements.

Action 2: Implement or expand training and staff development in the assessment and treatment of substance use disorders and co-occurring mental and addictive disorders throughout preservice and continuing education.

Objective 6: Educate prospective students about best practices in training and education to inform their selection of a training program or training provider.

Action 1: Develop and disseminate a *Guide to Selecting Relevant and Effective Training* designed for prospective students.

Objective 7: Identify and implement strategies to support and sustain the use of newly acquired skills in practice settings.

Action 1: Identify strategies proven to be effective in supporting and sustaining newly acquired skills and behavior change within organizations.

Action 2: Adopt organizational actions to support and sustain newly acquired skills and measure sustained behavior change within the workforce.

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

Objective 1: Identify leadership competencies tailored to the unique challenges of behavioral health care.

Action 1: Conduct a comprehensive review of available competency models.

Action 2: Develop a leadership core competency model tailored to behavioral health.

Action 3: Finalize development of supervision competencies tailored to behavioral health.

Action 4: Disseminate broadly the core leadership and supervision competencies.

Action 5: Adapt the core leadership competency model and supervision competencies to meet the needs of diverse sectors of the field.

Objective 2: Identify effective leadership curricula and programs and develop new training resources to address existing gaps.

Action 1: Identify existing leadership curricula and programs and evaluate them using selected criteria.

Action 2: Develop and disseminate a catalog of available leadership curricula and programs.

Action 3: Identify gaps in leadership curricula and training models and develop resources to close the gaps.

Objective 3: Increase support for formal continuous leadership development with current and emerging leaders in all segments of the workforce.

Action 1: Allocate funding to support the expansion or creation of competency-based leadership development initiatives.

Action 2: Allocate funding and time to support the participation of individuals in leadership development initiatives.

Action 3: Establish mentorship programs.

Action 4: Provide competency-based training to all supervisors.

Action 5: Provide incentives, recognition, and rewards for participation in leadership development programs.

Objective 4: Formally evaluate leadership development programs based on defined criteria and revise the programs based on outcomes.

Action 1: Use data-based continuous quality improvement methods in all leadership development initiatives.

Action 2: Commission an independent evaluation of leadership development initiatives.

Action 3: Develop, maintain, and routinely disseminate a summary of findings from the evaluation of leadership programs to support ongoing quality improvement of leadership development efforts.

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

Objective 1: Create a National Technical Assistance Structure that coordinates and provides information, guidance, and support on workforce development to the behavioral health field and advises the federal government.

Action 1: Develop the specifications for a National Technical Assistance Structure on workforce development.

Action 2: Establish the National Technical Assistance Structure.

Action 3: Establish a National Council on the Behavioral Health Workforce to monitor workforce status, set national workforce development priorities, and advise the federal government on workforce policy (as recommended in the IOM's 2006 report).

Objective 2: Create a federal Behavioral Health Workforce Partnership, led by a SAMHSA Workforce Team.

Action 1: Establish a standing SAMHSA Workforce Team with representatives from CMHS, CSAT, and CSAP to coordinate SAMHSA activities on workforce development.

Action 2: Convene a standing federal Task Force on Workforce Development to prioritize, coordinate, and implement interagency collaborations.

Objective 3: Finance workforce demonstrations through a National Workforce Development Fund and foundation-sponsored initiatives.

Action 1: Establish a National Workforce Development Fund.

Action 2: Encourage foundations to prioritize support for workforce development initiatives.

Objective 4: Change the economic market for services to create conditions that improve the quality of care and strengthen the workforce.

Action 1: Increase parity with other health care in coverage for behavioral health services.

Action 2: Improve provider payment systems to create incentives for consumer satisfaction, effectiveness, and efficiency and to reduce levels of undercompensated care.

Action 3: Create an Advisory Panel on Workforce Economics to develop financing and performance monitoring strategies to improve workforce practices and quality of care.

Objective 5: Increase the use of data to track, evaluate, and manage key workforce issues.

Action 1: Encourage professional associations and states to adopt in their workforce surveys the employee-specific Human Resources Data Set developed by the Alliance of Mental Health Professions. (Note: This set captures data on the individual practitioner, such as professional discipline, level of education, medical specialties, employment status, employment setting, hours per work week, etc.) [Note 2: This recommendation requires further review to determine the current availability of and mechanisms for collecting data on the substance use disorders treatment and prevention workforce.]

Action 2: Develop an organization-specific, standardized Human Resources Data Set for recommended use by all organizations that employ a behavioral health workforce. (Note: This

set will capture data on organizational variables, such as employee vacancy and retention rates, reasons for turnover, use of temporary staff, cultural composition of the workforce, staff satisfaction, investment in training and development, etc.)

Action 3: Implement a data-driven continuous quality improvement process on workforce development in every behavioral health organization.

Action 4: Collect and disseminate benchmarking data on human resources.

Objective 6: Strengthen the human resources and training functions, staffing, and levels of expertise in behavioral health organizations.

Action 1: Provide technical assistance in evaluating and strengthening human resources and training functions.

Action 2: Develop and implement a plan in each behavioral health organization to strengthen human resources and training functions.

Action 3: Provide training and technical assistance in workforce development best practices to human resources and training personnel.

Objective 7: Promote the increased availability and use of information technology to support the workforce during training and service delivery.

Action 1: Finalize an action plan for strengthening the behavioral health information infrastructure, drawing on recommendations from the National Summit on Behavioral Health Information Management.

Action 2: Reduce the burden of needlessly variable or purposeless data-reporting requirements for the workforce.

Action 3: Provide information-management and decision-support tools to the workforce.

Action 4: Increase the use of information technology to track and manage workforce performance.

Objective 8: Identify Magnet Centers in workforce best practices, drawing on the “Magnet Hospital” concept from the field of nursing.

Action 1: Create standards and accreditation procedures for Magnet Centers in behavioral health.

Action 2: Implement an accreditation process for Magnet Centers in behavioral health.

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

Objective 1: Increase the quantity and quality of workforce-related research through creation of a federal interagency research collaborative.

Action 1: Establish a standing federal Research Collaborative on Workforce Development with representatives of NIMH, NIDA, NIAAA, NINR, HRSA, AHRQ, SAMHSA, and other selected federal agencies.

Action 2: Convene a panel of workforce experts, including persons in recovery and family members, to assist in identifying priority research topics and questions.

Action 3: Identify and fund research priority areas and issue an annual report on funded studies and their outcomes.

Action 4: Summarize and disseminate research findings routinely to foster their impact on training curricula; licensing, certification, and accreditation standards; and provider workforce practices.

Objective 2: Increase the quantity and quality of formal evaluations of workforce development practices by providing technical assistance to the field.

Action 1: Develop technical assistance materials and methods for delivery.

Action 2: Build evaluation capacity in the field through the provision of technical assistance.



CHAPTER 6

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

One of the most profound changes in contemporary health care has been the emergence of the concept of patient-centered care. The IOM (2001), in its seminal report *Crossing the Quality Chasm: A New Health System for the 21st Century*, identified patient-centeredness as one of the six aims for health care improvement. The concept was defined as "...providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" (IOM, 2001, p. 40). Ironic as it may seem, health care historically has not been patient-centered. Providers and the systems in which they work dominated decision-making processes; individual differences among the persons receiving care were largely ignored, and little information was provided to individuals and their families about illnesses and treatment options.

Individuals and their families are increasingly informed about health and health care. Recipients of services increasingly are bringing information to their providers, asking for information, and insisting on having a greater role in decisions about their care. While progress has been made on this front, the ideal of an individual and family fully informed and actively involved in decision making still occurs far too infrequently (IOM, 2001).

Evolving Roles in Mental Health and Addictions

Significant historical differences have existed between the mental health and addiction sectors regarding the roles of individuals and families. Treatment interventions for persons with substance use disorders carried a tradition of nonmedically driven approaches in which the client has been expected to assume significant responsibility for his or her recovery, and persons in recovery largely staffed treatment programs. In sharp contrast, the mental health field historically has centered on the medical model in its approach, emphasized the expertise and influence of a professional workforce, and considered

consumers and their families as recipients of the care or treatment selected by professionals. While these historical differences are important, there is evidence of convergence toward an approach in which the contributions of professionals and of persons in recovery and their families are simultaneously valued and emphasized. In the addictions sector, there is a growing emphasis on evidence-based practice, competencies, and the development of a professional workforce to deliver care, while also retaining and valuing the contribution of persons in recovery as members of the workforce. In mental health, a forceful consumer movement has been a counterbalance to the autonomy and independence of professionals; the consumer movement has emphasized consumer roles in treatment decisions as peer volunteers, as paid employees in the workforce, and as members of the governing boards of provider organizations and service systems. Simultaneously, families have made their voices heard as they have demanded information, influence in treatment decisions, and greater access to care, quality of care, and safety of services provided.

Senior advisors to the Annapolis Coalition grappled with the traditional and divergent ways in the behavioral health field of conceptualizing and describing the therapeutic relationship between persons in recovery and persons providing care. The advisors, hoping to move toward some common ground around the goal of improved care, made every effort to resolve, or at least address, the philosophical and language differences that often divide the field. Success in this effort was substantial, yet clearly only partial. The process revealed a common thread in all sectors and traditions, which is a core respect for the individual and family in need of care, and a desire to strengthen the notion of a partnership between those needing and those providing care. It is a partnership in which caregivers, whatever their training and professional status, have essential knowledge and skills to offer, and in which clients, consumers, or patients bring to the process their self-knowledge, values, and wisdom drawn from the lived experiences of mental and addictive disorders and efforts to achieve recovery.

The language and conceptual difficulties are compounded by the variability in the presentation, course, and severity of mental health and addictions conditions among individuals. For example, there are points in the experience of nearly all severe behavioral health conditions at which the capacity of the individual to fully participate in treatment decisions may be impaired. Thus, differing levels of intervention are required, and each must remain exquisitely sensitive to the dignity and personhood of the recovering individual.

The role of families also is complicated. Family members of children and young adults never lose their role as parent or sibling, and yet they are in a very real sense both primary caregivers and individuals in need of support to sustain their own health and well-being. For adults with mental health conditions, the

situation is even more complex because the family's role in treatment may be limited by the desires or needs of the client.

Persons in Recovery and their Families as Members of the Workforce

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

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

Objective 1: Provide information and education to individuals in care or recovery and their families to enable them to fully participate in or direct their own care and to assist and support each other.

There have been notable efforts to provide information and education to persons in recovery and family members. Examples in the area of substance use disorders treatment include the long-standing work of the Hazelden Foundation and the Johnson Institute. In mental health, the recent work of organizations such as the National Alliance on Mental Illness (NAMI), Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD), and the Depression and Bipolar Support Alliance (DBSA) to educate clients or consumers and family members is particularly noteworthy.

Despite these efforts, there is a general consensus that most individuals and family members with behavioral health needs lack adequate and timely information about illness and treatment options. Much of the information available is not considered user friendly. Furthermore, just as in professional education, there is a serious lag in making the findings or implications of recent studies available to those seeking help. Providing accurate and scientifically sound information to persons in recovery and family members is a core objective and an essential step in supporting their efforts to care for themselves and each other.

A requisite action step is to create mechanisms for developing or updating educational materials that are peer reviewed, scientifically sound, and tailored to individuals of diverse cultures, languages, and points across the life span. Parents also warrant special attention; they require unique information and education because of their evolving roles and needs as their children develop and transition to adulthood.

Several action steps are recommended to make educational materials accessible. They include using multiple media formats and creating a central clearinghouse from which individuals can directly access current information or link to sources of reliable educational materials. This action should be complemented by a searchable database of recent research findings that presents information in layman's language. Public and private health care payers should ensure that persons covered through health plans are provided with links to readily accessible information. State behavioral health agencies each should have an explicit system or structure for educating the public, including individuals receiving state-supported services.

Providers should be trained in communication skills with individuals and their family members, including the art of providing information. In large part, this training should be delivered by persons in recovery or family members, who are uniquely qualified to educate the workforce about the needs and perspectives of the individuals who will be receiving the information. All approaches to disseminating information must address issues of timing and need for repetition. A frequently heard complaint among persons in recovery and their families is that information is typically offered once, if at all, or in a cursory manner during a crisis, when neither the person in recovery nor a family member is likely to retain the information, however useful.

Objective 2: Develop shared decision-making skills among individuals receiving care and their families and service providers.

Education provides a foundation from which persons in recovery and their families are better prepared to exert more influence over their care. Evidence-based practice, as developed in general medicine, places a heavy emphasis on provider and patient collaboration in treatment decisions, informed by the best available and most relevant information for that individual (Guyatt & Rennie, 2002; Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). This concept of shared decision-making has been emerging as a model in multiple areas of health care (Charles & Demaio, 1993), including prevention (Sheridan, Harris, & Woolf, 2003), the treatment of persons with cancer (Cassileth, Zupkis, Sutton-Smith, & March, 1980), and diabetes care (Greenfield, Kaplan, Ware, Yano, & Frank, 1988).

The term *shared decision-making* has not been widely used in behavioral health (Hamann, Leucht, & Kissling, 2003), but it has roots in the field, embedded in efforts to assess client preferences, provide client-centered care, and implement self-directed care (Adams & Drake, 2006). The Annapolis Coalition recommends that efforts be expanded to further develop and widely disseminate this approach in the behavioral health field. This would entail adopting promising practices from other areas of health care and building on emerging models within the field, such as illness management and recovery (Mueser et al., 2002; Mueser et al., 2006) and person-centered (or family-focused and youth-guided) treatment planning (Adams & Grieder, 2004).

Increased adoption of these collaborative approaches will require training targeted not only to providers but also to persons in recovery and family members. Provider-focused trainings will target skills related to communication, building a therapeutic alliance, and eliciting and responding to questions and concerns of individuals and their families; client-focused interventions will facilitate the sharing of opinions and concerns (Adams & Drake, 2006). In addition to these skills-development approaches, the Coalition recommends attention to a range of documentation requirements, accreditation and licensing standards, and reimbursement practices that could be modified or adopted as action steps to support and reinforce shared decision-making practices.

Shared decision-making approaches are intimately related to issues regarding engagement in treatment (Adams & Drake, 2006). The substance use disorders community has focused successfully on the engagement issue by developing strategies such as motivational interviewing (Bernstein et al., 2005; DeJonge, Schippers, & Schaap, 2005; Hettema, Steele, & Miller, 2005). These strategies should be incorporated more broadly into provider training and skills development.

Objective 3: Significantly expand peer- and family-support services and routinely offer them in systems of care.

The role of peer supports and self-help has been at the foundation of substance use disorders treatment for decades. In mental health, formal peer- and family-support programs have a more recent history, yet there has been substantial growth in these approaches over the past decade. Fostering a strong and expanded role for persons in recovery and family members in formally helping their peers is a core workforce objective.

For the adult mental health community, this objective has special meaning; the emergence of peer supports as a Medicaid reimbursable service has become a major theme in system reform. There is an emerging body of evidence supporting peer services for persons with serious mental illnesses (Campbell & Leaver, 2003; Sabin & Daniels, 2003; Solomon & Draine, 2001). The evidence from implementing Medicaid reimbursable services in state systems such as Georgia and South Carolina adds support to the movement. It is recommended that all states pursue implementation of Medicaid reimbursable peer support. To foster this development, the federal Centers for Medicare and Medicaid Services (CMS) should work with its regional officers, states should develop relevant regulations for their Medicaid plans, and work must continue on identifying competencies and developing a curriculum for peer specialists.

On a parallel track, systems need to devise strategies to support the expanded use of volunteers, whenever possible. The 12-step and other mutual aid communities have values and traditions that mandate voluntary service, and many persons in recovery and family members are not interested in paid positions within systems of care. Their contributions cannot be slighted, or worse, thwarted by policies or practices that ensue from efforts to expand peer-support programs tied to Medicaid.

It is essential that family support initiatives, such as the Family to Family program developed by NAMI, be substantially expanded. Training in peer- and family-support models should be routinely available in all provider settings. Furthermore, these approaches to providing support must be adapted to the unique needs of individuals of color, non-English-speaking populations, and residents of rural communities. Finally, a more robust research and evaluation agenda should be mounted to ensure that emerging and promising practices in peer and family support receive adequate focus in the nation's effort to identify, develop, and fund evidence-based practices.

Though addressed elsewhere in this document, it is important to note that participants in the planning process called for all persons in recovery, family members, *and* providers to receive support. The

repeated message was that recovery can be stressful and demanding, regardless of one's role in the process. The benefits of peer support are not limited to individuals with a diagnosis or disorder.

Objective 4: Increase the employment of individuals in recovery and family members as paid staff in provider organizations.

The substance use disorders treatment community has far outstripped the rest of behavioral health in employing persons in recovery. However, all sectors of the behavioral health field have work to do to ensure that people in recovery are provided opportunities to enter the paid workforce, not only in positions identified as peer-support roles, but in standard or traditional workforce positions as well. A special challenge is to provide meaningful career ladders for people in recovery, so that they can not only enter but also remain in the field and continue to grow personally and professionally. Individuals in recovery and family members should hold supervisory and management positions within prevention and treatment organizations, in addition to the frontline, direct care positions for which they are so often recruited.

The realities of achieving increased employment of persons in recovery and family members are complex and will require creativity and flexibility in dealing with issues such as the education and licensure requirements for selected positions, as well as workforce-related provider accreditation standards. It will also require the creation of reimbursement policies that go beyond academic preparation and licensure as eligibility requirements for compensation. There is a strong need to recognize and pay for the services of individuals who bring life experience as a qualification and have demonstrated their competency in nontraditional ways.

To monitor and drive progress on this objective, all provider organizations, systems of care, and state behavioral health agencies should formally monitor the number and percentage of self-identified persons in recovery and family members that they directly employ or fund through contracts. Specific targets should be set on this objective within each organization and pursued through a comprehensive plan to recruit and orient peer and family employees, and most critically, to support individuals once they are engaged in these roles.

Objective 5: Formally engage persons in recovery and family members in substantive roles as educators for other members of the workforce in every provider training and education program.

One of the largest gaps in the field is the absence of individuals in recovery and their families as teachers of the traditional workforce about the experience of illness and treatment and the process of recovery.

These rich perspectives from lived experience are undervalued and are seldom provided in traditional academic preparation or continuing education. The conversation changes profoundly when people in recovery and their families are included as faculty in workshops or academic course work. Such inclusion, particularly in early phases of training, has the potential to foster a sense of partnership and collaboration, and to counter the paternalist attitudes and approaches that are taught in traditional academic curricula. This is less of an issue in substance use disorders training, given the historical engagement of persons in recovery as treatment providers. Yet, there is room to expand the role of these individuals as teachers.

A number of concrete strategies can further this objective. First, the educational accreditation bodies of the traditional behavioral health disciplines should endorse inclusion of individuals in recovery and family members on the faculties of their professional training programs and monitor the extent to which this actually occurs in a meaningful fashion. The leaders of state and county mental health and addiction systems can mandate that all trainings² paid for with state or county funds include presentations by members of the recovery community and their families. At the federal level, participation of persons in recovery and families could be required in the design, delivery, and evaluation of all federally sponsored training related to behavioral health. Similarly, organizations that accredit continuing education could require that selected course offerings be designed so as to include consumer and family educators.

Conclusion

Inherent in the concept of transforming the mental health system, as the New Freedom Commission on Mental Health called for in 2003, is a shift in power. Emerging approaches to care in behavioral health involve shifts in the locus of decision making and forming more equal partnerships between persons in recovery and family members, and providers. Many individuals who participated in the development of the Action Plan considered this strategic goal, focused as it is on an expanded role for persons in recovery and family members, to have the greatest potential to transform systems of care, especially within mental health. Persons in recovery and family members too often are unrecognized as members of the workforce. They currently make enormous contributions caring for themselves and each other, but they can have even greater impact if provided with information, skills in shared decision-making, opportunities to provide formal peer and family support, and a role in educating the traditional workforce. Given what appears to be an insurmountable gap between the demand for and supply of traditional providers, engaging individuals with the most at stake in roles that are more meaningful and effective

² There would be obvious exceptions for technical or organizational training matters or the use of content-specific instructors (e.g., epidemiologists, pharmacists, etc.).

provides the additional hope of reaching many individuals who have not connected with traditional systems of care.

Just as persons in recovery and family members are unrecognized members of the workforce, so too are communities. The role of communities in the workforce, a second potentially transformational strategic goal, is addressed in the following chapter.

Table 6.1: Objectives & Actions for Goal 1

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

Objective 1: Provide information and education to individuals in care or recovery and their families to enable them to fully participate in or direct their own care and to assist and support each other.

Action 1: Identify and make available to people in care and their families a body of peer-reviewed, scientifically sound, culturally and linguistically relevant materials in a variety of formats (text, video) and languages, and make these materials accessible to people with different educational levels.

Action 2: Routinely provide families and other natural caregivers and supporters information about optimal ways to help and support loved ones with behavioral health conditions; this information is developed and provided by consumers, family members, educators, researchers, and providers working in partnership(s) and reflects the range of cultural and linguistic differences of the country.

Action 3: Routinely engage persons in recovery and family members in teaching providers how best to work with persons seeking recovery from the perspective of the lived experience of mental or substance use conditions.

Objective 2: Develop shared decision-making skills among individuals receiving care and their families and service providers.

Action 1: Expand the knowledge base about shared decision-making.

Action 2: Make person-centered (or family-focused or youth-guided) treatment planning the norm in behavioral health interventions.

Action 3: Make consumer, family, and provider education a part of every provider interaction – no matter how often the provider has seen the consumer or family.

Objective 3: Significantly expand peer- and family- support services and routinely offer them in systems of care.

Action 1: Implement certified peer specialist (CPS) services as Medicaid reimbursable in all states by 2010.

Action 2: Expand the use of volunteer and grant-funded peer-support programs where indicated.

Action 3: Expand family support services (such as the NAMI Family to Family program and similar programs) in all provider settings, and adapt these programs to meet the needs of diverse communities (based on race, class, sexual orientation, geographic isolation, and language).

Action 4: Continue to build the evidence base on peer-support practices.

Action 5: Create opportunities for providers to support each other emotionally. (The emotional demands of their jobs are intense, and support among providers would be an excellent way to build resilience.)

Objective 4: Increase the employment of individuals in recovery and family members as paid staff in provider organizations.

Action 1: Develop mandates and standardized reporting mechanisms for self-identified consumers and family members employed as providers in non-peer-support positions, as well as in peer-support positions.

Action 2: Advocate for CMS endorsement of the use of appropriately trained individuals in recovery or family members as providers under state Medicaid plans.

Objective 5: Formally engage persons in recovery and family members in substantive roles as educators for other members of the workforce in every provider training and education program.

Action 1: Propose that national oversight bodies for each of the major behavioral health disciplines endorse inclusion of individuals in recovery and family members on the faculties of their pre-professional training programs.

Action 2: Propose that national educational oversight organizations that accredit residencies and practica endorse the use of individuals in recovery and family members as preceptors or consultants to preceptors.

Action 3: Include individuals in recovery and family members in the design, oversight, delivery, and evaluation of all state-sponsored training.

Action 4: Include individuals in recovery and family members in the design, oversight, delivery, and evaluation of all federally sponsored training.

Action 5: Include a course led by consumers and family members regarding recovery from the consumer and family member perspective in all provider-sponsored continuing education programs.

Action 6: Encourage providers, states, and organizations to use teams of consumers and providers to offer continuing education.

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CHAPTER 7

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

The importance and centrality of the role of communities in promoting and maintaining behavioral health and wellness was captured by Wagenaar and colleagues (1994), who stated that “[T]he community is not simply the *site* for the intervention but the *vehicle* for change.” This idea makes clear that communities are the locus for defining their health needs, priorities, and strategies, which in turn, leads to a broad vision of person-centered, family-centered, and *community-centered* approaches to behavioral health and wellness. Communities are a key element of the workforce in a manner quite parallel to the way in which persons in recovery, children, youth, and families are central to the workforce, as described in the preceding section of this report.

A broader vision of behavioral health is not the only rationale, however, for placing focused attention on communities. Recurrent concerns emerged in the planning process about the prevalence in many communities of stigma related to substance use disorders and mental illnesses, accompanied by a lack of community support for or connection with local behavioral health systems of care. Such concerns emerged, for example, among a panel of experts convened as part of this planning process by the Western Interstate Commission on Higher Education (WICHE). The panel concluded that the workforce crisis in rural behavioral health care could not be addressed effectively unless and until stronger links were forged between behavioral health systems and their host communities to combat stigma, build support for behavioral health services, and build interest among community members in serving formally or informally as part of the behavioral health workforce.

For these diverse reasons, expanding the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness emerged as a core strategic goal, relevant to all sectors of the behavioral health field. The proposed vehicles for accomplishing this goal involve (1) competency development with communities and their coalitions, (2) competency development of the behavioral health workforce focused on community collaboration and capacity building, and (3) interventions to strengthen existing ties between communities and their behavioral health systems.

While a focus on community has varying traditions in the substance use disorders and mental health fields, the emphasis on this goal emerged most forcefully from the National Prevention Network (NPN) Workforce Development Subcommittee, which served as a planning panel in this process. This group of prevention experts recognized the long-standing practice and value of involving the community in efforts to understand, reduce, and prevent substance abuse and its adverse health and social consequences (Chou et al., 1998). The panel initially agreed and subsequently confirmed through the larger planning process that it was logical and necessary, from a workforce perspective, to extend the emphasis on community capacity and action to other areas of behavioral health.

Objective 1: Support communities in their development of the core competencies of assessment, capacity building, planning, implementation, and evaluation.

The concept of community is amorphous and definitions of *community* vary. In this planning process, community was defined as coalitions or collaborations focused on the needs of a particular geographic area and comprising residents, groups, businesses, agencies, schools, parents, religious organizations, and governments and their various departments. Coalitions of this nature have a unique capacity to connect multiple sectors of the community, develop a comprehensive understanding of a community's problems or needs, craft systemic solutions, and harness the power of diverse groups and individuals to take coordinated action. These processes have the potential to generate community-based knowledge, insight, and strategies quite distinct from those that emerge in expert-driven processes (National Community Anti-Drug Coalition Institute, 2004).

Translating the potential of communities into actual capacity requires a framework for action and the development of competencies within community coalitions to plan and act effectively. Work on such a framework and related competencies has occurred in the area of prevention. The Annapolis Coalition strongly recommends that these efforts be further supported, developed, and broadly disseminated and implemented in all other sectors of behavioral health care.

A cogent model of community planning and action has been detailed in the Strategic Prevention Framework (SPF), which was developed with support from SAMHSA (DHHS, 2004). The model entails five core steps involving (1) assessing community needs; (2) building capacity to address needs; (3) conducting planning activities; (4) implementing policies and practices; and (5) continually evaluating and refining interventions. The Community Anti-Drug Coalitions of America (CADCA), through its National Community Anti-Drug Coalition Institute and its partner, Community Systems Group, Inc., has developed

a set of core community competencies tied to the SPF (2005). CADCA has also developed curricula and technical assistance capacities to assist communities in developing these competencies.

The Annapolis Coalition recommends that SAMHSA pursue efforts to give this work much greater visibility in the field and to build consensus around a common framework and competency model for community development and action. These steps should be followed by a sustained effort to identify and further strengthen relevant curricula, training models, and toolkits that can be used to develop community competencies in assessment, capacity building, planning, implementation, and evaluation. Putting these tools into practice requires development of a comprehensive dissemination plan with shared responsibility among numerous organizations, including the Centers for the Application of Prevention Technologies (CAPT), the Addiction Technology Transfer Centers (ATTCs), CADCA, other technical assistance providers, state behavioral health authorities, and provider agencies.

To make significant progress in this arena will require efforts by federal and state agencies to review and address the financing of community development activities. Most funding sources and financing mechanisms reimburse behavioral health organizations for the provision of treatment services only and do not cover activities related to competency development, or even collaboration, with communities. Funding that is available directly to communities to foster their capacity building also is quite limited.

Objective 2: Increase the competency of the behavioral health workforce to build community capacity and collaborate with communities in strengthening the behavioral health system of care.

The workforce within behavioral health organizations has the potential to make key contributions to improving the quality of life in communities. However, working effectively with communities requires specialized knowledge of existing community organizations and coalitions; an understanding of their scope, similarities, and differences; and a set of skills to build a community's capacity to assess and address its health and wellness. Perhaps most important is the ability to work comfortably on the "turf" of organizations outside of behavioral health.

The specific competencies needed for working with communities have not been well defined. Building on the competency development initiatives with communities, the Annapolis Coalition recommends that core competencies focused on community development and community collaboration be developed for the behavioral health workforce. This work should be guided by a diverse expert panel that includes representation from community coalitions, various sectors of the behavioral health field, and state, federal, and tribal governments. It must be complemented by curriculum development and a

dissemination plan that leads to the incorporation of the work into the competencies and curricula for the behavioral health workforce throughout the field.

Objective 3: Strengthen existing connections between behavioral health organizations and their local communities.

It is critical to emphasize the bidirectional nature of the relationships envisioned for this agenda. The behavioral health workforce must support and assist in the development of community capacities. In turn, communities must support and foster the efforts of the behavioral health workforce through a host of actions, such the provision of resources, volunteers, and assistance in dealing with community concerns about the location of service programs. As the complicated and long-term effort to strengthen competencies within communities and within the behavioral health workforce unfolds, there is an immediate need to strengthen the connections between the two. As a short-term objective, the Annapolis Coalition recommends that every behavioral health organization formally reassess its current connections to local community coalitions and to the varied groups and organizations that constitute the community. Supported by technical assistance regarding potential models for such assessments, each organization should craft and implement an action plan to increase the diversity of these ties and the strength of current relationships with its local community.

Conclusion

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

To achieve this objective, efforts to identify community competencies and build capacity must be significantly enhanced. Similarly, behavioral health providers must further develop competencies to support and collaborate with their local communities. As these competency-development and capacity-building initiatives unfold, it is incumbent on behavioral health organizations to reassess and strengthen their current connections to community organizations and coalitions.

Table 7.1: Objectives & Actions for Goal 2

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

Objective 1: Support communities in their development of the core competencies of assessment, capacity building, planning, implementation, and evaluation.

Action 1: Increase the level of consensus and support for using SAMHSA's Strategic Prevention Framework and CADCA's related competencies as the basis for competency development with communities.

Action 2: Identify and further develop competency-based curricula, training models, and technical assistance toolkits for use in building community capacities.

Action 3: Implement training and deliver technical assistance to communities.

Action 4: Evaluate the efficacy of the competencies, curricula, training models, and toolkits in increasing community capacity.

Objective 2: Increase the competency of the behavioral health workforce to build community capacity and collaborate with communities in strengthening the behavioral health system of care.

Action 1: Identify the core competencies needed by the behavioral health workforce to build community capacity and to collaborate with communities.

Action 2: Develop competency-based curricula and training models.

Action 3: Provide training and staff development to the behavioral health workforce in community capacity-building and collaboration.

Action 4: Evaluate the efficacy of the training approaches in developing the competency of the behavioral health workforce to support and collaborate with communities.

Objective 3: Strengthen existing connections between behavioral health organizations and their local communities.

Action 1: Provide technical assistance to behavioral health organizations in assessing and strengthening community ties.

Action 2: Encourage behavioral health organizations to develop and implement plans to strengthen their connections to local community coalitions, organizations, groups, governments, and agencies.

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CHAPTER 8

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

Recruitment and *retention* are two words that are mentioned in every discussion about the behavioral health workforce. They are almost always mentioned in the same breath, yet the process of recruitment is quite distinct from that of retention. Further complicating the issue is the dichotomy between recruiting individuals into and retaining them in the field of behavioral health care versus efforts to recruit them into and retain them in a specific organization, job, or role. Thus, there are four interrelated areas of focus for this topic, as captured in Figure 8.1.

Figure 8.1: Examples of Recruitment & Retention

	Field	Job
Recruitment	Minority recruitment efforts by professional schools in behavioral health.	Search and hiring activities by service organizations.
Retention	Initiatives to keep retired professionals active within the field through paid or voluntary roles.	Use of monetary and non-monetary incentives to keep employees from leaving an organization or position.

A comprehensive review of the literature on recruitment and retention in behavioral health, published from 1990 to 2005, was conducted as part of the strategic planning process. A broad array of electronic search tools was used to identify articles related to recruitment or retention of the mental health and addiction workforce, including articles on the topic of burnout in the workforce. Also reviewed was the

literature from general nursing, a field in which recruitment and retention have been major areas of concern and a focus of action. Several striking conclusions emerged from the comprehensive review.

With respect to recruitment, the literature is limited; it focuses principally on engaging minorities in graduate-level training. Little data exist regarding the outcomes of these initiatives. There also are few published articles on the recruitment of individuals into paid positions or volunteer roles. The articles that do exist are essentially devoid of data. Around the country, there are certainly many efforts to recruit individuals into employment or other roles, and some of these efforts use novel strategies. However, few of the recruitment efforts have been documented in any form and virtually no data on their impact have been reported.

In contrast, there is a more substantial body of published work on the topic of retention in behavioral health, although much of this literature is based in England and other foreign countries. Nine studies published since 1994 reported actual turnover data for rather diverse segments of the behavioral health workforce in the United States. The findings ranged from a low turnover rate of 13.2% (Connor et al., 2003) to a high of 72.6% in a single year (Ben-Dror, 1994). It is impossible to arrive at broad conclusions about retention or turnover nationally because few studies report data. Of the studies that do, the findings are highly variable, and each study typically examines a single sample of workers in only one work setting from a single job classification (Blankertz & Robinson, 1997b; Gallon, Gabriel, & Knudsen, 2003).

Some of the best data on retention were generated through the National Treatment Center Study. The authors of a key report from this ongoing study (Knudsen, Johnson, & Roman (2003), stated in their findings that there was an "... average turnover rate of 18.5% among substance use disorders treatment counselors. This rate far exceeds the national average of 11% across all occupations and is significantly higher than the average annual turnover rates of teachers (13%) and nurses (12%), occupations traditionally known to have high rates of turnover..." (p. 130). There is further reason to be concerned about retention in the addiction workforce, as a recent study by McLellan, Carise, and Kleber (2003) found a 53% turnover rate in a single year in substance use counselors and the directors of the agencies under study. In addition, Gallon, Gabriel, and Knudsen (2003) conducted a survey in which responses from 197 substance abuse agencies and 469 individual staff members, all from the Pacific Northwest area of the United States, were obtained. The researchers found that the average yearly turnover rate among staff was 25%, and that it was mostly voluntary in nature. The big difference in the turnover rates in these studies is difficult to interpret.

Examining workforce "need" nationally is complicated by a host of factors. There is no national census on the behavioral health workforce that adequately captures the number of trained or employed individuals

working in the field. There are important differences among the professions, with the number of psychology graduates increasing significantly (Wilk et al., 2004), for example, and the number of graduates from advanced practice psychiatric nursing programs in decline (Wilk et al., 2004). The issue of how many individuals are in the workforce is different from the issue of where they are. Professional groups abound in urban areas and are virtually absent in rural and frontier America. Distribution of the workforce is also an issue with respect to areas of expertise, with most practitioners focused on the care of adults and relatively few focusing on needs across the life span.

Another element of workforce need relates to the growing challenge of recruiting and retaining culturally and linguistically diverse and competent providers. The recent supplement to the Surgeon General's report *Mental Health: Culture, Race, and Ethnicity* (DHHS, 2001a) and the report of the President's New Freedom Commission on Mental Health *Achieving the Promise: Transforming Mental Health Care in America* (2003) compellingly described the lack of access to services that are tailored and responsive to the individual needs, preferences, and cultural context of racial and ethnic minority communities. The relative scarcity of providers who can render culturally competent services to these populations and the relative scarcity of providers who are from culturally and linguistically diverse backgrounds constitute workforce issues that contribute to the current disparities in care.

Despite these complexities, it remains clear that recruiting and retaining individuals is of grave concern and a major problem for many of the leaders who are managing local provider organizations and state behavioral health systems. Qualified providers clearly are not available in sufficient numbers in sections of the country and for selected populations, such as children and the elderly. Stability in staffing over time is considered a cornerstone of program and treatment consistency and therapeutic relationships (Connor et al., 2003). High rates of turnover among counselors have been noted to threaten the stability of addiction counseling centers, undermine quality of care, and strain finances due to the costs associated with recruiting, hiring, and training replacements (Knudsen, Johnson, & Roman, 2003).

Better data on recruitment and retention are sorely needed. While that information is being generated, there is simply no time to delay action. The strategic planning process has identified a range of practical strategies to foster improved recruitment and retention and to build a workforce that is more culturally and linguistically diverse. The strategies are outlined here.

Objective 1: Disseminate information and technical assistance in effective recruitment and retention strategies.

Currently, there is no readily accessible source of information that provides descriptions of innovative recruitment and retention strategies or an assessment of the available evidence of their effectiveness. This is true for the field, as well as for specific jobs or roles. Organizations that employ the workforce are largely on their own to devise and test recruitment and retention strategies and are seldom able to formally evaluate the effects of their efforts.

Other sections of this report call for a greatly expanded national research and evaluation agenda on behavioral health workforce issues, including recruitment and retention. The Annapolis Coalition recommends that the proposed National Technical Assistance Structure on workforce issues, discussed under Goal 6, routinely collect, analyze, and summarize information and data on recruitment and retention practices and disseminate this information through print and electronic media and the provision of direct technical assistance. Given that published studies on these critical issues are likely to remain sparse, such a clearinghouse could be potentially effective in identifying innovations in field settings that might not otherwise come to light.

Through this strategy, for example, information could be disseminated on the factors that appear to affect turnover in behavioral health organizations. While the data are weak, the Coalition’s initial review of the published literature suggests that there is at least some evidence that the variables listed in 8.1 affect turnover. Therefore, there is merit in identifying interventions that have a positive impact on these variables.

Table 8.1: Potential Factors Related to Turnover

Salary & Benefits:

- Advancement potential
- Salary (level, satisfaction, increases)
- Use of tuition reimbursement programs

Job Characteristics:

- Job and role clarity
- Professional challenge
- Level of autonomy
- Input into decisions
- Level of flexibility
- Workload and work demands
- Level of job stress
- Level of administrative support
- Adequacy of orientation and staff training

Work environment:

- Physical work environment
- Quality of relationships with coworkers
- Competent and cohesive coworkers
- Culturally sensitive staff
- Support for creativity
- Support from supervisors & coworkers
- Opportunities for professional development

Rewards:

- Positive performance evaluations
- Promotions
- Performance-based rewards

Objective 2: Select, implement, and evaluate recruitment and retention strategies tailored to the unique needs of each behavioral health organization.

Recruitment and retention strategies must be tailored to the unique needs of a profession, a geographic area, or a behavioral health organization. As will be discussed in the section of this report on infrastructure, it is essential that each organization implement a data-driven continuous quality improvement process focused on workforce issues. The unique recruitment and retention needs of each organization would be identified, strategies to address those needs would be selected and implemented, and the outcome of those actions would inform efforts to continually refine the interventions and strengthen the workforce within that organization.

Objective 3: Expand federal financial incentives, such as training stipends, tuition assistance, and loan forgiveness, to increase recruitment and retention.

There is a long-standing tradition of using federal and state financial incentives as a mechanism to increase the recruitment to and retention of professionals in the behavioral health field. Unfortunately, these incentives have been reduced dramatically over the last several decades. In mental health, for example, federal support for professional training rose to an annual high of \$117 million in 1972, but has fallen to a current level of just \$1 million per year. Evaluation data generated by staff of the National Institute of Mental Health (NIMH) demonstrated that the majority of professionals supported by these training funds subsequently joined the workforce in the nation's public mental health sector (NIMH, 1994). These findings provide evidence of the value of a federal investment in generating a workforce to meet the nation's behavioral health needs.

Federal financial incentives have been used to support recruitment in the field of addictions and to encourage professionals-in-training to focus on selected populations, such as persons with severe mental illness. Many states also have funded professional training through grants and contracts to academic programs or through tuition assistance to state employees interested in pursuing an advanced degree. However, this type of support has also been in decline due to budget constraints within the states. While the costs of this approach are self-evident, the use of incentives to recruit individuals into the behavioral health field has proven its utility and stands as a ready tool for addressing workforce needs. An increased federal and state commitment to such incentives would serve to strengthen the workforce significantly.

A prime example of federal financial incentives exists in the area of minority recruitment. Since their inception in the 1970s, minority fellowship programs offered through the American Psychiatric

Association, the American Psychological Association, the American Nurses Association, and the Council on Social Work Education (CSWE) have provided graduate- and post-graduate-level training and educational opportunities that directly address recruitment and retention. From one vantage point, the desired impact of these programs is to decrease the disparities found in the provision of mental health and addiction prevention and treatment services to ethnic and racial minority communities by attracting and retaining individuals capable of and committed to providing culturally and linguistically competent care. During the last 3 decades, these programs have jointly graduated more than 1,000 mental health and addiction professionals, with approximately 80% of these individuals reporting employment in public or private nonprofit settings (Francis, Jones, Phillips, & Serlin, 2003). To further assess the effectiveness of its initiative, the American Psychological Association's Minority Fellowship Program is undergoing a formal evaluation. While better data are needed to understand the impact of these programs, it appears that they have led to greater diversity within the workforce.

The Loan Repayment Programs (LRPs) of the National Institutes of Health (NIH) and the National Health Services Corps (NHSC) also have had a role in efforts to recruit and retain culturally competent professionals. The NIH LRP repays qualified educational debt through five possible components, with two specifically targeting health disparities research. The goal of these components is to retain qualified doctoral-level professionals in the pursuit of health disparities research that includes clinical and service-oriented study with ethnic and racial minority populations. From 2002 to 2005, the NIH LRP granted 571 awards through its health disparities components; the program currently is undergoing an early-stage evaluation of its effectiveness. The NHSC LRP uses a similar format to the NIH LRP, but targets health care professionals, including mental health care clinicians, committed to providing care to underserved populations in approved sites designated as health professional shortage areas.

Due to rapid increases in the populations of ethnic and racial minorities, there is a workforce shortage of catastrophic proportions. Although fellowship and loan repayment programs targeting graduate and postgraduate training appear promising, additional funding is necessary to recruit and retain a "critical mass" of culturally competent professionals. In addition, there is a need to target students at the postsecondary and undergraduate levels through initiatives such as mentoring and paid internships. While it is expected that the opportunities gained from early exposure and experiences will result in a broader pool of potential candidates, it is imperative that the outcome of the proposed incentives be rigorously evaluated to assess for long-term impact.

Objective 4: Provide wages and benefits commensurate with education, experience, and levels of responsibility.

Throughout the planning process, concerns repeatedly were expressed that salaries and benefits too often are inadequate to recruit or retain individuals in positions within service organizations. Experts and leaders in the substance use disorders field and managers of nonprofit mental health organizations raised this issue repeatedly. While the data on this issue, like so many others, are less than adequate, the comments suggest that compensation is a significant factor that affects turnover, particularly among workers in the lowest paid positions within the field.

Providing compensation that is commensurate with the level of education, experience, and responsibility of the employee is not only a matter of equity, but also is essential if the field is to recruit and retain a qualified workforce. However, determining fair and reasonable compensation is a complex issue. There is a reservoir of expertise on issues of employment, wages, and benefits within federal and state departments of labor. As a first step, the Annapolis Coalition recommends that SAMHSA and state behavioral health agencies establish working partnerships with departments of labor and draw on their expertise to develop information on state and local labor markets, compensation levels that constitute a “living” wage, and benchmarks on wages and benefits by level of education, experience, and job responsibility.

This, of course, is only a first step. The data would have to be used to inform decisions regarding service funding and reimbursement levels by states and insurers so that appropriate levels of staff compensation are feasible within behavioral health organizations. These organizations similarly would have to use the data to inform their internal decisions about wages and benefits.

Objective 5: Implement a comprehensive public relations campaign to promote behavioral health as a career choice.

Several times during the course of this planning process, members of the Coalition were handed draft versions of recruitment flyers describing the benefits of working in the behavioral health field. These homegrown and rather crude documents, generated on a desktop printer, are a testament to the perception held by many in the field that a well-honed message and basic communication tools are needed to generate interest in behavioral health career options and employment.

In the field of general nursing, where recruitment and retention have been daunting problems, the Johnson & Johnson Foundation launched a *Discover Nursing* campaign (www.discovernursing.com) to

market the profession. The Annapolis Coalition recommends that a professional marketing firm be engaged to develop a formal marketing campaign in behavioral health following a somewhat similar model. The campaign would identify target audiences, craft key messages, and develop toolkits with strategies, messaging, and marketing materials that could be provided to local organizations at no cost. The marketing campaign would be implemented at a national, state, and local level.

A Web portal should be established around workforce issues in behavioral health. The portal should be designed to meet the needs of a range of individuals and organizations, including prospective students and employees, as well as employers. The Web site should directly facilitate job postings and placements or link to other sites that are equipped to handle such functions. The *Discover Nursing* Web site and a recent site launched by the Mental Health Workforce and Education Exchange (<http://www.mhwee.org>) are two excellent examples on which a national behavioral health Web site could be modeled.

Objective 6: Develop career ladders.

A critical impediment to retention in the field involves the missing rungs in career ladders. The ladder is the system of educational and certification or licensure steps that an individual takes to move up in a profession or in the field. When an educational or certification step is missing it may be difficult for an individual to advance. This is typically a problem for those who enter direct care positions without a college degree and perhaps without any formal training in behavioral health.

Several states are addressing the career ladder issue by creating partnerships between the behavioral health and educational systems within their borders. The Annapolis Coalition recommends this strategy for all states in order to address career advancement and other workforce needs. The Alaska Behavioral Health Workforce Initiative (Western Interstate Commission for Higher Education, 2004) is a model of such collaboration. Public behavioral health, public education, tribal governments, and a foundation have been working together to identify and address the gaps in Alaska's behavioral health career ladder. Actions have included creating distance-education programs accessible to residents of remote areas of the state and establishing a bachelor's-level social work program and a doctoral program in clinical psychology within the University of Alaska system. Efforts are underway to strengthen the ladder through expanded certification options as well. Certification and licensure are important complements to additional education because they are usually associated with eligibility for reimbursement or increased levels of reimbursement.

Objective 7: Expand the use of “grow-your-own” recruitment and retention strategies focused on residents of rural areas, culturally diverse populations, and consumers and families.

In addition to national efforts to bolster recruitment and retention initiatives within the behavioral health field, the Coalition recommends that state and local organizations implement “grow-your-own” strategies to recruit and develop a diverse staff. The goal is to design, implement, and evaluate recruitment and retention initiatives that foster the entry of priority populations into the behavioral health field, including residents of rural areas, culturally diverse populations, and consumers and family members.

In selected geographic areas, grow-your-own strategies have been implemented to address the lack of culturally diverse individuals, persons in recovery, and family members in the workforce. These strategies increasingly are being used in response to the failure of efforts to recruit, train, and retain professionals in rural communities.

Because these initiatives are not widely known, it is recommended as a first step that technical assistance materials on grow-your-own strategies be developed and broadly disseminated to foster their adoption in other locations. Specifically, efforts should be made to identify and assemble descriptive information, review evidence of effectiveness, and disseminate this information via printed materials, Web-based media, and through the direct provision of technical assistance.

Models and lessons learned may also be drawn from efforts to train community health workers; a practice which has also shown promise in the provision of care to Hispanic and rural communities in the United States. Community health workers are local residents who are trained in a variety of tasks, including conducting or performing outreach, basic health care, health promotion groups, and interpretive services (Brach & Fraserirector, 2000; DHHS, 2001b). The use of community health workers has helped to bridge the divide that often exists between patient and caregiver as a result of cultural and linguistic barriers.

Sustaining the training of entry-level workers will require additional strategies. These include mentoring, in-service training, additional education, tuition assistance, loan forgiveness, and apprenticeship opportunities. These supports increase the probability that entry-level workers will be able to progress up the career ladder.

Objective 8: Increase the cultural and linguistic competence of the behavioral health workforce.

Culturally competent care involves “the delivery of services that are responsive to the cultural concerns of racial and ethnic minority groups, including their language, histories, traditions, beliefs, and values”

(DHHS, 2001a; as cited in the President's New Freedom Commission on Mental Health Report, 2003). In order to provide culturally and linguistically competent services, however, it is not enough to increase the number of individuals in the workforce who are representative of underserved groups. Definitive action must be taken to emphasize the cultural competence of the entire workforce. As stated by the IOM, "It is the right thing to do...the smart thing to do" (IOM, 2001).

Innovation is occurring on this agenda at various levels across the country. The Annapolis Coalition recommends implementation of a concept outlined in the final report of the *National Standards for Culturally and Linguistically Appropriate Services in Health Care* (CLAS; DHHS, 2001b), which called for an Internet-based national clearinghouse and dissemination center on culturally competent practice. This entity would facilitate broad distribution of a variety of resources, including: standards, such as those detailed in the CLAS report; assessment tools, such as the *DSM-IV-TR* Outline for Cultural Formulation (American Psychiatric Association, 2000); and model training strategies and programs.

Responsibility rests largely with academic and training organizations, service providers, and professional and trade associations to implement strategies designed to promote the cultural competence of the workforce. A range of training programs at the undergraduate, graduate, and postgraduate levels has been implemented and shown promise. For example, Our Lady of the Lake University in Texas has developed two exemplary programs designed to increase the cultural and linguistic competence of professionals providing services to Spanish-speaking populations. One program is Communicative and Cultural Competency for Mental Health Providers and the other is a certificate in Psychological Services for Spanish Speaking Populations, which is offered to students seeking master's and doctoral degrees in psychology (<http://www.ollusa.edu/academic/secs/psychology>).

The training approaches that have been used to build cultural competence have been quite varied. They include diversity courses, practicum placements, externships, and internships that provide unique mentoring, supervision, and direct clinical experiences with racial and ethnic minority populations (Castellanos, Gloria, & Kamimura, 2006). Other recruitment and retention techniques merit attention because they are used by graduate programs that the American Psychological Association has designated as "exemplary." The techniques include increased financial aid, organizational links with historical institutions of color, involvement of existing minority faculty and minority students in recruitment efforts, establishing a critical mass of students of color, and having opportunities for students to engage in research on diversity issues with faculty (Rogers & Molina, 2006).

Moreover, the professional development of culturally diverse faculty at the undergraduate and graduate levels demands increased attention. The Annapolis Coalition recommends increased funding for faculty professional development initiatives, such as teaching institutes, consultation on curriculum, travel

support to attend conferences, awards, and financial support for participation in multicultural activities (Rogers & Molina, 2006). It is anticipated that such concentrated efforts in recruiting and retaining a critical mass of culturally competent faculty to serve as mentors and role models will result in a skilled workforce of students who not only are interested in providing culturally and linguistically sensitive behavioral health services, but who also are well prepared to do so.

For individuals who are not fluent in English, interpreters have an important role in service delivery. Communication with people who do not speak English well occurs through on-site professional interpreters, off-site interpreters accessed telephonically, staff members in nontreatment roles who are pressed into service as interpreters, and friends and family who often serve this function. To address the many substantial concerns about the competence of interpreters, the Annapolis Coalition supports the CLAS recommendations to develop national standards for the training, skills assessment, certification, and codes of ethics for interpreters. The recommendations call further for federal, state, and private insurance entities to examine how best to structure reimbursement for interpretative services to ensure that it is adequate to make competent interpretive services readily accessible.

Consistent with the CLAS recommendations (DHHS, 2001b), a further recruitment source is foreign-trained professionals. Large numbers of foreign-trained behavioral health professionals living in the United States are unable to practice within their field of specialty due to credentialing restrictions. Exploring this untapped resource has the potential to increase the critical mass of culturally and linguistically competent professionals available to provide services to underserved populations and to meet the needs of all populations in workforce shortage areas.

In addition to interventions targeted to the groups described above, specific strategies must be implemented to enhance the overall core cultural competence of the entire workforce. Training in cultural competence must move beyond single-session, didactic presentations to sustained efforts at developing competence through ongoing education, combined with supervision and mentoring on culturally relevant practice. Funding should also be made available to provide financial incentives or rewards for special workforce skills, such as fluency in multiple languages.

Conclusion

The vast majority of behavioral health expenditures are related to labor and are estimated to be as high as 80% to 85% in community mental health settings (Blankertz & Robinson, 1997a). Thus, recruiting and retaining staff is a major activity in behavioral health organizations, and one that has become of

paramount concern in many sectors of the field over the past decade. As a field, it is imperative to develop and disseminate a body of knowledge about effective recruitment and retention practices and to implement those practices that are designed to meet the specific needs of each behavioral health organization.

Federal and state financial incentives should be created or restored to encourage individuals to choose behavior health as a career, with a special focus on engaging persons in recovery and their families, persons of color, and residents of rural America. Partnerships should be forged across the country with the federal and state departments of labor to promote compensation commensurate with education, experience, and levels of responsibility.

A comprehensive marketing campaign focused on behavioral health careers should be initiated. Career ladders should be strengthened in each state, and grow-your-own strategies should be adopted to recruit individuals into entry-level positions on the career ladder. These and other strategies require attention to ensure that the workforce and its teachers become more culturally diverse and that the entire workforce develops greater levels of cultural competence.

Table 8.2: Objectives & Actions for Goal 3

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

Objective 1: Disseminate information and technical assistance in effective recruitment and retention strategies.

Action 1: Collect, analyze, and summarize descriptive information and outcome data on recruitment and retention strategies on a routine basis.

Action 2: Provide information and technical assistance in recruitment and retention to behavioral health organizations.

Objective 2: Select, implement, and evaluate recruitment and retention strategies tailored to the unique needs of each behavioral health organization.

Action 1: Identify the recruitment and retention needs of each behavioral health organization.

Action 2: Implement and evaluate interventions designed to address the unique recruitment and retention needs of each organization.

Objective 3: Expand financial incentives, such as training stipends, tuition assistance, and loan forgiveness, to increase recruitment and retention.

Action 1: Convene an expert panel to propose the funding sources, priority areas, and target recipients of increased federal and state financial incentives.

Action 2: Increase federal financial and state incentives and evaluate their effectiveness.

Objective 4: Provide wages and benefits commensurate with education, experience, and levels of responsibility.

Action 1: Develop partnerships with state and federal departments of labor in employment, wage, and benefit issues.

Action 2: Use data generated through collaborations with departments of labor to adjust wages and benefits.

Objective 5: Implement a comprehensive public relations campaign to promote behavioral health as a career choice.

Action 1: Engage a national marketing firm to develop the campaign.

Action 2: Develop and implement comprehensive marketing campaigns at the national, state, and local levels.

Action 3: Create a Web portal that is a comprehensive resource for people recruiting for or seeking positions and careers in behavioral health.

Objective 6: Develop career ladders.

Action 1: Conduct a review of career pathways through educational, certification, and licensing systems.

Action 2: Develop additional curricula, training programs, and certification or licensure procedures to address gaps in the career ladders.

Objective 7: Expand the use of “grow-your-own” recruitment and retention strategies focused on residents of rural areas, culturally diverse populations, and consumers and families.

Action 1: Develop and distribute technical assistance in existing initiatives to recruit these priority populations into entry-level positions and foster their continued professional development through a career ladder.

Action 2: Increase the use of this recruitment and retention strategy with these priority populations.

Objective 8: Increase the cultural and linguistic competence of the behavioral health workforce.

Action 1: Initiate broad dissemination of standards and tools for culturally competent practice.

Action 2: Increase the cultural competence of interpreters used in delivering services through the development of standards, training models, and reimbursement strategies.

Action 3: Create workplace environments that are conducive to a diverse workforce.

Action 4: Expand the pipeline of culturally and linguistically competent professionals who are entering the behavioral health field.

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CHAPTER 9

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

Throughout this planning process, all types of stakeholders expressed major concerns about the nature of training and education currently offered to the workforce. In virtually every setting in which the Coalition sought input for the Action Plan, three themes resounded: the content of current training and education offerings often is not relevant to contemporary practice; teaching methods are ineffective in changing the actual practice patterns of the workers being trained; and access to training and education is often quite limited, particularly in rural communities and for culturally diverse populations. The concerns applied to preservice professional training, the initial training offered to direct care paraprofessional staff, and the continuing education of all members of the workforce. The concerns were not specific to a particular sector of the field or discipline, but were described as generally applicable to the field as a whole. There also were many concerns about the absence of educational supports for persons in recovery, children, youth, and families. These issues have been addressed explicitly under Goal 1 (Chapter 6) and are not repeated below.

National Concerns about Health Professions Education

Concerns about the current state of education and training are not peculiar to behavioral health. Nationally, there has been widespread unease about the education of the general health care workforce. The IOM, in its seminal report *Crossing the Quality Chasm* (IOM, 2001), noted the dramatic changes in service delivery in the United States that require new skills among those working in delivery systems. The changes include the shift in emphasis from acute care to chronic care, the rapidly expanding evidence base, the increasing use of team-based and other complex service delivery structures, and more collaborative patient-clinician relationships. The report further noted that the basic approach to health care education has not been revamped since 1910 in response to the issuance of the Flexner Report on medical education (Flexner, 1910). The static nature of health care education is of major concern to medical school deans, three quarters of whom acknowledge that fundamental change in the current approach to medical education is required.

To stimulate needed reforms, the IOM subsequently convened a committee and a national, multidisciplinary summit on education. The final report from this process, titled *Health Professions Education: A Bridge to Quality* (IOM, 2003), offered a vision for workforce education to support 21st century health care systems:

All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics. (p. 3).

The authors of the IOM report argued for a training focus on the five core competencies that are embedded in this vision. They suggested that change within educational systems be leveraged by working with the oversight organizations that accredit, certify, and license training programs, service programs, and individual practitioners.

Issues Surrounding Behavioral Health Education & Training

Graduate education has been the cornerstone of professional workforce development in mental health and, increasingly, in the addictions sector. There is a strong foundation to graduate education, derived from nearly a century of educational experience. However, there is a widely held perception that graduate training has not kept pace with recent changes in the field, producing a “training gap” (Borus, 1994; Brooks & Riley, 1996; Feldman & Goldman, 1997; Hoge, 2002; Hoge, Jacobs & Belitsky, 2000; Hoge, Jacobs, Belitsky, & Migdole, 2002; Lewis & Blotcky, 1993; Meyer & McLaughlin, 1998; Morris & Hanley, 2001; Raskin & Blome, 1998; Sabin, 1991; Sabin & Borus, 1992; Strom-Gottfried, 1997; Stuart, 2001).

Despite the fact that most graduate training occurs in academic settings, it is ironic that this training often is inadequately grounded in the scientific evidence base regarding prevention and treatment. Evidence-based practice is the conscientious, explicit, and judicious use of the best evidence gained from systematic research for the purpose of making informed decisions about the care of individuals (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). It blends a practitioner's clinical expertise with the best available research evidence. It is also a method of self-directed, career-long learning in which the clinician continually seeks the best possible health outcomes and implements effective interventions based on the most current research evidence. Such evidence reflects verifiable, replicable facts and relationships that have been exposed to stringent scientific criteria. This research has less potential for bias than other bases for practice, in particular, the traditional “that’s how we’ve always done it” basis for practice.

It is important to remember, however, that not all clinical practice is based on science. Many aspects will not or cannot be adequately tested empirically. Furthermore, clinical acumen or intuition is important, particularly with respect to certain clinical situations in which scientific inquiry may be unable to give clear guidance on the variables related to clinical decisions. In these cases, the judgment developed from experience is even more essential. Finally, new ways of thinking take the field beyond evidence-based practice. It has been suggested that there is evidence-supported, evidence-informed, and evidence-suggested practice, as well as evidence-based practice.

The explosion of knowledge in the field makes it difficult for educational programs to remain current. The gap in knowledge and practice is exacerbated by the slow evolution of curricula in academia and the reluctance in many professional programs to train students in evidence-based or empirically validated treatments (Crits-Christoph, Chambless, Frank, Brody, & Karp, 1995). For example, a recent survey by Weissman and colleagues found that 67% of doctoral-level clinical psychology programs and 62% of social work programs did not require didactic and clinical supervision in any evidence-based psychotherapy (Weissman et al., in press). Similarly, practice guidelines, which draw on expert opinion to translate the evidence base into practical recommendations regarding treatment options, appear not to be used or taught widely in course work, supervision, and clinical placements (Yager, Zarin, Pincus & McIntyre, 1997).

Graduate programs have been slow to respond to numerous critical trends in practice, such as shared decision-making with persons in recovery, youth, and families; prevention, rehabilitation, and resilience- and recovery-oriented approaches to care; peer support; outreach; home-based services; systems of care, managed care; and patient safety. Training continues to be conducted in disciplinary silos, despite the fact that there is an emphasis in the field on interdisciplinary team-based practice, a substantive literature on inter-professional education, and historical attempts to promote interprofessional collaboration (American Psychological Association Office of Rural Health, 1995; Casto & Julia, 1994; Richards, 1996; Zlotnik et al., 1999). Perhaps most distressing is that among graduate programs focused principally on mental health, few are providing adequate training on substance use and co-occurring disorders, despite the overwhelming evidence of the prevalence of these conditions and the frequency with which individuals with such conditions seek help from mental health practitioners (Harwood, Kowalski, & Ameen, 2004).

As a consequence of the slow response of academia to the changing health care environment, the leaders of provider organizations that employ the workforce almost universally view new graduates as ill prepared for critical aspects of practice (Blumenthal, Gokhale Campbell, & Weissman, 2001; Shueman &

Shore, 1997). This makes the transition from training to practice particularly difficult for the new graduate and the employer (Gabbard, 1992), with an estimated 2 years of post training experience required to develop the requisite knowledge and skills (Blumenthal & Their, 1996).

There are many dedicated faculty in academic settings, but it is important to note that they are seldom rewarded for excellence in teaching and frequently are not even compensated for their educational activities. Many faculty report feeling constrained by the discipline-based training accreditation standards, which are slow to evolve and tend to be highly prescriptive in the areas of training content and required training experiences. Faculty efforts at reform are further hampered because training is often embedded in complex and highly bureaucratic university and health system settings, which also are slow to change. Support and development of faculty and educators remain critical areas of need if workforce development in the behavioral health field is to advance. The work on interdisciplinary faculty development in addictions through Project Mainstream, administered by the Association for Medical Education and Research in Substance Abuse (AMERSA at <http://www.amersa.org>) and supported by the Health Research and Services Administration (HRSA) and CSAT, is one exceptional model that should be studied and emulated by other sectors of the field (Haack & Adger, 2002).

Beyond the many issues surrounding graduate education and faculty development are other daunting training problems in behavioral health. Large portions of the direct care workforce are not graduate-level prepared, and yet these workers receive little substantive orientation or training about behavioral health problems and their treatment. Of further concern is that continuing education for all segments of the workforce tends to rely on single-session, didactic approaches which have proven ineffective in changing workforce practice patterns. Finally, the positive effects of training too often are thwarted when the environment in which the trainee works fails to support or perhaps even hinders the use of newly learned skills. Each of these critical issues is addressed in the context of a series of objectives and actions designed to strengthen workforce training and education.

Objective 1: Identify core competencies and focused competencies for behavioral health practice.

Competency identification, development, and assessment are getting increasing attention in all areas of health care, including behavioral health. This trend is driven by the compelling notion that, for a field to advance, there must be more precision in specifying the optimal attitudes, knowledge, and skills of the workforce. Once those competencies have been identified, the objective is to build them into the workforce and to demonstrate, using various assessment strategies, that the competencies have been acquired by individual health care providers.

In May of 2004, the Annapolis Coalition convened an expert panel on competencies as a national consensus conference (Hoge, Morris, & Paris, 2005). Experts who were developing competencies in 13 sectors of the behavioral health field met to report on their work and to learn from each other (Hoge, Paris et al., 2005). It became clear that many initiatives were underway to identify competencies and to develop comprehensive competency models and assessment strategies. It was also clear, however, that the initiatives largely were occurring in isolation, without benefit of the knowledge of competencies emerging in other disciplines or sectors of the field. For example, an extensive planning process on competency identification in one discipline reportedly occurred without any discussion of competencies being developed related to recovery- and resilience-oriented practice.

Recommendations from the consensus conference included a call for the establishment of a Competency Collaborative that would link multiple groups and organizations developing behavioral health competencies. Each group would retain independence in its work, but substantial benefits and efficiencies would accrue from the collaboration with other groups. As outlined in the conference recommendations, members of the proposed collaborative could be linked electronically and through periodic meetings to accomplish the following tasks:

- Share information regarding ongoing efforts to develop and employ competency models and to assess competence;
- assemble key resources on competency development and assessment and make these readily accessible to individual and organizational members of the collaborative;
- identify common, core, or cross-cutting competencies and competency domains;
- consider cooperative endeavors to develop and implement core competency models and assessment strategies or to jointly acquire technical assistance;
- review the relevance of competencies identified by one sector of the field (e.g., substance use disorders) for other groups and organizations that are developing competency models;
- identify areas where new competencies are needed, such as those related to patient advocacy, working in interdisciplinary teams, and informatics;
- cross-walk existing and emerging competency models to promote further development of competencies for treating individuals with co-occurring mental illnesses and substance use disorders;
- identify and disseminate case examples of successful efforts to identify and assess competencies; and
- communicate collectively and formally with professional associations, state departments of health, accrediting organizations, and other relevant bodies to inform them of available

competency models, and promote the adoption of these competencies in training, certification, and licensing processes.

(p. 660; Hoge, Morris, Daniels, et al., 2005)

One of the greatest frustrations among the experts who are developing competencies is the slow adoption of this work in training programs. The proposed Competency Collaborative could serve a critical dissemination function as its members worked together to leverage more rapid adoption of competencies and competency assessment. The collaborative also could provide faculty development in the integration of these competencies in curricula and clinical training programs. Finally, the collaborative could develop consensus standards for evaluating competency models and competency assessment procedures both on rigor and relevance to contemporary practice.

The substance use disorders treatment field has pioneered work on core competencies for addiction counseling through the development of Technical Assistance Publication (TAP) Series 21 (DHHS, 1998). This work has been extraordinarily well received, translated into multiple languages, and adopted as a focus of training and certification in numerous countries around the world. In contrast, a widely recognized set of core competencies for mental health practice simply does not exist. While many of the mental health professions are developing their own competencies, there are many high-school-, associate's-, or bachelor's-degreed members of the workforce for whom a well-developed competency model is not available and for whom competency-based training is seldom provided.

The Annapolis Coalition strongly recommends that a set of core competencies for mental health practice be developed. Senior advisors to the Coalition on substance use disorders recommended that this effort use the TAP 21 addiction counseling competencies as a base of departure. The work could be further informed by competencies sponsored by the Center for Mental Health Services (CMHS) for practice in managed care environments (e.g., Coursey et al., 2000a; Coursey et al., 2000b; <http://www.uphs.upenn.edu/cmhpsr/cmhs>) and by the training models developed by organizations such as the Center for Psychiatric Rehabilitation at Boston University (<http://www.bu.edu/cpr>). The core competencies should include basic skills related to the assessment and treatment of substance use disorders and co-occurring mental and addictive disorders.

Some efforts have been made to develop specialty competencies related to the care of children and adolescents, older persons, and other populations and specialty sectors (Hoge, Paris, et al., 2005). The locus of continued activity on competency development in these areas must be identified and adequate funding must be provided to support the continued work. In addition, concerted, systematic attention is needed to ensure that competencies are developed in such specific and critical practices as: person-

centered planning; culturally competent care; development of therapeutic alliances; shared decision-making; prevention, routine use of evidence-based practices; recovery- and resiliency-oriented care; rehabilitation; interdisciplinary and team-based practice; advocacy, use of informatics; and continuous quality improvement.

Objective 2: Develop and implement competency-based curricula.

An obvious corollary to the development of the competencies is to design and implement curricula that are competency based. One area of urgent need is to develop a competency-based, portable curriculum for entry-level, direct care staff in settings where individuals with mental illnesses and co-occurring mental and addictive disorders receive services. Despite the fact that these staff members are often the primary caregivers in many publicly funded programs, it appears that, across the nation, they receive little substantive training. To the extent that states and provider organizations are attempting to educate this critical segment of the workforce, they appear to be cobbling together homegrown curricula and relying on brief didactic orientation programs that are highly unlikely to build competency in core skill areas.

The Annapolis Coalition recommends that a panel of experts be convened to guide the development of competency-based curriculum for this segment of the workforce. The curriculum should be field-tested, finalized, and made broadly available to states and service organizations at low cost or no cost. While core competencies are more developed in the addiction sector of the field (DHHS, 1998), existing curricula based on those competencies similarly should be identified, reviewed, strengthened if necessary, and broadly disseminated.

The locus of competency-based curriculum development in all specialty sectors of the field needs to be identified, and efforts to do so should be supported and advanced. The field lacks a set of consensus standards for evaluating the quality of curricula, and the proposed Competency Collaborative would be capable of developing such standards, in consultation with other groups and organizations. Most critically, education and training program administrators must speed the process of curriculum reform by reviewing and updating their curricula biannually. To create transparency in this process, the Coalition recommends that all education and training program administrators evaluate the relevance and effectiveness of their curricula and make these assessments available to prospective and current students, persons in recovery, youth, family members, advocates, and the general public.

Objective 3: Adopt evidence-based training methods that have been demonstrated as effective through research.

It is common to discuss the evidence base for prevention and treatment interventions, but the field has paid less attention to the evidence base for teaching methods. There is a solid evidence base in medicine regarding effective and ineffective teaching and skill development approaches (Davis et al., 1999). The core finding in this literature is that didactic, single-session, noninteractive teaching approaches may increase knowledge, but are ineffective in building skills among trainees (Mazmanian & Davis, 2002). Unfortunately, it is the didactic, single-session approach that predominates in continuing education and is quite prominent in preservice education as well. Thus, enormous amounts of training time and resources likely are being squandered. The data on this issue are so consistent that Davis and his colleagues (1999) concluded that continuing education credit should probably not be offered for most continuing education events.

There is a growing body of evidence on effective teaching practices that produce behavior changes among learners (Stuart, Tondora, & Hoge, 2004). To be effective in building skills, it is necessary to combine multiple teaching strategies as there is no single “magic bullet” (Oxman, Thomson O’Brien, Davis, & Haynes, 1995). Strategies that have proven effective are: interactive approaches; sequenced, longitudinal learning experiences; outreach visits, known as academic detailing; auditing of practice with feedback to the learner; reminders; the use of opinion leaders to influence practice; and patient-mediated interventions, such as providing information on treatment options to persons in recovery, which in turn influences the practice patterns of their providers (Borgiel et al., 1999; Davis et al., 1999; Soumerai, 1998; Thomson O’Brien et al., 2003).

The evidence on effective teaching strategies is evolving rapidly and it is imperative that this knowledge base have an impact on current training practices. This will require focused faculty development initiatives. To achieve this objective within behavioral health, the Annapolis Coalition recommends that an expert, multidisciplinary panel of educators be convened to review, summarize, and disseminate the evidence on effective teaching approaches. The panel, with assistance from the proposed National Technical Assistance Structure, should also develop an evaluation tool for use by training and education organizations to conduct self-assessments of their teaching practices. The results of these evaluations should be made available to the public, just as the self-evaluations of curricula are. Because educational practices are largely driven by accreditation standards and processes (IOM, 2003), it is imperative that these standards be modified to require the use of evidence-based teaching approaches in both preservice and continuing education.

Enormous amounts of training resources in behavioral health are invested in conferences and meetings, supported by state and federal resources or financed as fee-based continuing education events. Given the research findings on effective teaching and learning strategies, there is little reason to believe that the conference model leads individual participants to change their practice patterns or other professional behaviors. Furthermore, the noneducational objectives and outcomes of these large meetings often seem unclear.

As a first step in addressing the issue of adapting evidence-based training methods that research has shown to be effective, the Annapolis Coalition recommends that the proposed panel in effective education develop and disseminate technical assistance on alternative conference and meeting models. The organizers of the meetings are responsible for adopting more effective approaches to such gatherings. The funders of such meetings, including federal and state agencies and professional associations, should require the use of effective teaching models and demonstrated outcomes as a condition of financial support.

Objective 4: Use technology to increase access to and the effectiveness of training and education.

Clearly, major advances in the use of technology to support teaching and learning have occurred. A virtual explosion in the use of computer-assisted and Web-based instruction has provided greater access to curricula. Less evident is the effectiveness of these methods in teaching clinical skills. Critical questions remain about the key elements that must accompany technology-assisted instruction, such as supervised experience and mentoring, for these electronic methods of educational delivery to be effective for clinicians.

Given the promise of technology as a vehicle of workforce training and development, the Annapolis Coalition recommends that the evidence-based and best practices in this arena be summarized and broadly disseminated to the field. Widespread implementation of these best practices will require funding of demonstration programs as organizations adopt and adapt new technologies to behavioral health. As educators self-assess their use of effective teaching practices, so too should they evaluate whether their technology-assisted teaching approaches are supported by research evidence.

Objective 5: Launch a national initiative to ensure that every member of the behavioral health workforce develops basic competencies in the assessment and treatment of substance use disorders and co-occurring mental and addictive disorders.

Nearly 22 million persons ages 12 and older, totaling 9.4% of the U.S. population, are dependent on or abuse alcohol or illicit drugs. Only 1 person in 10 with a drug use disorder and 1 person in 20 with an alcohol use disorder receive treatment for the condition (Wright, 2004). Furthermore, the prevalence of persons with co-occurring mental and addictive disorders has been on the rise. For example, one study found that 61% of individuals with a severe mental illness had a substance abuse or dependence problem (Jaffee, Comtois, Calsyn & Saxon, 1998).

Individuals with addictive and co-occurring mental and addictive disorders frequently seek help from members of the workforce who are trained as mental health practitioners. Research suggests that, depending on the practice setting, between 20% and 75% of persons seeking services from mental health practitioners have co-occurring disorders (Menezes et al., 1996). One review found that half of all individuals presenting with psychiatric emergencies had a substance abuse problem (McNamara, Schumacher, Milby, Wallace, & Usdan, 2001).

Unfortunately, few mental health professionals are adequately trained to address the needs of persons with substance use disorders or problems. CSAT, in collaboration with six professional associations, created the Practitioner Services Network to study this issue among association members (Harwood, Kowalski, & Ameen, 2004). The findings revealed that in private-practice settings 15% to 25% of clients presented with substance abuse problems, while in treatment facilities, the percentages ranged from 20% to 40%. Despite the prevalence of addiction problems among individuals being served, no more than half of the mental health practitioners surveyed through the Practitioner Services Network had any formal coursework or internship in addiction treatment.

The need to train professionals in the prevention, recognition, assessment, and referral to or basic treatment of persons with substance use disorders is glaring, yet little progress appears to be occurring on this agenda. As an example, a survey of 10 doctoral psychology programs by Aanavi, Taube, Ja, and Duran (1999) found that none required coursework on substance use disorders and that half offered only a single elective course on the topic. In another study, three quarters of social workers surveyed in New England indicated that they had either a moderate, significant, or maximum need for additional training in addictions (Hall, Amodeo, Shaffer, & Vander Bilt, 2000).

The obstacles to educating the mental health workforce in basic addiction-related competencies are complex. They relate to the structures and processes surrounding curriculum development, the accreditation of training and provider programs, and the certification and licensing procedures for providers. To explore and address the many obstacles, the Annapolis Coalition recommends the creation of a Commission on the Adoption of Competencies related to the treatment of substance use disorders and co-occurring mental and addictive disorders. The Commission would bring together the key organizations that govern curricula, accreditation, certification, and licensure to systematically identify and implement strategies to overcome each of the barriers that historically have hindered major progress on this agenda. The Commission would issue an annual report to the nation on the progress made on the agenda. Beyond addressing the urgent need to expand training in addictions, this process would shed light on the dynamics of change necessary to curriculum development, accreditation, certification, and licensure. It would inform future efforts to speed the translation of sciences to services in workforce development activities.

Objective 6: Educate prospective students about best practices in training and education to inform their selection of a training program or training provider.

Students are at a disadvantage as they pursue training because there are currently no tools to assist them in evaluating the quality of competing preservice and continuing education programs. The Annapolis Coalition recommends the creation, field-testing, and broad dissemination to prospective students of a guide that outlines best practices in training and education programs. The objective is to help prospective students choose training programs that have the greatest likelihood of effectively preparing them to enter the workforce with the skills required in the contemporary health care environment. A student “shopping guide” was developed and successfully implemented in primary care medicine by the Partnerships for Quality Education (<http://www.pqe.org>), which is a consortium of academic programs focused on preparing young doctors for community-based practice in a managed care environment. Helping students to become informed “purchasers” of training and education has the potential to leverage change and relevance more rapidly within behavioral health training systems.

Objective 7: Identify and implement strategies to support and sustain the use of newly acquired skills in practice settings.

There is evidence that an effectively trained provider will fail to use newly acquired skills if he or she returns to a work environment where the new skills are not understood and actively supported. Building skills and changing practice involves a combination of training and environmental change. Without attention to the work environment, training efforts will be undermined. As Geary Rummier, an expert in

human performance, has so cogently stated, “When you pit a bad system against a good performer, the system almost always wins” (Rummler, 2004).

There is a growing body of knowledge and evidence related to sustaining newly acquired skills, drawn from efforts to implement evidence-based practices (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). The Coalition recommends that experts on the environmental changes required to support new practices be convened to distill and subsequently disseminate this knowledge through the provision of technical assistance to states and organizations that employ the workforce.

Conclusion

Increasing the relevance, effectiveness, and accessibility of training and education are urgent priorities for the field of behavioral health. Achieving reform in current approaches to training and education will be an essential step in improving quality and transforming systems of care.

Continued work on competency identification and assessment will be a foundation for this work, with collaboration among the many groups and organizations that are tackling this issue for specific populations or sectors within the field. Curricula that are competency-based and delivered via instructional techniques that are evidence based are also key elements of needed reform, with greater emphasis on the use of technology to facilitate access to educational materials.

Perhaps most important, it is essential to unpack and address the roadblocks that prevent the timely updating of curricula, training programs, accreditation standards, and certification and licensure processes. These are the key elements and drivers of the education and training system. It is imperative that they become more relevant to prevention and treatment in current health care systems.

[Table 9.1: Objectives & Actions for Goal 4](#)

GOAL 4: Increase the relevance, effectiveness, and accessibility of training and education.
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Objective 1: Identify core competencies and focused competencies for behavioral health practice.

Action 1: Establish a Competency Collaborative that links organizations developing behavioral health competencies and provides technical assistance.

Action 2: Develop a model set of core mental health competencies.

Action 3: Identify and further develop specialty competencies, relevant to specific areas of behavioral health practice.

Action 4: Identify and further develop competencies in critical practices that include (a) person-centered planning, (b) culturally competent care, (c) development of therapeutic alliances, (d) shared decision-making, (e) evidence-based practice, (e) recovery- and resilience-oriented care, (f) rehabilitation, (g) interdisciplinary and team-based practice, (h) advocacy, (i) use of informatics, and (j) continuous quality improvement.

Objective 2: Develop and implement competency-based curricula.

Action 1: Develop model, portable curricula for entry-level, direct care staff based on the core competencies.

Action 2: Develop a set of consensus standards for evaluating curricula on relevance and effectiveness.

Action 3: Identify or further develop competency-based specialized curricula, relevant to specific areas of behavioral health practice.

Action 4: Require training and education organizations routinely to review and update their curricula and conduct self-evaluations using the consensus standards.

Objective 3: Adopt evidence-based training methods that have been demonstrated as effective through research.

Action 1: Identify effective teaching methods through a systematic review of available research.

Action 2: Employ evidence-based teaching methods in training and education organizations.

Action 3: Require (through accreditation standards for preservice and continuing education) the use of evidence-based teaching methods.

Action 4: Identify and adopt conference and meeting models that have demonstrated impact on participant learning and behavior.

Objective 4: Use technology to increase access to and the effectiveness of training and education

Action 1: Provide technical assistance to training and education organizations in best practices in the use of technology for learning.

Action 2: Employ best practices in the use of technology-assisted instruction.

Action 3: Fund demonstration initiatives in technology-assisted instruction.

Objective 5: Launch a national initiative to ensure that every member of the behavioral health workforce develops basic competencies in the assessment and treatment of substance use disorders and co-occurring mental and addictive disorders.

Action 1: Incorporate addiction and co-occurring competencies into all competency models, preservice and continuing education curricula, training accreditation and program accreditation standards, and certification and licensure requirements.

Action 2: Implement or expand training and staff development on the assessment and treatment of substance use disorders and co-occurring mental and addictive disorders throughout preservice and continuing education.

Objective 6: Educate prospective students about best practices in training and education to inform their selection of a training program or training provider.

Action 1: Develop and disseminate a *Guide to Selecting Relevant and Effective Training* designed for prospective students.

Objective 7: Identify and implement strategies to support and sustain the use of newly acquired skills in practice settings.

Action 1: Identify strategies proven to be effective in supporting and sustaining newly acquired skills and behavior change within organizations.

Action 2: Adopt organizational interventions to support and sustain newly acquired skills and measure sustained behavior change within the workforce.

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CHAPTER 10

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

Most efforts to strengthen the workforce center on issues of recruitment, retention, and training. However, it is clear that simply finding, educating, and keeping more individuals to staff prevention and treatment programs, while necessary, is not sufficient to sustain systems of care, let alone transform them. A host of sources and factors has drawn attention to the critical need both for leaders and for leadership development as an explicit agenda in efforts to strengthen the workforce. Just one example is a 2004 report prepared for CSAT by TASC, Inc., titled *Leadership Development in Substance Abuse Treatment and Recovery: Lessons Learned and Future Directions* (TASC, 2004). A clear and compelling case is made regarding the need for urgent attention to the issues surrounding leadership development in the substance abuse field to "...ensure the continuing evolution of leadership and viability of the field in terms of both service quality and sound public policy" (p. 2).

Of immediate concern is the reality that most leaders currently in the behavioral health field are part of the "graying" workforce, nearing retirement. Unfortunately, many of the federally funded training stipends and leadership programs that supported the entry of these individuals into the field and their subsequent professional development no longer exist. In mental health, for example, federal support for professional training stipends peaked in 1972 at an annual total of \$117 million, but now totals only \$1 million per year. Concurrently, the NIMH Staff College, which served as a core leadership development vehicle through which many of today's leaders were trained, was eliminated in 1981.

In the ensuing two-and-a-half decades the need for leadership and the demands on leadership have increased exponentially. The current health care environment has become much more complex due to major changes in financing that have created enormous pressures for efficiency in behavioral health programs and systems. Simultaneously, there have been many new demands to improve services by providing evidenced-based practices, reducing cultural disparities, increasing patient safety, and demonstrating outcomes, among other things. Yet, this changing health care landscape, which has

heightened the need for strong leadership, has at the same time created increased instability in many organizations, undermining their ability to retain and develop the next generation of leaders. For example, a study of substance use disorders treatment organizations by McLellan, Carise, and Kleber (2003) found a 50% turnover within a single year in the directors of the agencies under study.

While it is natural to focus on the need for leadership in treatment organizations, leadership is essential among all key stakeholder groups and sectors of the field if improvements in the equity, efficiency, and effectiveness of behavioral health care are to be achieved. Other relevant groups include educators, prevention specialists, policy makers, and administrators engaged in the certification and licensure of the workforce and in accrediting training and service organizations. Developing and expanding a cadre of leaders among persons in recovery and their family members is particularly critical to achieving transformation of current service systems and models of care.

In common parlance, individuals at the top of an organizational hierarchy are referred to as leaders. But individuals at multiple levels have responsibilities that require leadership skills, including supervisors, team and program directors, and executive or senior managers. Each role involves leadership functions that are essential to the successful operations of an organization or group, whether in prevention or treatment systems, peer-support programs, educational systems, regulatory and oversight organizations, or consumer and family advocacy initiatives.

There are some innovative leadership development efforts underway in substance abuse prevention, substance use disorders treatment, and mental health. A strategic workforce goal for the field is to build a stronger foundation for these efforts through competency and curriculum development, and to substantially expand the organized efforts to develop the next generation of leaders.

Objective 1: Identify leadership competencies tailored to the unique challenges of behavioral health care.

Historically, the prevailing wisdom was that leaders are born, not made. However, recent developments in leadership theory and practice have shifted the emphasis away from the inherent traits and characteristics of leaders to the skills and other attributes that are required for effective leadership. The latter perspective emphasizes the process through which individuals learn and grow into leadership roles over time through education, experience, and support.

During the strategic planning process, it became clear that there is broad recognition in the behavioral health field of the need for expanded leadership development. It is equally clear that there is considerable confusion in the field about the concept of leadership and the competencies that constitute

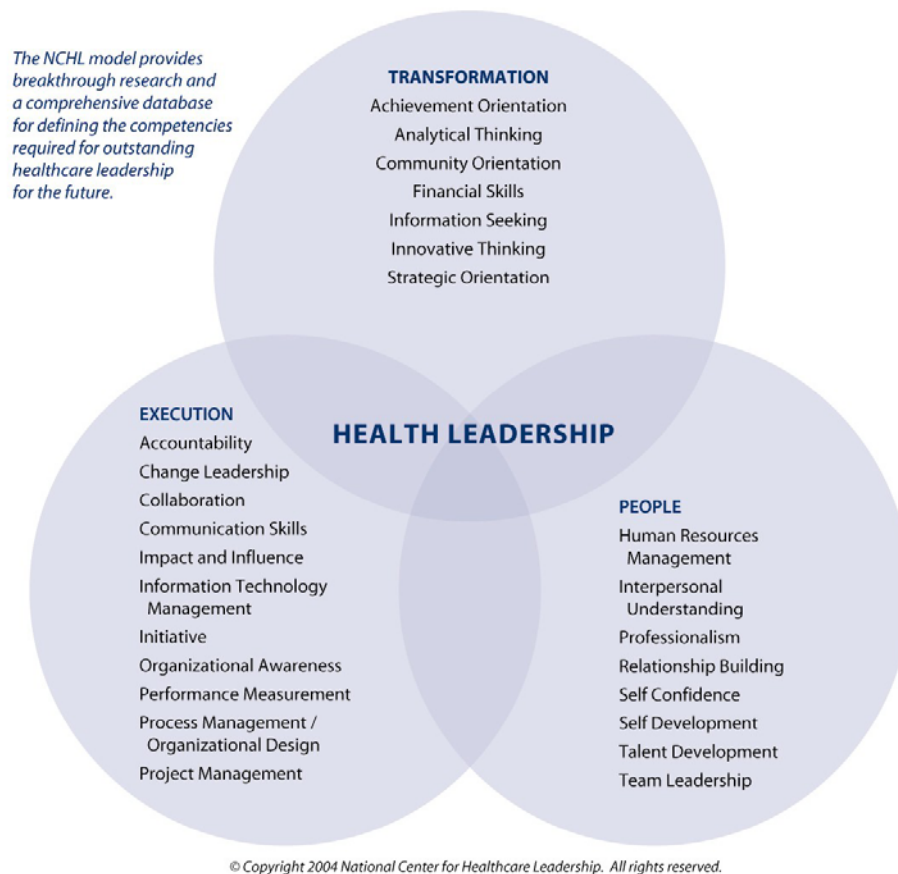
it. The term *leadership*, when used, seems to evoke a very basic and shared meaning. Beyond that, however, there is considerable lack of clarity and difference of opinion about how to define it, the competencies that it requires, and its relevance to different jobs or roles in the workforce. This lack of clarity does not appear to be simply one of semantics. Rather, the ambiguity seems to permeate many leadership development initiatives.

The established approach for defining the optimal attitudes, knowledge, and skills for a role or position involves developing a competency model. The Annapolis Coalition recommends that at least one model be developed that identifies core leadership competencies tailored specifically to the behavioral health field. The first step would be to form an expert panel to identify existing leadership competency models, review any research and evaluation data on their application, and assess their potential relevance to behavioral health. This process would inform the second stage of work, in which a leadership competency model is developed specifically for behavioral health through a process that is data-driven and informed by broad input from the diverse sectors of the field.

As a source of information and a potential partner in this effort, the Coalition calls attention to the National Center for Healthcare Leadership (NCHL at <http://www.nchl.org>). This relatively young and dynamic organization has released the second version of its Health Leadership Competency Model (Figure 10.1). The model is notable in that it is based on empirical investigation of leadership in health care organizations and encompasses many of the concepts found in other theoretical and competency-based models of leadership. NCHL is partnering with many specialties in health care and has emerging collaborations focused on behavioral health.

Figure 10.1

NCHL Health Leadership Competency Model



Becoming a supervisor is arguably the first step in assuming leadership responsibilities in many organizations. Of all the concerns about leadership expressed by key informants of this Action Plan, the erosion in the supervision of services was the most prominent. Increasing financial pressures in behavioral health organizations have, no doubt, restricted the amount of time available to provide and receive supervision. But the absence of competency-based training for new supervisors and support for ongoing skill development for existing supervisors was repeatedly and forcefully presented as one of the most pressing workforce issues facing this field.

Several organizations, such as the American Board of Examiners in Clinical Social Work, have been developing supervision competencies (2004). Perhaps most relevant to public sector practice are the CSAT-sponsored *Competencies for Substance Abuse Treatment Clinical Supervision*, which are under development and expected to be released in 2006. The Annapolis Coalition recommends that both the

core leadership competencies and the CSAT-sponsored supervision competencies be widely disseminated to the field, with recognition that various sectors of the field may choose to tailor these competency models to meet their unique needs.

Objective 2: Identify effective leadership curricula and programs and develop new training resources to address existing gaps.

Large numbers of training resources and programs focus on general organizational leadership; smaller numbers focus on leadership in health care. Even fewer training and development resources focus on the unique challenges of leadership development in behavioral health. For this area of workforce development to gain more attention and momentum, it is important to create and disseminate a readily accessible compendium of available leadership development resources, including the evidence on their effectiveness. This work will serve as a foundation for identifying and subsequently addressing current gaps in the availability of relevant and effective curricula.

At the request of SAMHSA, the National Association of State Mental Health Program Directors Research Institute (NASMHPD RI) in 2005 completed two monographs that provide a comprehensive review and cataloging of leadership development programs and resources within the country's leading business and management schools and other training institutions. These papers provide a great deal of detailed information about curricula and training strategies used outside of the mental health and substance use disorder fields, and are a potential resource in helping to identify effective strategies as well current gaps (Mazade, 2005a; Mazade, 2005b).

To accomplish these objectives, the Coalition recommends the development of a protocol for standardizing descriptions and summarizing the evidence of effectiveness for currently available curricula, training and mentoring programs, leadership collaboratives, and other leadership development initiatives that have relevance to behavioral health care. Surveys of leadership experts and an open call for recommendations could be used to identify and catalogue existing resources, with the resulting summary disseminated through print and electronic media. This compendium of resources would facilitate identification and prioritization of needs for further curricular and program development.

There are substantive and noteworthy leadership initiatives that can inform and serve as a base for expanded efforts in this arena. The National ATTC Network (<http://www.nattc.org>) is now offering Leadership Institutes around the country to assist in the preparation of emerging leaders in the field of substance use disorders treatment. The ATTCs have drawn on the work of The Graduate School at the U.S. Department of Agriculture, which has a well-developed leadership program that entails four phases: assessment, didactic instruction, experiential learning, and recognition.

In addition, there have been several state-based initiatives in leadership development for the addiction field, including the work of the Governor's Institute in North Carolina (<http://www.nc-atod.org>). This private nonprofit organization has had a leadership development program for several years as part of its overall mission to assist health professionals in addressing the problem of substance use disorders. Other noteworthy initiatives include the BACCHUS Network on leadership development in substance abuse prevention (<http://www.bacchusgamma.org>) and the Developing Leadership in Reducing Substance Abuse initiative funded by the Robert Wood Johnson Foundation and based at Portland State University in Oregon (<http://www.developingleadership.org>).

Within the field of mental health, there also are noteworthy initiatives, such as the Ohio Mental Health Executive Leadership Program at Case Western University (<http://www.weatherhead.case.edu/hsmc/>) and the California Institute of Mental Health's Leadership Effectiveness Program, operated in partnership with the University of Southern California (<http://www.cimh.org>). The National Council on Community Behavioral Health (<http://www.nccbh.org>) has placed considerable emphasis on management development through activities such as its Middle Management Academy, hosted over multiple days each year at its annual training conference; the Certified Behavioral Healthcare Executive Program; and other leadership development initiatives. The American College of Mental Health Administration (<http://www.acmha.org>), itself a leadership organization in the field, convened experts on behavioral health leadership development in March of 2005 to plan for the expansion of its leadership initiatives, which include a mentoring program and an emerging collaboration with NCHL in developing a learning network on leadership in behavioral health. Additionally, CMHS convened an expert panel and commissioned a comprehensive review of the concept of "transformational leadership" as a foundation for supporting the New Freedom Commission agenda to transform mental health care.

Objective 3: Increase support for formal, continuous leadership development with current and emerging leaders in all segments of the workforce.

Implementing formal and continuous leadership development is the core objective of this workforce goal. Enhancing leadership in the behavioral health field will entail increasing the resources to support leadership development and allotting time for emerging and existing leaders to participate in the initiatives. It will require organizations to explicitly engage in succession planning at all levels, develop leadership competencies among individuals as they assume new leadership roles, and provide continuing development opportunities to existing leaders to aid them in grappling with the rapidly changing and extraordinarily challenging health care environment.

Service organizations must ensure that supervisors have the skills that are actually necessary to supervise and that supervision is routinely provided for care that is delivered. Mentoring must emerge, both formally and informally, as a routine practice for nurturing the subsequent generations that will lead this field. Recognition, both of a monetary and nonmonetary nature, must accrue to those who step forward to assume leadership responsibilities and demonstrate effectiveness in these roles. Achieving these outcomes will be a collective responsibility of federal and state governments, educators, foundations, and the highly varied organizations which the behavioral health field comprises.

Objective 4: Formally evaluate leadership development programs based on defined criteria and revise based on outcomes.

In fields outside of mental health, there are well-documented studies on the effectiveness of leadership development programs; however, with few exceptions, this type of program evaluation has not occurred in the human services and mental health fields (N. Adams, personal communication with N. A. Mazade, NASMHPD RI, April 14, 2006). Like so many workforce practices identified in this Action Plan, formal evaluation is essential if the goal is to implement and refine interventions that have demonstrated impact. Data-driven continuous quality improvement processes should be adopted by all leadership development programs. Independent outcome evaluations should be conducted, particularly around larger or federally or foundation-supported initiatives that become a major locus of leadership development activities for the public sector. As the body of evidence grows, a compendium of findings should be assembled, routinely updated, and disseminated to support ongoing quality improvement efforts in leadership programs throughout the field.

Conclusion

Implementing best practices requires effective training combined with an organizational environment that supports members of the workforce in using their newly learned skills. Because both of these conditions must be met, the Annapolis Coalition views leadership development as a workforce goal that is potentially transformational in nature. Directing resources toward developing leaders in all sectors of the field and at multiple levels of the workforce will create a cadre of individuals who are positioned to educate the workforce effectively and mold the environment in which it functions, and will support rather than thwart the efforts of the workforce to practice safely, equitably, efficiently, and effectively. Leaders are positioned to address workforce development and organizational development simultaneously, and both are critical elements of reform.

Achieving this goal will require increased precision in leadership development efforts. Competency models tailored to behavioral health must be developed. Existing leadership curricula and training

resources relevant to this goal must be identified, and gaps in training resources must be addressed. It is imperative that leadership development initiatives in the field be greatly expanded and that the number of emerging and current leaders who are participating in the initiatives be increased. At every turn, continuous quality improvement and formal evaluation should be the norm in order to strengthen efforts in the field to develop the next generation of leaders.

Table 10.1: Objectives & Actions for Goal 5

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

Objective 1: Identify leadership competencies tailored to the unique challenges of behavioral health care.

Action 1: Conduct a comprehensive review of available competency models.

Action 2: Develop a leadership core competency model tailored to behavioral health.

Action 3: Finalize development of supervision competencies tailored to behavioral health.

Action 4: Disseminate broadly the core leadership and supervision competencies.

Action 5: Adapt the core leadership competency model and supervision competencies to meet the needs of diverse sectors of the field.

Objective 2: Identify effective leadership curricula and programs and develop new training resources to address existing gaps.

Action 1: Identify existing leadership curricula and programs and evaluate them using selected criteria.

Action 2: Develop and disseminate a catalog of available leadership curricula and programs.

Action 3: Identify gaps in leadership curricula and training models and develop resources to close the gaps.

Objective 3: Increase support for formal continuous leadership development with current and emerging leaders in all segments of the workforce.

Action 1: Allocate funding to support the expansion or creation of competency-based leadership development initiatives.

Action 2: Allocate funding and time to support the participation of individuals in leadership development initiatives.

Action 3: Establish mentorship programs.

Action 4: Provide competency-based training to all supervisors.

Action 5: Provide incentives, recognition, and rewards for participation in leadership development programs.

Objective 4: Formally evaluate leadership development programs based on defined criteria and revise the programs based on outcomes.

Action 1: Use data-based continuous quality improvement methods in all leadership development initiatives.

Action 2: Commission an independent evaluation of leadership development initiatives.

Action 3: Develop, maintain, and routinely disseminate a summary of findings from the evaluation of leadership programs to support ongoing quality improvement of leadership development efforts.

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CHAPTER 11

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

The recently released IOM report *Improving the Quality of Health Care for Mental and Substance-Use Conditions* concluded that most of the workforce problems in this field are “not new,” and it highlighted the many “...well-intentioned, but short lived...” efforts to address these problems, dating back to the 1950s and 1960s (IOM, 2006). The IOM committee that authored these conclusions argued that effectively addressing workforce development in behavioral health requires the creation of a more permanent infrastructure at the national level that can mount and sustain a focused effort to improve recruitment, retention, education, and training. The Coalition has endorsed and further elaborated on the IOM recommendation by identifying a series of infrastructure developments that it believes are essential if the workforce crisis is to be effectively addressed. In this context, infrastructure refers to an organized system of supports.

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

With so many unmet needs among persons with mental illnesses and substance use disorders, there is a natural reluctance to invest in infrastructure. Policy makers and program managers tend to pour every

available dollar into direct service. Yet this is precisely the dynamic that has contributed to a workforce that is now inadequately developed and supported. The cogent analysis of workforce financing provided as part of this planning process by Horgan and colleagues, and included in Chapter 21, describes how organizations have stretched or diluted inadequate resources to meet demand, leading to “...under-capitalization, substitution of lower-cost workers, ... downward pressure on workers’ incomes...” and difficulty providing evidence-based, quality care. Like most other resources, human resources require maintenance, development, and support to be effective and efficient. Infrastructure development is simply essential to sustain the human resources in the behavioral health field.

Objective 1: Create a National Technical Assistance Structure that coordinates and provides information, guidance, and support on workforce development to the behavioral health field and advises the federal government.

Notably absent from the landscape is a robust structure for supporting, coordinating, and providing continuity in workforce development efforts. Despite a growing body of knowledge and expertise on workforce issues, few vehicles exist for routinely gathering, analyzing, synthesizing, or broadly disseminating this information. Numerous individuals and organizations are engaged in workforce innovation, such as the development of competencies, yet these efforts occur largely in isolation, with limited mechanisms to foster information-sharing or collaboration across the diverse sectors of the field. Organizations that recognize a pressing workforce need have few places to turn to in order to obtain consultation or resources to address the need. Key leaders in the field who shape state and federal programs, policies, and regulations have fragmented and ever-changing sources of information from which to glean the status of the workforce and the evidence on effective workforce practices.

The federal government has engaged the Annapolis Coalition to develop a set of proposed specifications for a National Technical Assistance Structure to address the infrastructure need. Potential models will be proposed for review by SAMHSA and other federal agencies. There currently are many resources in the field that do provide technical support related to workforce issues, such as the ATTCs, which have provided training and consultation nationwide on substance use disorders treatment. The proposal that emerges will emphasize, first and foremost, increased linkages with, coordination among, and access to existing resources, supplemented by additional supports or systems to fill existing voids.

In its recent report on behavioral health, the IOM (2006) placed considerable emphasis on the need for a permanent, federally authorized structure to guide strategic planning on workforce development. Conceptualized as a National Council on the Mental and Substance-Use Health Care Workforce, this public-private partnership is modeled on two groups: the congressionally mandated Council on Graduate Medical Education (<http://www.cogme.gov>), which focuses on physician workforce issues, and the

National Advisory Council on Nurse Education and Practice (<http://bhpr.hrsa.gov/nursing/nacnep>), which has a similar role for the field of nursing. Functions of the newly proposed national council for behavioral health would be diverse, and would include monitoring workforce trends, establishing funding priorities in connection with critical workforce issues, promoting more uniform standards for credentialing and licensure, and issuing an annual report to the nation on the status of the workforce.

The Annapolis Coalition strongly endorses the concept of a National Council, established federally through the legislative or executive branch. Members should include national experts in workforce development across the diverse sectors of the field, with organizational linkages to the accrediting, licensure, certification, and related professional associations. The proposed National Council and National Technical Assistance Structure should be linked, as the latter can support the Council and serve as a vehicle for carrying out its strategic plan.

Objective 2: Create a standing federal Task Force on Behavioral Health Workforce Development.

The work of many federal departments and agencies has relevance to the fate of the behavioral health workforce. Linkages have long existed among the various agencies on issues related to mental illnesses and substance use disorders. Enormous strides have been made over the past several years in strengthening these connections and collaborations, catalyzed in part by the recent mandate to implement the recommendations from the President's New Freedom Commission on Mental Health (2003).

These developments are promising, but it is essential to bring the full force of a concerted and coordinated federal effort to bear on workforce issues in behavioral health. The recently released federal action agenda on mental health (DHHS, 2005) establishes, under the leadership of the Secretary of Health and Human Services, a Federal Executive Steering Committee, charged with coordinating federal efforts on mental health transformation, in part through convening a standing intra- and inter-agency task force on workforce development. The Coalition strongly endorses the concept of a standing federal Task Force on Behavioral Health Workforce Development, but suggests that it be broadly inclusive of the issues and agencies germane to prevention and treatment of both mental illnesses and substance use disorders.

While the Federal Executive Steering Committee might be a ready vehicle for facilitating the organization of such a Task Force, there is absolutely no intention of subsuming workforce issues pertaining to substance use disorders under a mental health agenda. The vehicle for launching a federal collaborative on workforce development is a practical matter. Its effectiveness in mobilizing federal resources in a coordinated manner across the diverse range of behavioral health workforce issues is the desired and

critical outcome. Relevant departments and agencies for potential inclusion in the Task Force are listed in Table 11.1.

**Table 11.1: Federal Agencies & Departments
with a Role in Workforce Development**

U.S. Department of Health and Human Services

Administration on Aging (AOA)

Administration for Children and Families (ACF)

Agency for Healthcare Research and Quality (AHRQ)

Centers for Disease Control and Prevention (CDC)

Centers for Medicare and Medicaid Services (CMS)

Health Resources and Services Administration (HRSA)

Indian Health Services (IHS)

National Institutes of Health (NIH)

- National Institute on Alcohol Abuse and Alcoholism (NIAAA)
- National Institute on Drug Abuse (NIDA)
- National Institute of Mental Health (NIMH)
- National Institute of Nursing Research (NINR)

Substance Abuse and Mental Health Services Administration (SAMHSA)

Within the HHS Office of the Secretary, the:

- Assistant Secretary for Planning and Evaluation (ASPE),
- Office for Civil Rights (OCR),
- Office on Disability (OD), and
- Office of Public Health and Science (OPHS)

Other Federal Departments and Agencies

Department of Housing and Urban Development (HUD)

Department of Veterans Affairs (VA)

Department of Education (ED)

Department of Justice (DOJ)

Department of Labor (DOL)

Social Security Administration (SSA)

White House Office of Faith-based and Community Initiatives

This federal effort can be supported, in part, by a Workforce Team within SAMHSA comprising representatives from the Office of the Administrator and from each of SAMHSA's three centers, CMHS, CSAT, and the Center for Substance Abuse Prevention (CSAP). Such a structure also can ensure a coordinated workforce effort across the portfolio of SAMHSA-funded activities.

Objective 3: Finance workforce demonstrations through a National Workforce Development Fund and foundation-sponsored initiatives.

There is growing recognition of a workforce crisis in the field and broad interest in taking action. A variety of existing and proposed resources will help create a blueprint to guide that action. These include the recent *Quality Chasm* report on behavioral health from the IOM (2006), the CSAT-sponsored report *Strengthening Professional Identity: Challenges of the Addiction Treatment Workforce* (DHHS, in press), this Action Plan, and several structures proposed above: a federal Task Force, Technical Assistance Structure, and National Council.

A structure is required to select and fund innovation and action on the workforce development agenda. Small and scattered pockets of resources to address critical workforce issues exist but are far from adequate to address the tremendous range of workforce needs that demand attention. The Annapolis Coalition proposes the creation of a National Workforce Development Fund, established and supported by the legislative or executive branch of the federal government. The proposed Fund would support workforce initiatives prioritized by the National Council and federal government. Management of the Fund is proposed as a cooperative public-private endeavor involving federal agencies and the National Technical Assistance Structure.

The Coalition further recognizes the critical role that private foundations could have in selecting and supporting workforce initiatives that match their areas of interest. Federal agencies, advocacy organizations, and professional groups should reach out to foundations to educate them about workforce problems and to engage them as partners in a coordinated effort to address these needs.

Objective 4: Change the economic market for services to create conditions that improve the quality of care and strengthen the workforce.

Throughout the course of this strategic planning process, the advisors and panel members who recruit, train, and employ the workforce offered many practical recommendations for improvement, drawn largely from their personal efforts and experience. Yet, a recurring theme haunted the discussions. Stated bluntly, it is the sobering notion that the present economic market for services simply does not support the provision of quality behavioral health care, and therefore undermines efforts to support and develop the workforce.

Behavioral health economics is an extraordinarily complex issue, shaped by forces that are difficult to alter and that reach far beyond issues of workforce development. These forces cannot be ignored. A chorus of voices asserted that an action plan for behavioral health workforce development can have no

credibility unless it contains specific efforts to change the economic market for services in order to create conditions that adequately fund services and create incentives that drive quality and desired outcomes.

Recommended action steps for this agenda include parity in behavioral health care insurance coverage with other health care conditions (Goldman et al., 2006). Responsibility for this action step rests with the Congress, state legislatures, and insurers, with continued advocacy from persons in recovery, children, and youth, and their families and other stakeholders. Another fundamental change includes reducing the level of unfunded or undercompensated care, which results in the dilution of workforce resources as organizations stretch their limited supply to meet demand. A related recommendation calls for increased use of performance management systems that create incentives for achieving increased consumer satisfaction, health care outcomes, and efficiency. Responsibility for changes in funding levels and funding mechanisms rests with federal, state, and county governments and other payers.

Few stakeholders have a detailed understanding of behavioral health economics, its impact on workforce issues, and options for reform. To address the knowledge gap, the Annapolis Coalition recommends the creation of a behavioral health Advisory Panel on Workforce Economics to develop detailed recommendations and implementation plans on a range of economic and financing issues. The recommendations and plans would include strategies to (1) more accurately define and measure service demand and supply in an effort to better predict workforce need; (2) effect improved distribution of the workforce into underserved areas and for underserved populations; (3) benchmark the wage and benefit levels of the behavioral health workforce with work groups of comparable education, experience, and responsibility; (4) improve recruitment and retention through changes in the financing of services, the financing of education and training, and wage and benefit packages; (5) finance peer and family interventions, including self-help; and (6) increase the incentives and flexibility in financing methods so as to improve consumer and family satisfaction, increase the use of evidence-based practices, and improve provider performance and efficiency. Ideally, the proposed advisory panel would be linked to the other three proposed initiatives: the federal Task Force on Workforce Development, the National Council, and the National Technical Assistance Structure.

Objective 5: Increase the use of data to track, evaluate, and manage key workforce issues.

Given the central role of the workforce in the prevention and treatment of substance use disorders and mental illnesses, there is a striking lack of reliable and uniform data with which to monitor, evaluate, and manage the workforce. Bits and pieces of information are available, but this information has been collected by many different organizations, each with its unique method for examining different variables, and with no consistency regarding the period of time under study. The data within employer organizations and states on their workforces and workforce practices also tend to be limited. Even if an

organization has reliable data, there is an absence of benchmarks that it can use for purposes of comparison.

For a number of years, the professional associations in behavioral health have convened, with federal support, to compare and assemble their workforce data for inclusion in the biannual report *Mental Health, United States* (Manderscheid & Henderson, 2004). This group, currently named the Alliance for Mental Health Professions, has developed a draft Human Resources Data Set that captures data on individual practitioners, such as professional discipline, level of education, medical specialties, employment status, and employment setting. The Annapolis Coalition recommends that the draft data set be finalized, reviewed, and approved by the proposed Task Force on Workforce Development and the National Council, and then adopted by all professional associations with a uniform biennial survey calendar. The Coalition also recommends that the Alliance for Mental Health Professions collaborate with the National Association of State Alcohol/Drug Abuse Directors (NASADAD) and NASMHPD to adopt the standard data set and calendar for biennial surveys by states of their behavioral health workforces.

As a companion to this data set, which is focused on individual practitioners, the Coalition recommends developing a complementary, standardized data set focused on organizational workforce variables, such as employee vacancy and retention rates, reasons for turnover, cultural composition of the workforce, staff satisfaction, and financial investment in training and development. Organizations that employ a behavioral health workforce should adopt and use the data set as they implement a continuous quality improvement process in which each organization identifies its workforce problems, implements interventions to address the problems, and evaluates and refines its interventions through the use of data.

As part of this continuous quality improvement process, every organization should have a written workforce development plan that is updated at least biannually. The proposed National Technical Assistance Structure should collect and disseminate benchmarking data on variables in the standardized data sets to support behavioral health organizations in the use and interpretation of such data.

Objective 6: Strengthen the human resources and training functions, staffing, and levels of expertise in behavioral health organizations.

With a large percentage of expenditures invested in the workforce, there is a substantial role for the staff in human resources (HR) and training departments within behavioral health organizations. Yet in most of these organizations, HR departments appear to be thinly staffed and their duties appear to be limited principally to basic personnel functions, such as hiring, processing of family and medical leaves, disciplinary actions, and maintaining compliance with personnel-related accreditation standards. During the strategic planning process, the Coalition also heard many anecdotes about training departments

being downsized, training budgets being reduced, and release time for continuing education dramatically curtailed.

HR and training staff are key elements of the nation's behavioral health infrastructure, specifically charged with developing and supporting the workforce. Strengthening this infrastructure is an essential step in efforts to address the current workforce crisis. These efforts should be modeled after approaches frequently adopted in the nation's business sector, in which human resources and training departments are recognized as key vehicles for developing and routinely updating competency models for positions, systematically finding qualified staff to fill vacancies, ensuring a thorough orientation, crafting individualized staff development plans, providing or arranging continuing education, managing the evaluation process, developing succession plans, and preparing individuals to assume future roles as managers and leaders.

The Coalition recommends that technical assistance resources be developed and disseminated as an aid to each behavioral health organization as it conducts a thorough review of the functions, staffing, and level of expertise of its HR and training departments. HR and training capacities and performance should be a major area of focus within each organization's continuous quality improvement process. Interventions to build greater capacity should be implemented and evaluated. These interventions include increasing the allocation of funding and staffing for HR and training functions; upgrading senior HR and training positions; providing continuing education to HR and training staff; obtaining outside consultation on HR and training issues; and creating an agency task force on workforce quality improvement.

Finally, as the nation strives to improve leadership development within the behavioral health workforce, HR personnel and training staff should be shifted from their role as an often neglected segment of the workforce to a priority group for further training, development, and technical support.

Objective 7: Promote the increased availability and use of information technology to support the workforce during training and service delivery.

The past decade has witnessed a revolution in information technology and management that has fundamentally changed the operations and culture within many sectors of society. However, the infusion in health care of information technology and management and its impact have lagged behind many other areas (Goldsmith, 2000), evidenced in part by the fact that most information about health care consumers and the services they have received is still captured through the handwritten word. In a recent review of infrastructure within substance use disorder provider agencies, McLellan, Carise, and Kleber (2003) found that 20% of the organizations surveyed had no information systems, including e-mail or voicemail

systems. In an additional 50% of these organizations, information systems existed but were not available to the direct-care counseling staff.

The IOM Committee on Health Professions Education (IOM, 2003) has identified the expanded use of information technology (IT) as one of four strategic directions for strengthening training in health care. The Annapolis Coalition concluded that IT has enormous potential in the area of behavioral health workforce development, of which training is but one critical application.

A federally funded National Summit on Behavioral Health Information Management was convened in 2005, resulting in a series of recommendations that SAMHSA currently is considering. The recommendations should be circulated for review by experts in workforce development to ensure that the final plan includes IT interventions relevant to workforce issues. Implementation of the final plan should include attention to the following issues:

- incorporation of behavioral health into the National Health Information Infrastructure (NHII);
- adoption of electronic health records;
- establishment of common data standards, including implementation of the IOM (2004) recommendation on the adoption of standards for data that support patient safety;
- access to secure platforms for the exchange of protected health information;
- increased use of decision-support tools, including algorithms;
- increased use of technology for performance management of workforce activities;
- financing of information technology development, infrastructure, and provider capacity;
- mechanisms for providing technical assistance on information technology;
- competency-based staff training and development in information management; and
- infrastructure needs to support the expansion of computer, Web-based, and distance learning.

Plan implementation should lead to increased IT tools in the hands of frontline behavioral health prevention and treatment personnel and managers of programs, agencies, or systems of service. As part of these development efforts, a critical objective should be to eliminate data-reporting requirements that do not produce useful information and to standardize needlessly variable reporting requirements. On multiple occasions during the strategic planning process, program managers literally wept when describing the administrative burden on their employees to report data that serve no apparent purpose or that are redundant with other submissions.

Objective 8: Identify Magnet Centers in workforce best practices, drawing on the “Magnet Hospital” concept from the field of nursing.

As a result of the significant nursing shortage in the early 1980s, the American Academy of Nursing conducted research to identify hospitals in the United States that were successful in recruiting and retaining nurses, and that had structures in place to support the professional development of nurses (Havens & Aiken, 1999). These institutions were subsequently designated “Magnet Hospitals,” and their effectiveness in reducing turnover and increasing job satisfaction among nurses has been validated through further research (Kramer & Hafner, 1989; Upenieks, 2003). In a study by Lafer, Moss, Kirtner, and Rees (2003), for example, the turnover rate for registered nurses employed in Magnet Hospitals in 2000 was 7.6%, compared with an average of 14% for other hospitals. Factors that appear to contribute to these lower rates in Magnet Hospitals include “...delegated authority, adequate staffing, competitive compensation, and a collaborative culture” (JCAHO, 2002, p. 22).

The status of Magnet Hospital is awarded by the American Nurses Credentialing Center through a process that involves self-nomination, an application, and a site visit that focuses on a review of 65 quantitative and qualitative standards. The designation of Magnet Hospital is now considered a gold standard by which nursing workforce practices and quality of care are measured in the United States and the United Kingdom.

Because the process of designating Magnet Hospitals can drive a national focus on standards and excellence in workforce practices, the Annapolis Coalition recommends that Magnet Center standards and accreditation processes are similarly established in behavioral health, relevant to diverse types of prevention and treatment organizations. The proposed National Council on the Behavioral Health Workforce could play a principal role in establishing the standards, with support from the proposed National Technical Assistance Structure in managing the accreditation process.

Conclusion

Developing and sustaining the behavioral health workforce will require enhancing existing infrastructure and creating new structures and supports. At the macro level, fundamental changes are required in the economic market for services in order to create conditions that support the efforts of the workforce to improve care. Financing strategies are also needed to support innovation in workforce development.

At the federal level, structures that promote increased inter- and intra-agency cooperation are essential to coordinate focused efforts to strengthen the workforce. Standardized Human Resources Data Sets must be finalized and implemented nationwide, supported by a robust plan to expand the information

technology infrastructure available to collect and manage data and to support training. Establishing structures to accredit Magnet Centers will foster the development of quantitative and qualitative workforce standards in behavioral health and help stimulate a competitive drive for excellence in workforce practices and improved quality of care.

Prevention and treatment organizations are being asked to implement data-driven continuous quality improvement processes focused explicitly on their workforces. As part of this improvement process, they must strive to strengthen their HR and training departments with respect to their functions, staffing, and levels of expertise.

Establishing a National Technical Assistance Structure on workforce development is a high-priority infrastructure objective. Many organizations and individuals across the United States are increasing their efforts to address workforce issues. However, the efforts too often occur in isolation and remain uninformed by the experience and evidence generated by other people and organizations. Improved structures are needed to gather, synthesize, and disseminate information about best practices on workforce development, to facilitate access to existing sources of technical support, and to greatly expand the coordination of efforts on workforce development across the broad and diverse behavioral health field.

Table 11.2: Objectives & Actions for Goal 6

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

Objective 1: Create a National Technical Assistance Structure that coordinates and provides information, guidance, and support on workforce development to the behavioral health field and advises the federal government.

Action 1: Develop the specifications for a National Technical Assistance Structure on workforce development.

Action 2: Establish the National Technical Assistance Structure.

Action 3: Establish a National Council on the Behavioral Health Workforce to monitor workforce status, set national workforce development priorities, and advise the federal government on workforce policy (as recommended in the IOM's 2006 report).

Objective 2: Create a federal Behavioral Health Workforce Partnership, led by a SAMHSA Workforce Team.

Action 1: Establish a standing SAMHSA Workforce Team with representatives from CMHS, CSAT, and CSAP to coordinate SAMHSA activities on workforce development.

Action 2: Convene a standing federal Task Force on Workforce Development to prioritize, coordinate, and implement interagency collaborations.

Objective 3: Finance workforce demonstrations through a National Workforce Development Fund and foundation-sponsored initiatives.

Action 1: Establish a National Workforce Development Fund.

Action 2: Encourage foundations to prioritize support for workforce development initiatives.

Objective 4: Change the economic market for services to create conditions that improve the quality of care and strengthen the workforce.

Action 1: Increase parity with other health care in coverage for behavioral health services.

Action 2: Improve provider payment systems to create incentives for consumer satisfaction, effectiveness, and efficiency and to reduce levels of undercompensated care.

Action 3: Create an Advisory Panel on Workforce Economics to develop financing and performance monitoring strategies to improve workforce practices and quality of care.

Objective 5: Increase the use of data to track, evaluate, and manage key workforce issues.

Action 1: Encourage professional associations and states to adopt in their workforce surveys the employee-specific Human Resources Data Set developed by the Alliance of Mental Health Professions. (Note: This set captures data on the individual practitioner, such as professional discipline, level of education, medical specialties, employment status, employment setting, hours per work week, etc.). [Note 2: This recommendation requires further review to

determine the current availability of and mechanisms for collecting data on the substance use disorders treatment and prevention workforce.]

Action 2: Develop an organization-specific, standardized Human Resources Data Set for recommended use by all organizations that employ a behavioral health workforce. (Note: This set will capture data on organizational variables, such as employee vacancy and retention rates, reasons for turnover, use of temporary staff, cultural composition of the workforce, staff satisfaction, investment in training and development, etc.)

Action 3: Implement a data-driven continuous quality improvement process on workforce development in every behavioral health organization.

Action 4: Collect and disseminate benchmarking data on human resources.

Objective 6: Strengthen the human resources and training functions, staffing, and levels of expertise in behavioral health organizations.

Action 1: Provide technical assistance in evaluating and strengthening human resources and training functions.

Action 2: Develop and implement a plan in each behavioral health organization to strengthen human resource and training functions.

Action 3: Provide training and technical assistance in workforce development best practices to human resources and training personnel.

Objective 7: Promote the increased availability and use of information technology to support the workforce during training and service delivery.

Action 1: Finalize an action plan for strengthening the behavioral health information infrastructure, drawing on recommendations from the National Summit on Behavioral Health Information Management.

Action 2: Reduce the burden of needlessly variable or purposeless data-reporting requirements for the workforce.

Action 3: Provide information-management and decision-support tools to the workforce.

Action 4: Increase the use of information technology to track and manage workforce performance.

Objective 8: Identify Magnet Centers in workforce best practices, drawing on the “Magnet Hospital” concept from the field of nursing.

Action 1: Create standards and accreditation procedures for Magnet Centers in behavioral health.

Action 2: Implement an accreditation process for Magnet Centers in behavioral health.

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CHAPTER 12

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

A recurring theme in the planning process, which has been reflected throughout this report, is the paucity of reliable and valid data on the status of the workforce and on workforce development strategies. Despite the centrality of the workforce to the delivery of care, it is seldom the focus of research. While it is occasionally the focus of scholarly articles and reviews (Hall & Hall, 2002; Mor Barak, Nissly, & Levin, 2001), the data in these works, if they contain any data at all, are usually descriptive in nature (Ebb & Haiman, 1990; Puskar & Bernardo, 2003; Wehman & Targett, 2002). While many behavioral health organizations are increasing efforts to address their workforce problems, it is uncommon for the outcome of these efforts to be evaluated with even a modicum of rigor. With few exceptions, the evidence on workforce practices and interventions is largely anecdotal.

Some data sources can be used to inform and shape workforce development initiatives. For example, there is a rapidly growing body of evidence regarding effective prevention and treatment services in behavioral health (Becker, Drake, & Naughton, 2005; Center for Substance Abuse Treatment [CSAT], 2000; Drake, Brunette, Mueser, & Green, 2005; Knudsen & Gabriel, 2003; McCabe, 2004). While controversy surrounds movement toward evidence-based practice (Cabana et al., 1999; Gibbs & Gambrill, 2002; Hyde, Falls, Morris, & Schoenwald, 2003), the research is producing another stream of data and information that can help guide efforts to train the workforce and monitor its performance (Miranda et al., 2003; Posternak, Zimmerman, & Solomon, 2002; Shumway, 2003).

There is a robust body of knowledge on effective and ineffective training strategies (Bauchner, Simpson & Chessare, 2001; Mazmanian & Davis, 2002; Oxman, Thomson O'Brien, Davis, & Haynes, 1995), which was discussed in the section of this report on training and education. While that research has been conducted principally in medical education, it has considerable relevance for all of behavioral health. In a similar fashion, the field may have to look well beyond its borders to find additional evidence to inform its

workforce practices. For example, the growing body of knowledge on the diffusion of innovation (Fixsen et al., 2005; Rogers, 1995) may offer such guidance.

While borrowing evidence from other fields is an important and efficient strategy, the Annapolis Coalition believes it is imperative to build a strong workforce research and evaluation base within behavioral health. Research and evaluation may focus on similar issues, interventions, or variables. Research implies more formal and controlled studies conducted by individuals trained in the use of research methodology. Evaluation focuses on the methods typically employed in field settings using noncontrolled designs to study applied interventions. A partial list of topics for potential research and evaluation is identified in Table 12.1.

Table 12.1:
Potential Topic Areas for Workforce Research and Evaluation

- Illness self-management and other forms of self-care
- Peer and family support
- Consumer and family education
- Shared decision-making
- Therapeutic or “working” alliance
- Community capacity-building
- Cultural disparities, cultural diversity of the workforce, and cultural and linguistic competence
- Recruitment and retention
- Rural workforce development models
- Structures, processes, and outcomes of workforce Magnet Centers
- Training models and effectiveness
- Interprofessional education and models of care
- Competencies: reliability and validity; assessment; impact on process and outcome
- Competencies for care across the life span
- Diffusion of innovation
- Fidelity of workforce behavior to practice models and standards
- Sustaining workforce behavior change
- Influence of system, organization, and program characteristics on workforce behavior

Objective 1: Increase the quantity and quality of workforce-related research through creation of a federal interagency research collaborative.

Developing a substantive body of empirical knowledge on workforce development requires a national research agenda that systematically examines the effectiveness of practices related to recruitment, retention, education, training, and the sustained adoption of newly learned skills in real-world service environments. The Annapolis Coalition calls for the development of a national research agenda that (1) supports empirical investigation principally focused on these topics and (2) greatly expands the examination of workforce variables and practices in the portfolio of all other ongoing behavioral health prevention and treatment research.

The recommended mechanism for building this national research agenda involves the creation of a federal interagency Research Collaborative on Workforce Development composed of representatives from SAMHSA and the agencies that fund behavioral health research, such as NIMH, the National Institute on Drug Abuse (NIDA), the National Institute on Alcohol Abuse and Alcoholism (NIAAA), the National Institute of Nursing Research (NINR), HRSA, and the Agency for Healthcare Research and Quality (AHRQ). The proposed Research Collaborative should first convene a panel of content experts, drawn from diverse sectors of the behavioral health field, to assist the federal agencies in identifying the priority research areas and research questions. Persons in recovery and family members should be critical members of this panel, informing all discussions, especially those related to person-centered care, shared decision-making, illness self-management, and peer and family support.

Having received recommendations from the expert panel, the members of the proposed Research Collaborative should develop consensus on shared workforce research priorities and identify the research-specific priorities of individual agencies. Funding should be secured and awarded to support these priorities, with the Research Collaborative issuing an annual report on the portfolio of research and study findings.

To address the science-to-services gap, it is recommended that the proposed federal Research Collaborative develop and implement a plan to routinely gather, summarize, and disseminate the findings of the research it funds that has relevance for workforce development. This would require establishing or strengthening linkages to academic, training, accreditation, licensing, certification, and provider organizations, as well as to state agencies, in order to foster the timely flow of information that can shape workforce practices.

Objective 2: Increase the quantity and quality of formal evaluations of workforce development practices by providing technical assistance to the field.

The poet T.S. Elliot (1971) once wrote, “We have had the experience, but missed the meaning.” This aptly describes the typical situation in the field as behavioral health organizations scramble to address the growing workforce crisis but, too seldom, evaluate in a systematic fashion the impact of their efforts.

In the previous section of this report on infrastructure (Goal 6), the Annapolis Coalition recommended the development of standardized Human Resources Data Sets and called for each behavioral health organization to adopt these as they implement data-driven continuous quality improvement efforts to strengthen their workforce. The next logical step is to use these data and continuous quality improvement processes as the foundation for formal evaluation of each organization’s workforce interventions. This necessitates that organizations develop, or perhaps acquire through consultation, technical expertise on evaluation methods. To facilitate this capacity building, the Coalition recommends that technical assistance resources be prepared and technical assistance be provided to the field on workforce evaluation methods. A diversity of methods could be used to provide this technical assistance, including Web-based dissemination, the creation of learning collaboratives, and training series initiated at national meetings of providers, educators, and state behavioral health agencies, accompanied by ongoing consultation.

Conclusion

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

It will take time to develop a federal research portfolio on workforce issues, a cadre of researchers interested and skilled in this area, and the capacity within behavioral health organizations to formally evaluate their workforce practices. It will take time to complete studies and analyze results, while simultaneously implementing interventions in behavioral health organizations and evaluating their effects. The magnitude of these tasks makes it all the more important that the work on this critical goal begin immediately.

Table 12.2: Objectives & Actions for Goal 7

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

Objective 1: Increase the quantity and quality of workforce-related research through creation of a federal interagency research collaborative.

Action 1: Establish a standing federal Research Collaborative on Workforce Development with representatives of NIMH, NIDA, NIAAAA, NINR, HRSA, AHRQ, SAMHSA, and other selected federal agencies.

Action 2: Convene a panel of workforce experts, including persons in recovery and family members, to assist in identifying priority research topics and questions.

Action 3: Identify and fund research priority areas and issue an annual report on funded studies and their outcomes.

Action 4: Summarize and disseminate research findings routinely to foster their impact on training curricula; licensing, certification and accreditation standards; and provider workforce practices.

Objective 2: Increase the quantity and quality of formal evaluations of workforce development practices by providing technical assistance to the field.

Action 1: Develop technical assistance materials and methods for delivery.

Action 2: Build evaluation capacity in the field through the provision of technical assistance.

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SECTION III

FOCUSED TOPICS



CHAPTER 13

CHILDREN AND FAMILY ISSUES

IN BEHAVIORAL WORKFORCE DEVELOPMENT³

Introduction

Workforce issues are particularly complex for the field of children's behavioral health, given the increasing prevalence of emotional, behavioral, and substance use disorders among children and youth, children's ever-changing developmental stages, their complicated needs, their family contexts, and the multiple systems in which they are involved (Huang, Macbeth, Dodge, & Jacobstein, 2004). The Surgeon General's report on mental health (DHHS, 1999) underscores the crisis in the children's behavioral health workforce in terms of critical shortages of providers and the need for training in new models of care that are emerging through system reforms and current research in treatment effectiveness. Advances in new service delivery models have outpaced preparation of the human services delivery workforce, resulting in a mismatch between training and practice. Finally, emerging characteristics of the child population and innovations in services require new provider competencies.

Demographic trends in children's mental health help define the challenges facing workforce development efforts. By the year 2030, there will be 83.2 million persons under the age of 18 in the United States, a 16% increase over the 2000 Census figures (DHHS, 2002). In 2000, four diverse groups—African American, Latino, Asian American, and American Indians—accounted for 39% of all American children (U.S. Census Bureau, 2002). In the 20 years from 1995 to 2015, growth rates among these groups are expected to far surpass those of non-Hispanic White youth, whose population actually will be decreasing by 3% (Snyder & Sickmund, 1999). Twelve percent of the current U.S. population was born outside the country, which raises the potential for linguistic isolation from existing helping systems (U.S. Census Bureau, 2002).

³ Larke Nahme Huang, Ph.D., and Joan Dodge, Ph.D., were the authors of this section. The work of the Expert Panel on Child, Adolescent, and Family Issues informed the contribution.

Epidemiological trends also define challenges for workforce development. Currently, in the United States, 1 child in 5 has a diagnosable mental disorder (Friedman, Katz-Leavey, Manderscheid, & Sondheimer, 1998). One child in 10 has a serious emotional disturbance that causes substantial impairment in functioning at home or school or in the community (National Advisory Mental Health Council, 2001). Increasing numbers of very young children are being referred to treatment agencies for help with social-emotional disturbances (Pottick & Warner, 2002). At least one third of the children being served by the mental health system in the United States are diagnosed with two or more psychiatric disorders (Warner & Pottick, 2004). Increasing numbers of youth are identified with co-occurring mental health and substance use disorders (Pottick, 2002). Increasing numbers of children are being recognized with co-occurring developmental disabilities and mental health disorders (Emerson, 2003). Some family members caring for children with emotional disorders also have mental health or substance abuse disorders or both. Fifty percent to 75% of youth involved with the juvenile justice system are estimated to have mental health needs (Cocozza & Skowyra, 2002; National Mental Health Association, n.d.). In child welfare, studies estimate that about 48% of children receiving state aid have significant emotional/behavioral problems (Burns et al., 2004). In rural areas, the mental health needs of children appear similar to the mental health needs of children in urban and suburban areas, but rates of service access and utilization in rural areas are uneven (Regier et al., 1990). In spite of the increasing prevalence of mental health disorders, only about 20% of children with mental health needs are receiving services or supports, and many of the children who do receive services are receiving inadequate services (DHHS, 2000).

Workforce Overview

Based on general workforce data, mental health professions are anticipated to grow during the next decade (McRee et al., 2003). The growth, however, is projected to be uneven across the professions and will not resolve the continuous shortage of providers for children. Child psychiatry is just one area in which provider shortages will be acute. The U.S. Bureau of Health Professions estimates that in 2020, 12,624 child and adolescent psychiatrists will be needed, far exceeding the projected supply of 8,312 such psychiatrists (American Academy of Child and Adolescent Psychiatry [AACAP], 2001). Currently, there are 6,300 child and adolescent psychiatrists practicing in the United States, with uneven distribution in rural and low-income areas (AACAP, 2001). Shortages of school psychologists and social workers exist in most regions and particularly in rural areas (Duffy et al., 2004).

The situation is even worse for the treatment of substance use disorders for adolescents. There is a severe lack of credentialed staff to treat substance use disorders among adolescents. Additionally, no state in the country offers adolescent-specific provider certification and only five states require adolescent-specific knowledge for licensure (Pollio, 2002). Although the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) Certification Program uses a competency-based

system of credentialing, there are no adolescent-specific knowledge requirements for any level of NAADAC certification (NAADAC, 2003).

Strategic Planning Process of the Child, Adolescent, and Family Expert Panel

An expert panel guided the strategic planning process, which included gathering data from a broad spectrum of stakeholder groups, and conducting an environmental scan and a literature review. The Expert Panel on Child, Adolescent, and Family Issues included family members and professionals. Also represented on the panel were four professional disciplines; expertise in mental health and substance abuse issues; developmental expertise ranging from infancy to transition-age adolescents; and diverse ethnic, racial, and cultural perspectives. In their work roles, panel members were state-level administrators, researchers, university faculty, representatives of national organizations, and public- and private-sector technical assistance providers and policy makers.

Panel members gathered input and recommendations from multiple stakeholder groups using a variety of mechanisms. Panel members

- presented workforce issues and convened discussion groups at 10 regularly scheduled meetings and conferences at the national, regional, state, and local levels from November 2004 to May 2005;
- conducted an environmental scan of states' activities related to workforce development, using state children's mental health directors as informants;
- participated in a number of board and advisory groups meetings that enabled panel members to have discussions with a diversity of stakeholders interested in children's mental health;
- conducted a literature review; and
- sent a broadcast e-mail request for comments to 96 grantees funded by the Comprehensive Community Mental Health Services Program for Children and Their Families.

Through these data-gathering efforts, panel members received approximately 120 independent recommendations that were compiled into a 28-page grid. The grid includes a detailed description of each recommendation, the source of the recommendation, and the date the recommendation was received. Workforce issues and recommendations generated from these data and from the expert panel are discussed below, presented according to the major goals of the Action Plan.

Relevance of the Core Action Plan Goals to Children, Adolescent, and Families Issues

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

Family-directed care is a radical change from traditional practice. It represents a bold step in transforming behavioral health care and service delivery, and making services more relevant and responsive to the needs of families of children with emotional, behavioral, and substance use disorders. Whereas families once were blamed for a child's disorders, families now are viewed as partners in interventions and in program planning and policy development. Families repeatedly remind policy makers and providers that they are an untapped resource poised to expand the capacity of the current and shrinking workforce in children's behavioral health care. To achieve this goal, the workforce in children's behavioral health requires training in the provision of services that are consistent with "family-driven" and "youth-guided" principles. The expert panel put forth strategies that promote partnering with families, collaborating in planning and delivery of services, and participating in training and preparation of the workforce.

The Child, Adolescent and Family Branch at CMHS, in conjunction with the Federation of Families for Children's Mental Health, has developed working definitions of *family-driven* and *youth-guided* care, and is working to implement the definitions in its grantee community. Toward this goal, the agency and federation also have developed some of the public-academic liaison programs that have engaged families as teachers and trainers in academic settings. Important resources in this area include the Federation, family specialists with the Technical Assistance Partnership for Child and Family Mental Health, and Keys for Networking, a leading family organization in Kansas that has a curriculum for family training and development

Change Strategy: The emphasis on family-driven and youth-guided care represents a major change in service delivery, training, and preparation of workers in the field. Major educational campaigns about the effectiveness of family trainers and family service providers need to be developed and evaluated. Families need to be prepared and trained in order to be partners in academic or other training venues. Incentives, including financial incentives, for training and hiring family members need to be identified and implemented. Reimbursement strategies for family providers need to be created and implemented, much as consumer peer support has become a billable service and reimbursable in some states by Medicaid.

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

Children with behavioral health needs live in all sectors of the community, yet rarely are they identified and served exclusively in the mental health or substance abuse sectors. Rather, children with behavioral health needs are identified and treated in schools, primary care, child welfare, juvenile justice, child care, and other systems that are not specifically designed to meet the mental health and substance use needs

of children. Yet in each of these systems, there are increasingly effective efforts to screen, identify, and intervene early to prevent the onset or exacerbation of behavioral health problems. A public health approach for children would target the range of behavioral health needs across the developmental stages. This approach would engage a broader workforce, including individuals in various settings in the community who are often closest to the children and their families and who may be the only individuals in a position to address mental health and substance abuse issues at their earliest stages, both by age and severity. The Expert Panel on Child, Adolescent, and Family Issues called for an expansion of the traditional mental health and substance use workforce for children, as well as a focus on the promotion of behavioral health and the prevention, early identification, and treatment of mental health and substance use disorders in the multiple child-serving systems and in community-based settings.

The growth of the behavioral health workforce significantly lags behind the increasing need for behavioral health services, which results in the need to enlist the de facto providers in other child-serving systems (e.g., education, child welfare, primary care, juvenile justice, child care, etc.). The workforce requires expanded training to address all ages of the developmental spectrum (e.g., infants and young children through adolescents) and to acquire the skills to practice promotion of behavioral health and effective prevention and treatment. Stigma not only is associated with the individuals who are suffering from behavioral health disorders but also affects people who practice in the field. Educational campaigns and key messages identifying incentives and rewards for working in the behavioral health field need to be developed and disseminated to attract students to the field.

Another key role of communities is to enlist the business sector. Understanding the behavioral health needs of children and families as an economic issue that affects work environments and employee productivity would ensure that appropriate services are included in benefit packages. For example, Employee Assistance Program workers need training to identify and intervene early with child and family behavioral health issues that affect employees' performance. Public education and anti-stigma campaigns should be implemented and piloted in selected states. Additional messages about careers in the field should be incorporated into these campaigns.

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

Although it is projected that the mental health professions are anticipated to grow over the next decade (McRee et al., 2003), shortages exist for certain populations, including children and youth with serious emotional disturbances. In addition, many clinicians are in clinic-or office- based settings, rather than in the public sector or in more natural settings for children and adolescents, and may lack the competencies needed to work with this population. Shortages of school psychologists exist in most regions. Similarly, significant shortages of social workers have been reported in several states and especially in rural areas (Duffy et al., 2004). The situation is even worse for substance abuse treatment designed for adolescents. There is a severe lack of credentialed staff to treat substance abuse disorders among adolescents.

The challenges of preparing the workforce in children's mental health are further complicated by the fluid nature of the workforce. Behavioral health care for children is often addressed by multiple child-serving systems. Frontline human service workers in child welfare, child care, education, or juvenile justice systems often are not recognized as part of the behavioral health workforce. Furthermore, there are large separations among these agencies and other parts of the practitioner community. The separations must be overcome (Friedman, 2000) because these agencies often are critical to identifying the behavioral health needs of children and youth and linking them with or providing behavioral health care. As a result, delineating and preparing workers who provide services to children with behavioral health needs are particularly complex tasks, not clearly defined by professional disciplines, service settings, or traditional academic training programs.

Another notable development was the creation in 1986 of Triple Board Programs, which offer combined training in psychiatry, child and adolescent psychiatry, and pediatrics. One major recommendation from the American Academy of Child and Adolescent Psychiatry (AACAP) to address the critical shortage of child and adolescent psychiatrists is to expand the Triple Board Program by doubling the current number of slots (21) and programs (10), and by providing Graduate Medical Education funding for a full 5 years (AACAP, 2002).

The Triple Board Program is popular; all medical residency slots are filled with highly competent residents. Doubling the number of slots would add some 20 new talented and well-trained specialized physicians (pediatrics, general psychiatry, and child and adolescent psychiatry) per year. Over time, this would represent a significant increase in the behavioral health workforce.

Change Strategy: The university system is an untapped resource for public behavioral health systems in both the recruitment of new workers and in the retention of professionals in their chosen fields. A clear identification of mutual benefits and incentives in terms of fiscal and human resources and research opportunities needs to be done. Cultivating the linkage between state and local community programs can further enhance this strategy. Other creative recruitment and retention strategies need to be developed at multiple levels.

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

The behavioral health workforce serving infants, children and adolescents, and their families, should be educated and trained to work in a manner consistent with nationally agreed-upon core competencies so that providers are prepared to (1) respect and partner with youth and families; (2) individualize care; (3) work across agencies and systems; (4) implement cultural and linguistic competence; (5) conduct strengths-based assessments that are linked to individualized service planning and service provision; (6) partner with natural supports; (7) collaborate across professions and disciplines; (8) use developmentally

appropriate evidence-based and best practices across the spectrum of promotion, prevention, early intervention, and treatment; and (9) work in a consultative role to nonspecialized mental health providers and agencies.

The behavioral health field is rife with deep-seated philosophical and conceptual differences. There are different schools of practice, diverse philosophies of care, and different perspectives among the child-serving disciplines and communities of practice. Reaching consensus in competencies across these groups is a challenging task. A “guild” mentality is deeply embedded in the field and promotes a sense of “professional preciousness” (Sarason, 1973) that often gets in the way of identifying core competencies that are relevant across disciplines. Change strategies should target the professional associations because they usually are involved in the licensing and accreditation process.

One recommendation is that SAMHSA issue a grant to bring key constituencies from the children’s behavioral health field together to confirm consensus around core competencies consistent with elements cited above; develop a core competencies training curriculum to be used nationwide; develop effective transfer strategies to ensure that the competencies are disseminated, understood, and put into practice throughout preservice and in-service education and training programs across all disciplines; evaluate the core competencies training curriculum; and evaluate the transfer strategy. Because the field of children’s behavioral health is often uncoordinated and piecemeal and lacks a defined set of competencies and a mechanism for accountability, having a core understanding of knowledge, skills, and attitudes needed for education and training would ensure (1) a level of care and quality among all practitioners; 2) a shared language and set of skills across disciplines and service systems; and 3) accountability and continuous professional and provider improvement. Having these core competencies in place also would help consumers and families in their expectations of care.

Recommendations for core competencies would likely result in a more standardized level and quality of care for all children. Disciplines would have shared core competencies which, rather than being discipline-specific, would be identified as essential in child behavioral health care. Discipline-specific competencies would supplement the core set of expectations and behaviors for practice. These shared competencies may facilitate better collaboration across disciplines and service systems.

Change Strategy: Payers of services need to be educated about the need for identified competencies among the workforce to ensure good outcomes and accountability. Payers may potentially drive the change in licensure and accreditation. The competencies then should be linked with the licensure and certification of practitioners and the accreditation of education and training programs. A less potent strategy would be to provide a template for consumer report cards and a mechanism for distribution.

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

The Expert Panel on Child, Adolescent, and Family Issues did not specifically address leadership issues, but effective leadership in the areas of developing a vision for change, initiating the change, and sustaining steps toward the vision is essential to a transformed behavioral health system. Many government, family, and advocacy leaders tend to describe their roles as “putting out fires” rather than as leading a movement of transformation (Kagen, 2004). Leaders in complex systems must move to meet a host of adaptive challenges. Leadership models for children, now emerging in human services, are critical to transformation of service delivery. In small programs and large agencies that are transforming care to children, leadership plays a critical role in identifying the values and principles of services and supports, implementing training and supervision, reflecting on the interaction between individuals and organizational structures, instilling an attitude of appreciative inquiry and growth, and cultivating individual and organizational resiliency. Leadership development is critical in the context of the transformation agenda, which requires skilled, effective leaders at national, state, and local levels.

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

Establishing core competencies for children’s behavioral health is meaningless without an infrastructure aligned to support these competencies at the national, state, and local levels. Licensing, accreditation, certification, credentialing, and reimbursement policies for programs and providers would need to be aligned with the core competencies.

Without a specific priority to build the infrastructure to address workforce issues, it is unlikely that the federal and state governments can effectively transform the systems that are in place to serve children with behavioral health issues and their families. Developing structures and strategic plans that incorporate the numerous elements needed to ensure that new workers are well educated as they enter the field, and are provided in-service training and opportunities for growth as they continue in the field, are essential for a quality workforce. Infrastructure components include, but are not limited to, workforce development plans and structures; data collection; strategies for recruitment and retention; collaborations between child-serving agencies and public higher education (state universities, community colleges); funding incentives; and public awareness of opportunities in children’s behavioral health.

There are significant obstacles to developing the infrastructure. A few of the hurdles are listed here.

- There is a lack of consensus for shared competencies that are cross-discipline and cross-system challenges to the entrenched guild mentality of professional disciplines that is built on areas of expertise. Building consensus involves recognizing areas of shared competencies and, to a certain degree, relinquishing professional turf. Additionally, as core competencies are developed, the field must be cautious about not creating yet another siloed children’s behavioral health workforce.

Rather, the field must expand the current mental health disciplines and increase the training of de facto providers.

- Different professions react differently to the inclusion of family involvement and development of family partnerships in providing care.
- State regulatory authorities are generally opposed to feedback regarding monitoring and regulating providers of behavioral health care.
- University and academic departments may be resistant to external (and even internal) input about curriculum development and core competencies.
- Financing infrastructure components as recommended will be a challenge.

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

An important recommendation by the Expert Panel on Child, Adolescent, and Family Issues is the development of systematic and regular data collection on the children's behavioral workforce. It may make sense for professional associations and guilds to track information about practitioners and adult providers that are serving children, particularly in substance abuse but also in mental health. Using payment mechanisms to identify and track providers may be a means of ensuring accurate data. Data collection around the prevalence of need and service use, and workforce development strategies that are relevant to diverse populations also are needed.

Unique Issues and Recommendations for Children Needing Behavioral Health Services and Supports and their Families

While the children's behavioral health field experiences many of the same obstacles as the adult field, workforce issues for children and their families have some unique elements, given the ever-changing developmental stages of children and youth, their family contexts, and the multiple systems in which children live and grow. Significant gaps exist in the core competencies of the children's workforce; there often is a mismatch between educational preparation and actual service provision and a time lag between the development of evidence-supported interventions and their implementation in the field through training. Few professionals receive adequate training in the values, skills, and attitudes consistent with reforms that call for partnerships with families, cultural competence in service delivery, comprehensive cross-agency interventions, individualized care, and home- and community-based approaches (England, 1997; Hansen, 2002; Morris & Hanley, 2001; Pires, 1996).

New Competencies Needed. New values, skills, and knowledge must be incorporated into today's workforce training. The concepts of building resilience in children and strengths-based interventions are just entering the language of clinical training programs. Children are constantly going through developmental stages, and new clinical approaches are being introduced to promote positive growth and well-being (Curie, Brounstein & Davis, 2004). Training programs in the past have emphasized clinical impairment and symptom reduction as opposed to focusing on the strengths of children and their families and improvement of functional status. The older training programs have given little attention to substance use disorders among youth. Even as there are more empirically validated treatment approaches for substance use disorders (e.g., cognitive behavioral and motivational enhancement therapies), the practices are not transferred to and implemented by the workforce for children and adolescents (McLellan & Meyers, 2004).

Mismatch Between Training and Practice. Another area that matches the shortage and retention of workers in urgency is the inability of education and training programs to keep up with the policy and practice changes in delivery of services to children and families (Morris & Hanley, 2001). There are concerns within the children's behavioral health field that preservice academic training bears little relation to the demands of the actual work with children and families in the community, the changing models of service delivery, and the comprehensive approaches necessary to meet the needs of the children and families served (Meyers, Kaufman, & Goldman, 1999). The last 15 years have seen dramatic changes in how services are being provided for children with complex needs and for their families, attributable in part to the system of care and family advocacy movements. The New Freedom Commission, in proposing transformation of the mental health system, built upon many of the values and principles of the system of care approach.

New Role of Families in Service Delivery. Families have moved from being seen as the cause of problems and recipients of care to key partners at all stages of the service system, from policy planning and development of services to treatment planning and delivery of care for their children. Families are seen as bringing expertise and in-depth experience not only about their own child's suffering and the concomitant stresses on the family, but also about policies and practices that can truly meet families' needs. When families are equal decision-makers, they may request support services such as respite care, in-home aides and employment assistance that are quite different from the outpatient therapy or day treatment more typical of what the mental health service system is used to providing (Duchnowski, Kutash, & Friedman, 2002). Clinical professionals no longer are viewed as the sole experts but as persons with expertise in a partnership with families whose children are in treatment. With these shifts in roles and in the power balance, the potential for conflict among family members and providers increases. Professional training programs for the children's workforce must focus on how to work with families as partners, demonstrate a genuine respect for families and diverse lifestyles, and harness family strengths and capacities. To be effective, individuals working with children and families must learn to subordinate

their own ego and status; listen, reflect, and synthesize information; acknowledge different areas of expertise; and create and sustain effective service planning teams.

Reducing Racial and Ethnic Disparities. The Surgeon General's report *Mental Health: Culture, Race, and Ethnicity* emphasized the role of culture in providing services to diverse ethnic and racial populations, and the severe shortage of providers in the core mental health professions trained to work with these populations (DHHS, 2001). As the population shifts and more youth of color are in need of behavioral health services, training programs must address cultural competence in care delivery. This has been an ongoing dilemma in academic settings. While an increasing body of knowledge (DHHS, 2001) and new tools for training exist (Cross, Bazron, Dennis & Isaacs, 1989; Trader-Leigh, 2002), the "political and academic will" has yet to be mobilized. In addition, structures and plans need to develop and training needs to be disseminated on culturally and linguistically effective practices for youth and families experiencing the most severe disparities in society (e.g., youth involved with child welfare and juvenile justice systems, and special populations such as multiracial, lesbian, gay, bisexual, transgender, questioning, and intersex [LGBTQI] youth, refugee youth, etc.). The structures could focus on data collection around need, service use, and workforce development strategies relevant to these diverse populations; incentives for minority-focused psychiatrists; training in culturally relevant skills in interventions with immigrants and refugees, and cultural parenting issues; developing new funding for training of providers, family members, and youth to encourage state and local governments to increase their commitment to serving children of color; building the capacity of diverse communities to train and hire workers from within their ranks; identifying supports and resources for this capacity building at the state and local levels and incorporating salary incentives when certification or licensure is achieved; and collaborating with area graduate schools in behavioral sciences to teach courses on cultural competency and working with children and youth of color.

Challenges of Collaboration and "Systems Thinking." Use of "systems thinking" to understand the multiple components of a child's life requires a team approach to a child's care and is a fundamental change from traditional categorical training (Meyers et al., 1999). Most professional training programs have curricula dictated by the professional associations, which tend to be siloed and discipline-specific. Yet in reality, community-based care is built on interagency collaboration and service integration, and it requires individuals from different disciplines and systems to value each other and work together to develop coordinated services and individualized care for children and their families. Rarely are professional providers taught how to collaborate in meaningful ways.

Accountability and Using "What Works." There are new expectations of the child-serving, behavioral health workforce based on issues of accountability and the use of evidence-based practice as a foundation for work done with children and their families. There are significant gaps between the development of evidence-supported interventions, the adaptation of these interventions to diverse

populations and real-world settings, and the training of these practices; and their implementation in the field.

Conclusion

Many accomplishments around children's services have occurred in the last 20 years, with the articulation of the values and conceptual framework for a comprehensive, community-based system of services and supports that is culturally and linguistically competent and individualized. The challenges for today are to operationalize the values and ensure a competent and quality workforce to do the many complex tasks needed to deliver services that result in positive outcomes for children and their families. Policy makers, planners, and practitioners need to strategically address the workforce challenges within their own communities and states. They need to develop new strategies for ensuring not only that there is an adequate supply of workers but also that the individuals who are working have the latest information and training in order to maximize their effectiveness in providing services to children with behavioral health issues and their families.

Innovation Highlight: Choices, Inc., Technical Assistance Center

The *Choices, Inc., TA Center* provides training, coaching, and technical assistance throughout Indiana for individuals and groups whose communities are building systems of care for children and their families. Training includes group training for mental health center employees, child welfare workers, educators, juvenile justice personnel, early childhood workers, university classes in education and social work, and other groups. Based on the unique needs of the individuals, organizations and communities, and using multiple, community-based methods, the training is relevant to all aspects of SAMHSA's service mandate, including prevention, intervention, and treatment, for both mental health and addictions services audiences. Choices, Inc. offers several products and resources to assist in coaching communities in system of care development.

Innovation Highlight: Endorsement for Culturally Sensitive Practices Promoting Infant Mental Health

The *Endorsement for Culturally Sensitive, Relationship-Based Practice Promoting Infant Mental Health* (www.mi-aim.msu.edu), developed by the Michigan Association for Infant Mental Health (MI-AIMH), provides a pathway for professionals from multiple disciplines to obtain a core set of competencies integral to quality services provided to infants, very young children, and families in many settings. Endorsement verifies that an applicant has earned an educational degree (as specified), participated in in-service trainings, worked with guidance from mentors or supervisors, and acquired knowledge promoting culturally sensitive, relationship-based services to infants, toddlers, parents, caregivers, and families. The competencies, process, and test materials may be purchased for use by other entities and states.

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CHAPTER 14

CONSUMERS AND FAMILIES / ADULT MENTAL HEALTH IN BEHAVIORAL HEALTH WORKFORCE DEVELOPMENT⁴

Introduction

The emergence of the consumer and family movement in mental health has been one of the sentinel events in the recent history of the behavioral health field. As the authors of this report note elsewhere, the consumer and family movement has parallels and corollaries in the recovery movement in addictions. The panel whose work informs this section has its roots in the mental health consumer/family movement. Consumers and families have expressed widespread dissatisfaction with the power differential that has existed in traditional or historic relationships between clinician and client. Clients, and even some clinicians, often have experienced these relationships as patronizing, or at best paternalistic.

Amid stinging criticism from influential national reports that advocate reform in general health care (IOM, 2001) and in behavioral health care (DHHS, 1999) – especially the New Freedom Commission’s Interim Report reference to the behavioral health system as “in shambles” (New Freedom Commission on Mental Health, 2002) – new models have emerged to achieve a more balanced configuration of interaction. The models include shared decision-making, pay for performance, and systems of care, and they are the building blocks of a consumer- and family-driven system designed to fundamentally transform not only the manner in which health care is delivered but also how it is constructed. The paradigm is not a re-model of what exists, but the creation of an entirely new edifice.

The Annapolis Coalition, in its focus on workforce, has always placed the role of the consumer or person in recovery and family perspectives at the center of the national workforce agenda.

⁴ Susan Bergeson, M.B.A., and Joyce Burland, Ph.D., were the authors of this section. The work of the Expert Panel on Consumers and Families informed the contribution.

Indeed, the *raison d'être* of the workforce and the reason for its needed transformation are the same: to serve consumers and families who are participants, recipients, and partners of compassionate, state-of-the-art, efficient, multidisciplinary behavioral and physical health care. Concepts such as recovery, prevention, early identification, functionality, rehabilitation, finance reform, and shared decision-making are the cornerstones of the intended transformation process.

Workforce Overview

Primary consumers and their family members traditionally have not been seen as members of the workforce, although self-care for adults and family care-giving for children and young adolescents are necessarily the largest components of the service delivery system. (Family members face an especially complex situation because they may be asked to have an active role in sophisticated interventions while also maintaining the very different role of parent, spouse, or sibling.) The authors have endorsed Donald Berwick's vision that the "true north" of reform in health care is "the experience of consumers and families and communities" (Berwick, 2002). Two members of the Annapolis Coalition have echoed this view in a recent report (Daniels & Adams, 2004).

For consumers and family members to assume their rightful place in the workforce they must receive educational and other supports, and their contributions to training colleagues, including peers, employees, and volunteers, from the perspective of lived experience must be enhanced.

Strategic Planning Process

Strategic planning for this segment of the report involved three phases. First, the lead consultants in the report's consumer and family content area convened an Expert Panel of adult consumers and family members for a 1-day meeting in Washington, D.C. At that meeting, Coalition board members Leighton Huey and John Morris presented the work of the Coalition. The Expert Panel was invited to comment on draft mission and vision statements and a preliminary set of goals. The panel's review and extensive comment shaped much of the subsequent work of the plan development.

Phase 2 of strategic planning occurred largely under the direction of the lead consultants and consisted of outreach to a wide range of consumers and families via telephone calls, meetings, e-mails, and several presentations and listening sessions at national meetings of organizations such as Alternatives, NAMI, the National Mental Health Association (NMHA), CMHS's Consumer Advisory Council, and more. The lead consultants worked closely with Coalition staff to draft preliminary recommendations and review detailed goals submitted by other work groups involved in strategic planning for this report. The initial

report of the Expert Panel on Consumers and Families was posted on the Depression and Bipolar Support Alliance's Web site for comment and reaction.

Special attention and energy were devoted to collaborating with experts from the substance use disorders treatment and recovery advisory group, which focused on the personal experience of recovery and the role of families in addictive disorders treatment.

In Phase 3, the lead consultants were invited to review all sections of the Coalition's draft report in advance of its submission to SAMHSA to ensure that issues of relevance to consumers and families had been adequately addressed.

Relevance of the Core Action Plan Goals

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

This goal epitomizes the spirit and substance of the system reforms that consumers and families seek. The goal's language is inclusive of people in recovery from substance use disorders, which is especially important given the numbers of adult consumers of mental health services who also have substance use disorders. Because the shift in paradigm to emphasize the role of individuals and their families in the recovery process is so significant, the subsets of messages in this goal deserve comment.

First is the issue of involvement in and direction of care. The Surgeon General (DHHS, 1999), the IOM (2001, 2006), and researchers such as Wagner, Austin, and Von Korff (1996) identify patient-centered care as a core element of quality care and emphasize the need to customize care to meet patients' needs and to fully involve them in clinical decision-making. Because this involvement will not happen automatically, the Expert Panel strongly urged that consumers and providers be included in training in the techniques of making shared decisions. Second is the issue of consumers and families providing supports to other individuals in recovery. The emergence of peer supports as a research-supported, Medicaid-financed service has validated this approach. Certainly the history of people in recovery from addictive disorders providing supports is significant in this regard, as well. The third issue is that of people with lived experience providing education about mental and addictive disorders to their colleagues in the workforce. Goal 1 makes clear that a range of expertise is needed to adequately prepare the behavioral health workforce, and that the lived experience of consumers and families is an integral part of the expertise.

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

The inclusion of a goal directed at community capacity is welcome to consumers and family members for several reasons. It reflects an awareness of the need for prevention and community education – both essential components of any successful strategy to combat the stigma that for so long has been associated with mental and substance use conditions. For adult mental health consumers and families, this goal also reflects a core value of the recovery movement, which is the recognition that individuals are guided, in the words of Patricia Deegan, by “the aspiration to live, work and love in a community in which one makes a significant contribution” (Deegan, 1988).

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

While the Expert Panel on Consumers and Families supports the broadest interpretation of improving recruitment and retention strategies for qualified workers from every discipline and at every level, the panel has a special interest in endorsing systematized approaches to the inclusion of peer and family workers, whether as paid staff or as volunteers. It will not be enough to improve retention and recruitment strategies by focusing only on the traditional behavioral health disciplines. An expanded understanding of workforce, coupled with the systematic action recommended in this report, has the potential to help close the yawning gap between the need or demand for services and the supply of people to provide them.

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

From the perspective of consumers and families, it is troubling that such a goal even needs to be stated. The authors concur that increasing the relevance, effectiveness, and accessibility of training and education is an essential need for the field. The Annapolis Coalition’s work (Hoge & Morris, 2002; Hoge & Morris, 2004; Hoge, Morris, & Paris, 2005) has documented the disconnection between current preservice and continuing education strategies and actual practices. Of special concern to constituents is the paucity of training resources dedicated to frontline staff members, who often are the ones who spend the most time with consumers and families (Morris & Stuart, 2002; Robert Wood Johnson Foundation [RWJF], 2006).

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

As the newest *recognized* members of the workforce, consumers of mental health services and other persons in recovery and their families must be given opportunities to provide leadership. Too often in the behavioral health field, leadership skills have been assumed rather than developed. Given the aging of

the current workforce and the potential for significant changes in the leadership of programs, services, and policy functions, consumer and family leadership opportunities must be created and seized if the field is to sustain the positive change envisioned for the recovery movement.

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

Unless attention is given to the underlying structure of behavioral health programs and services, consumers and families fear that change will falter or stall. Too many reforms have been predicated on the enthusiasm or charisma of a change agent, with insufficient attention given to the practical realities of sustained system reform. For example, revised training standards or the use of distance-learning technology may seem removed from the concerns of consumers and families. But these and other activities are critical to sustaining improved practices, and doing so efficiently. The behavioral health field has a significant stake in both sustainability and efficiency. Resources for services have always been limited, and so they must be used to achieve maximum impact. Reaching maximum efficiency is directly influenced by the technology and infrastructure available to support improved services.

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

In the listening sessions held around the country, the consultants heard consumers and family members urge that the best science be brought to bear to support advances in medical and psychosocial treatments for mental and substance use conditions. Concerns also were expressed about the need to continue and expand research on peer supports and other interventions that traditionally have not been in line to receive scarce research dollars. The involvement of consumers and families in research matters, as in all other areas, is essential to the creation of a research and evaluation agenda that will reflect the real-world needs of people.

Unique Issues and Recommendations

The Expert Panel and the Coalition would like to highlight a limited number of issues and recommendations culled from the extensive research and writing they have done in developing this report. The following list of unique issues and recommendations is by no means comprehensive or complete.

Consumers of mental health services and family members are seeking recovery-oriented treatment. The Consumer and Family Expert Panel suggests the following unique strategies to orient treatment to recovery.

- Incorporate recovery training into the curricula of all provider training programs. Link federal funding of training programs to implementation of these curricula.
- Link provider reimbursement to the creation and implementation of patient-centered, recovery-oriented treatment plans developed through shared decision-making.

Consumers and family members seek peer support as a recognized part of their treatment plan. The Expert Panel suggests the following strategies to enhance the role of peer support in treatment.

- Recognize peer support as evidence-based practice.
- Require that provider training include discussion of the value of and research behind peer support.

Consumers and family members are seeking to serve as providers of services. The Expert Panel suggests the following strategies to advance the role of peers as providers of service.

- Require every state and federally funded service to employ peer specialists in order to receiving funding.
- Allow peer specialist intervention as part of the rehabilitation option under state Medicaid plans.

The clinician population is aging and its initial training is out of date. The Expert Panel suggests the following strategies to deal with the aging provider population.

- Tie reimbursement levels to successful completion of clinician refresher courses every 3 years.
- Encourage the recruitment of new providers through aggressive forgiveness of student loans.

Consumers and family members are seeking to teach clinicians about their reality and about recovery from their perspective. The Expert Panel suggests the following strategies to encourage the use of consumers and family members in provider training.

- Require provider programs that receive federal funding to hire peers and family members to teach a core part of the curriculum.
- Encourage provider guilds and state and specialty organizations to use teams of consumers and providers to offer continuing education.

Consumers and family members seek partnerships with clinicians. The Expert Panel suggests the following strategies to ensure a more partnership-oriented approach by providers.

- Ensure that shared decision-making competency is included in provider training and in licensure examinations.
- Reimburse providers based on how well they design and implement patient-centered, recovery-oriented treatment plans created through shared decision-making.
- Develop standards of humanistic, patient-centered practice and add them to the ethical standards that are a part of licensure.

Mental health providers should work in interdisciplinary settings. Persons diagnosed with both substance use disorder and mental illnesses, or any other co-morbid condition, should not have to deal with two different systems to receive services. The Expert Panel suggests the following strategies to support the use of interdisciplinary teams.

- Require mental health professionals to work in culturally competent, interdisciplinary teams in which all team members are considered equal.
- Value family and consumers as equal members of the interdisciplinary team and empower them to provide peer support and training.

Providers must be taught to listen to consumers and family members. The Expert Panel suggests the following strategies to encourage the use of active listening by providers.

- Teach providers shared decision-making techniques as a core competency for graduation.
- Use as a basis for provider compensation consumer evaluations that include how well the provider listens to and acts on consumer and family member needs.

There are not enough adequately trained, multidisciplinary clinicians to meet the needs of the population. The Expert Panel suggests the following strategies to encourage more and better trained multidisciplinary providers to enter the field of mental health.

- Encourage the number of individuals seeking to enter the mental health field by adopting loan-forgiveness programs that are more aggressive.
- Encourage the advanced training of general practitioners and advance-practice nurses in mental health treatment and recovery algorithms by reimbursing them at higher levels upon completion of the training.

The need for competent providers is particularly acute in rural areas and among diverse populations. The Expert Panel suggests the following strategies to encourage access to culturally sensitive treatment, especially in rural areas.

- Provide scholarships to encourage individuals from ethnically diverse backgrounds to enter the mental health field.
- Expand the use of tele-health to meet access needs in rural areas.

Conclusion

The authors believe that many of the goals of this report have the potential to improve the behavioral health workforce. The goals that have the greatest potential to be transformative are those that support a robust leadership or partnership role for adult mental health consumers and other individuals in recovery and their families. As the behavioral health field moves forward, no satisfactory description of the workforce will ignore the essential contributions of consumers and families.

Innovation Highlight: Parent to Parent Family Training on AD/HD

Children and Adults with Attention-Deficit Hyperactivity Disorder's Parent-to-Parent Training (www.chadd.org) is a program developed by parents with lived experience with AD/HD that provides educational information and support for individuals and families dealing with AD/HD and learning to navigate the challenges of AD/HD across the life span. Courses are offered in local communities across the country and include 14 hours of class time. Participants receive extensive materials to support the class including articles, reference materials, handouts, and homework assignments.

Innovation Highlight: Georgia's Peer Specialist Training and Certification Program

Georgia's Peer Specialist Training and Certification Program (www.gacps.org) provides intensive training, testing, certification, continuing education, and ongoing support to consumers who want to support other persons in recovery. Certified peer specialists are trained in a specific skill set to role-model recovery and teach self-directed recovery tools and self-determination principles. Certified peer specialists work alongside clinically trained mental health providers in services such as ACT, community support individual and team, PSR, and peer support. Experiential training is delivered over a 2-week period. Participants receive a facilitators' guide with handouts that can be used on the job, and testing occurs approximately 1 month later. Curriculum materials, job descriptions, codes of ethics, and core competencies are available for use by other states and groups.

Innovation Highlight: META Services Peer Employment Training

META Services Peer Employment Training (www.metaservices.com) is a 70-hour class to teach individuals diagnosed with serious mental illnesses the skills needed to obtain competitive employment in the field of peer support. Peer employees work in all META's programs and teams as recovery educators, recovery coaches, and peer advocacy and support specialists. More than \$5 million in Medicaid-reimbursed services is provided annually by META peer staff. Available publications include the Peer Employment Training Workbook, Peer Employment Training Facilitator's Guide, and the Peer Employment Training Supplemental Guide.

Innovation Highlight: NAMI Provider Education Program

The *NAMI Provider Education Program* is a 10-week course for direct care staff and supervisors in public mental health agencies. The curriculum emphasizes the subjective view of the lived family and consumer experience of serious mental illness, treatment, and recovery. The course is taught by teams of family members and consumers, and uses group discussions, interaction, and exercises. There is a 250-page course notebook that includes readings and handouts that augment the training sessions. The course has been offered widely in the United States and Canada, and is about to be incorporated into a formal academic curriculum.

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CHAPTER 15

CULTURAL COMPETENCY AND DISPARITY ISSUES⁵

IN THE BEHAVIORAL HEALTH WORKFORCE

The President's New Freedom Commission on Mental Health (2003), the Surgeon General's report on culture, race, and ethnicity (DHHS, 2001a) and the IOM's report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2002), all come to the same conclusion: There are serious disparities in the quality of health care received by African Americans, Asian Americans, Native Hawaiians and other Pacific Islanders, Latinos, Hispanics, and First Nations Native Americans. The issue is not only one of access but also, in many cases, of a profound lack of culturally and linguistically competent care because of the dearth of providers who are grounded in diverse languages and cultures. The consequences of having health care provided by individuals who are inadequately prepared and trained can include misdiagnosis, inadequate or inappropriate treatment, and premature treatment termination, all of which can compound potential and existing behavioral and mental health problems. This is not quality health care.

Having too few competent providers or having providers who lack proper training in and sensitivity to cultural issues also can result in the misdirection and unintended displacement of culturally diverse individuals into other social systems, such as the criminal justice system. This is particularly true for African Americans, who make up 12% of the total adult population and 40% of all jail inmates (U.S. Department of Justice, 2002). Data from other ethnic groups reflect similar concerns suggesting disparities. For example, 75% of all deaths for American Indians and Alaskan Natives are due to violent causes, including unintentional injury, homicide, or suicide (Resnick et al., 1997). In studies done among refugees, up to 40% of Southeast Asians suffer from depression, 35% from anxiety, and 14% from posttraumatic stress disorder (Nicholson, 1997). The uninsured rate among Latinos is more than three times higher than that of non-Hispanic Whites, and, like other culturally diverse groups, Latinos are noticeably absent from clinical trials, making it unclear whether a particular medication or treatment plan is appropriate for their population.

⁵ D.J. Ida, Ph.D., and Oscar Morgan, M.H.C.A., were the authors of this section. The work of the Expert Panel on Cultural Competencies and Disparity Issues informed the contribution.

Clearly, there is a need to increase the number of service providers from each of these culturally diverse communities and to immerse nonculturally diverse providers in appropriate cultural training. In addition, the behavioral health field must work at improving the workforce, changing not only who is trained, but also what is included in training and how the training is delivered.

Workforce Overview

The need to improve the cultural diversity of the behavioral health workforce and increase the number of bicultural and bilingual service providers is reflected in the increasing discrepancy between the growth in minority populations and the number of service providers from each of the major communities of color. According to the 2000 Census, four major ethnic groups accounted for 30% of the population. By the year 2025, it is projected that these groups will represent almost 40% of the U.S. population. The four major ethnic groups are, however, greatly underrepresented among mental health and substance abuse service providers. Non-Hispanic Whites currently account for 75.7% of all psychiatrists, 94.7% of psychologists, 85.1% of social workers, 80% of counselors, 91.5% of marriage and family therapists, 69.8% of psychosocial rehabilitation practitioners, 95.1% of school psychologists, 83.8% of pastoral counselors, and 90.2% of female psychiatric nurses (Duffy et al., 2004).

Improving the workforce to provide competent services to diverse populations goes far beyond merely increasing the number of individuals from each of the respective groups. While this is clearly an important strategy, there is a need not only to increase the numbers but also to improve the quality of training for all clinicians, regardless of their racial, ethnic, cultural, or linguistic background. This also includes the necessity to recruit, train, and support interpreters.

Most graduate programs fail to adequately address the issue of cultural competency. Too often, they focus on diversity by providing information about each diverse group, but do not address the core issue of what clinicians should do once they have this information. Training from a culturally competent perspective also means revamping training programs to integrate primary health care with mental health care. This is a more appropriate model than the one that exists, as most individuals enter the service delivery system through their primary care provider. Increasing the number of interpreters who are trained specifically to work in mental health and addiction treatment settings is another important need. It is common for clinicians to use as trained interpreters a child, family or staff member, or other individuals who are not qualified. This practice can seriously compromise the quality of care.

Strategic Planning Process

The recommendations from the Annapolis Coalition's subcommittee report on cultural competency came out of a series of discussions, meetings, conference calls, presentations, and reviews of documents addressing the need for a culturally competent workforce. The final recommendations reflect the work of individuals and organizations in the field that have been advocating cultural competence for 30 years. A panel of experts representing various ethnic groups was convened to synthesize the thinking and formalize the recommendations that were submitted to the Annapolis Coalition. Feedback was also received through focus groups held at major national conferences, including NMHA, NAMI, and the National Rural Mental Health Association. Consumer input was received not only from the expert panel but also through meetings in San Francisco and Hawaii and one in Chicago that was hosted by the National Alliance of Multi-ethnic Behavioral Health Associations. The latter meeting brought together key stakeholders representing the National Asian American Pacific Islander Mental Health Association, the National Latino Behavioral Health Association, the African American Leadership Council and the First Nations Behavioral Health Association. A memorandum asking for input also was sent out to approximately 30 leading experts in the field, and conference calls were held with DHHS, SAMHSA, and CMHS workforce training grantees.

Relevance of the Core Action Plan Goals

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

Expanding the role of individuals and families in directing their own care is a critical issue in addressing culturally competent care and the current behavioral health workforce. The assessment, diagnosis, and course of treatment historically have reflected the cultural beliefs of the service provider, who too often ignored, misinterpreted, or negated the beliefs of the individual in need of services. The perspective that "the doctor is always right" can be damaging for any individual, but the problem and chances of making egregious errors are compounded when working across cultures. It is critical that individuals from various ethnic communities have an active voice in the direction of their own care and can support others from those communities who are in need of services. This includes educating service providers about the different perspectives one can use in defining a problem and identifying appropriate courses of action to follow.

One challenge has been, and continues to be, engaging individuals and family members to become proactive and more assertive health care consumers. For some people, being more proactive about their care goes counter to cultural beliefs to not question people in positions of authority. Some people receiving services find it difficult to voice their opinion, believing they have little to offer. Others may have tried to advocate on their own behalf only to find that their viewpoint was not respected; these people may

choose not to speak up again. For all of these reasons, it is critical to educate individuals and families about how to advocate for themselves and how to advocate on behalf of others. Vocal leaders of color in the consumer movement need support; there is the very real danger of isolation and stress if they do not seek – and receive – support from others.

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

When identifying their needs, communities of color must be part of the negotiation to define appropriate outcomes and look at strategies that will allow their members to achieve the outcomes. Communities of color also must be part of a process that assesses the strengths and challenges in the design, implementation, and assessment of any service model. Historically, the needs of ethnic and racial minorities have been defined for them based on biased or missing data. This practice has failed to provide an accurate picture of actual needs. It is important that communities of color be allowed to redefine their needs from a culturally and linguistically appropriate, recovery-focused perspective. It is equally important to assess how data are collected to assure that the collection is done in a culturally and linguistically appropriate manner. This includes having information translated into the relevant languages. It also means ensuring that questions are culturally appropriate and asked in a way that respects cultural norms. For example, using a telephone interview to ask personal questions of a stranger, even if the proper language is used, may not be an effective method of gathering sensitive information.

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

Experts agree that it is important to begin developing the workforce at an early stage, preferably while prospective candidates are in high school, and possibly earlier. Entering the behavioral health field may prove to be a challenge for some people because there can be considerable stigma associated with it. A successful recruitment strategy therefore must be accompanied by a broader educational campaign that enlightens the general public about the importance of a mentally healthy society. Such a campaign needs to include messages that respectfully and accurately portray the needs of communities of color.

Along with recruitment efforts, there must be stipends to support students who want to enter the field. Equally important, salaries must be competitive at nondegreed, predoctoral, and doctoral levels. To prevent employee burnout and to keep the workforce current on effective strategies for working with diverse populations, there must be ongoing support in the form of continuing education and supervision.

In summary, cultural competency is critical to the development of an ethnically and culturally diverse, effective service delivery system. Such a delivery system will not occur if cultural competency is viewed as optional. Certification and licensing processes or some other form of standardizing and monitoring cultural competency must be established for the behavioral health field.

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

A major problem with the current behavioral health workforce is its limited ability to properly train service providers to work with diverse populations. Reducing disparities in quality care will not occur if the focus is solely on increasing the numbers of providers from underserved populations. Developing a culturally and linguistically competent workforce involves changing not only who is trained, but also what is included in training and how the training is delivered. Service providers must understand how culture defines a problem and how language influences the expression of the problem. This means developing, implementing, and evaluating curricula that teach appropriate skills and competencies for all service providers, whether they are trained as professionals, consumers, family members, paraprofessionals, or interpreters, and regardless of one's ethnic or racial background.

Using the Outline for a Cultural Formulation found in the *DSM-IV-TR* is one strategy to integrate culture at all levels of assessing and diagnosing mental health disorders and developing appropriate treatment plans. Critically important to understand is that a culturally and linguistically appropriate workforce does not promote a simplistic approach that treats all persons of the same ethnic or cultural background as being the same. The challenge is to recognize the impact of culture on an individual, while also acknowledging the existence of individual differences. Indeed, a person's cultural presentation may shift from one setting to another.

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

Leadership cannot be reserved for people at the top. It must be developed at all levels of the behavioral health workforce to include consumers, family members, service providers, managers, and policy makers. Each has an important role in the development of a culturally competent service delivery system. Members of communities of color must be in leadership positions that allow them to make decisions that will have a positive impact on the quality of services for their communities. Without such leadership, decisions will continue to be made for them instead of by them. Leadership for each segment of the workforce should be developed to ensure that the components work in a cohesive fashion to enhance the overall goal of reducing disparities in the quality of care for ethnically diverse populations.

The desire to improve the behavioral health delivery system must be accompanied by an understanding of how change occurs and the skills needed to enact change, both for the individual and the system. Different skill sets are required for people in management positions than for people in direct care positions. It is not unusual for community-based organizations to promote from within, with clinicians assuming supervisory or management positions for which they may not be properly prepared. This

practice frequently results in well-intentioned and dedicated individuals operating in a fashion that ultimately may not be in the agency's best interest.

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

The infrastructure to enhance a culturally and linguistically competent workforce needs to be constructed at multiple levels. Many agencies that serve communities of color lack the necessary infrastructure to expand and meet the growing needs of their respective communities. A healthy infrastructure means developing a mechanism to provide ongoing support and training for managers and supervisors who occupy key roles in influencing the effectiveness of an agency. For supervisors, this may mean time to meet with other supervisors to discuss critical clinical issues, identify resources, and evaluate new intervention strategies. Managers and decision-makers within an agency must be able to understand and articulate the unique needs of diverse populations if they are to successfully seek funding to improve services. They must have grant-writing, program-development, and other related skills to carry out their responsibilities. One potential strategy would be to have regional training centers that look not only at cultural and linguistic issues, but also system issues that are evident in regional and geographical differences. For example, it may not be feasible to transport a program that is effective with Asian Americans in San Francisco and replicate it in Denver without modifications that take into consideration different types of community constraints and resources.

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

The current body of research related to best practices in behavioral health has not, for the most part, been based on clinical trials that incorporate communities of color in assessing the efficacy of particular treatments, programs, and services, although some efforts are underway to change this. The lack of research makes it difficult to ascertain whether current strategies are appropriate for diverse populations, including those with limited English proficiency. The difficulty in assessing current strategies has serious implications for the field, as funding sources increasingly are requiring the implementation of best-practices models. Asking for evidence of the cultural effectiveness of these interventions is most appropriate.

In addition, communities of color must be encouraged to conduct research on interventions that are seen as promising practices but are in need of additional research on diverse populations in order to gather critical data on generalized efficacy. A culturally and linguistically competent research agenda must include communities of color as subjects in clinical trials, as well as in the design and implementation of ongoing research in the field. Having a roster of capable research scientists is critical to creating a national research agenda in the area of cultural competency.

Unique Issues and Recommendations

Many challenges facing communities of color require special attention. The New Freedom Commission, the Surgeon General's report on culture, race, and ethnicity, and the IOM's document all conclude that the behavioral health needs of many of America's diverse cultural and ethnic communities have long been neglected. This has resulted in the lack of quality care, poor health outcomes, and inappropriate and disproportionate displacement of vulnerable individuals into other social systems, particularly the criminal justice system.

Providing culturally and linguistically competent services that can meet the needs of America's diverse population is a major challenge facing the current workforce. To achieve a culturally competent workforce, training must be expanded to include nondegreed professionals, family members, consumers, professionals from primary health care, and interpreters. The need for trained interpreters is critical, as the percentage of immigrants and refugees continues to grow at a much faster pace than the number of clinicians from the major ethnic and racial groups. Approximately 55.9 million persons, or one fifth of the total U.S. population, are foreign born or have at least one foreign-born parent (U.S. Census Bureau, 2002). Much of the growth in the Hispanic/Latino and Asian American populations is due to increased immigration. Among Asian Americans, 88% are foreign born or have at least one foreign-born parent. Almost half of Mexican Americans in the United States are immigrants (U.S. Census Bureau, 1999). In addition, 1.5 million Afro-Caribbeans and more than 600,000 Africans are in the United States.

Interpreters need be trained to work specifically in the behavioral health arena to develop the sensitivity to clinical issues not required in other settings. They must know when to do verbatim interpreting and when to act as a cultural broker. Because many clinicians are not properly prepared to work with culturally and linguistically different populations, well-trained interpreters often are the critical factor in determining whether quality services are being provided.

While cultural competency has received greater attention in the past few years, some workers still do not recognize the importance of addressing the unique cultural and linguistic needs of diverse populations. A mechanism must be established, therefore, to ensure that these needs are addressed in the processes of recruiting, training, and retaining the workforce. To that end, a single, overarching goal is presented, followed by four recommendations. While the recommendations are separate and distinct, they form a cohesive plan that will help ensure a more culturally and linguistically competent behavioral health workforce, one that is better equipped to reduce disparities and improve the quality of care provided to diverse populations.

The overall goal is to reduce and eliminate disparities in the health care of communities of color through the development of a culturally competent behavioral health workforce.

Recommendation 1: Increase the recruitment and retention of people of color in the workforce, which, in addition to the conventional workforce of bachelor's-prepared, predoctoral, and doctoral individuals, includes the use of nondegreed professionals, consumers, family members, natural healers, and trained interpreters.

The authors recommend that recruitment begin at the high-school level or earlier to help guide individuals to consider a career in behavioral health. In an effort to reduce the stigma and discrimination against people with mental health and substance use disorders, recruitment strategies should include a forceful public campaign to educate communities about mental health from a culturally responsive perspective. In addition to paraprofessionals, consumers and family members could add much to the workforce by contributing their personal knowledge and experiences. Incorporating them in greater numbers in the workforce would ensure that a consumer- and family-driven model is implemented that guarantees inclusion at all levels of the service delivery system.

Recommendation 2: Identify, develop, implement, and evaluate culturally competent training curricula for preprofessional trainees, service providers, consumers, family members, and nondegreed professionals, including traditional/indigenous healers and interpreters.

Merely increasing the number of providers of color does not necessarily translate into a workforce that is culturally competent. Regional cultural competence training centers could be established to work with community-based organizations and institutions of higher education to provide

- training and support for faculty, administrators, and staff on cultural competence;
- technical assistance in creating culturally competent programs;
- a venue for faculty, administrators, and staff of different programs to discuss teaching methods and ways in which students can work with culturally diverse populations;
- evaluation and feedback to staff, students, and faculty on cultural competency skills;
- programs for the credentialing of paraprofessional, interpreters, and consumer- and family-assisted mental health providers;
- training programs that integrate health and mental health as cultural paradigms for communities;
- feedback to academic and community agencies that adds to the field's ability to grow a culturally competent workforce.

Recommendation 3: Make cultural competency training a requirement for licensure and certification of professionals and interpreters.

It is critical to institutionalize cultural competency into the behavioral health workforce by requiring a working knowledge of cultural competency for certification and licensing. Caution must be exercised to avoid a training model that reinforces stereotypes. The core competencies should be based on standards that have been developed, including the CLAS Standards for Cultural and Linguistic Appropriate Services (DHHS, 2001b), the Cultural Competency Standards in Managed Care (DHHS, 1998) developed by WICHE and SAMHSA, and the Outline for Cultural Formulation found in the *DSM-IV-TR*. To date, these standards have not been applied consistently. They must be integrated into existing training programs that teach core competencies and skills.

Recommendation 4: Establish appropriate rates of reimbursement for use of trained, culturally competent professionals, nondegreed professionals, and interpreters.

Reimbursement rates from Medicaid and third-party payers must reflect the costs of using properly trained, certified professionals, nondegreed professionals, and interpreters. Providers should be properly compensated for their expertise without the costs being passed on to agencies, which cannot absorb the extra financial burden. Many agencies currently forgo using qualified personnel because of financial constraints. Too often, this practice results in substandard care that negates the efforts put into recruiting, training, credentialing, and licensing a culturally competent workforce. Pay-for-performance initiatives should require a workforce to meet certain standards in cultural competency to qualify for reimbursement.

Conclusion

The current behavioral health system has failed to meet the unique cultural and language needs of America's ethnically diverse populations. This failure has resulted in a serious disparity in health care services for African Americans, Asian Americans, Native Hawaiians and other Pacific Islanders, Latinos, Hispanics, and First Nations/Native Americans. The outcome of this failure is too often reflected in incomplete assessments and inaccurate diagnoses that lead to poor treatment plans, unnecessary hospitalizations, over- and under-medication, and negative treatment outcomes that include higher morbidity and mortality rates. Therefore, any plan for the behavioral health workforce must make cultural competency a priority.

Innovation Highlight: Communicative and Cultural Competency for Mental Health Providers

The *Communicative and Cultural Competency for Mental Health Providers (CCC-MHP)* (www.ollusa.edu/ACADEMIC/SECS/psychology/CCC-MHP.htm) is a training program to improve the language and cultural proficiencies of bilingual mental health providers who serve Spanish-speaking Latino clients and their families. Training targets mental health providers in community-based agencies and schools who have basic conversational skills in Spanish, but may lack the training and experience needed to use their education and professional skills, which were obtained in English, to work with Spanish-dominant clients. Training is offered in three formats: a 16-session continuing education course, a 4-week intensive summer institute, and through online instruction. Standards for culturally sensitive service delivery and professional language proficiency are being established and curriculum and training manuals are under development.

Innovation Highlight: Growing Our Own

Based on the *DSM-IV-TR* Outline for Cultural Formulation and developed in conjunction with consumers, the *Growing Our Own* (www.naapimha.org) curriculum is the first national effort to develop a core curriculum to train graduate students in the area of psychiatry, psychology, social work, and counseling on providing culturally and linguistically appropriate services for Asian American, Native Hawaiian and other Pacific Islander consumers. The curriculum provides a rich theoretical framework for making culturally appropriate assessments, diagnoses, and treatment plans. Standardized patient evaluation protocols are available for use in assessing the effectiveness of the training curriculum and the clinical skills of the interns. The curriculum is fully manualized with videotapes, training exercises, and reading materials identified for each module.

Innovation Highlight: Rural Human Services

The *Rural Human Services (RHS)* program (www.uaf.edu/iac/RHS/) is designed to enhance service delivery to communities in rural Alaska by training and employing village residents to work as providers in their communities. RHS provides culturally competent entry-level training (including basic skills development) and employment to village residents for delivering behavioral health services under the supervision of licensed clinicians. An important part of the program is the cohort system and the inclusion of indigenous instructors and elders on the instructional team. Classes are delivered in a series of intensive on-site training sessions (12 weeks over 4 semesters). Upon completion of the RHS certificate, students may continue with coursework in the associate's degree (human services); bachelor's degree (social work, psychology, human services, or rural development); master's degree; and doctoral degree programs.

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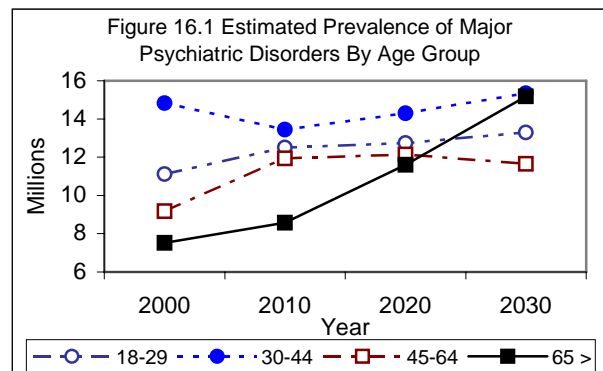
CHAPTER 16

OLDER ADULTS

AND THE BEHAVIORAL HEALTH WORKFORCE⁶

Introduction

Health care providers, consumers, and researchers share serious concerns that current behavioral health care services are inadequate to meet the mental health needs of older persons. Moreover, the inadequacies are expected to grow as the population of older Americans increases in the coming decades. One in 4 older adults has a significant mental disorder (26.3%), including 16.3% with a primary psychiatric illness, 3% with dementia complicated by significant psychiatric symptoms, and 7% with uncomplicated dementia (Jeste et al., 1999). The aging of the baby boomer generation will result in an increase in the proportion of persons over age 65 from 12.7% currently to 20% in 2030, with the fastest growing segment of the population consisting of individuals age 85 and older (U.S. Census Bureau, 2000), as Figure 16.1 illustrates. During the same period, the number of older adults with major psychiatric illnesses will more than double, from an estimated 7 million to 15 million individuals, meeting or exceeding the numbers of consumers in discrete, younger age groups (Jeste et al., 1999). The growth in the elderly population will have a major impact on the mental health service delivery system and on general health care.



A major initiative must be undertaken to address the needs of this rapidly growing population, and to equip the professional workforce with the requisite skills in geriatric mental health care. Responding to

⁶ Stephen J. Bartels, M.D., M.S., wrote this report. The work of the Older Adults Expert Panel informed the contribution.

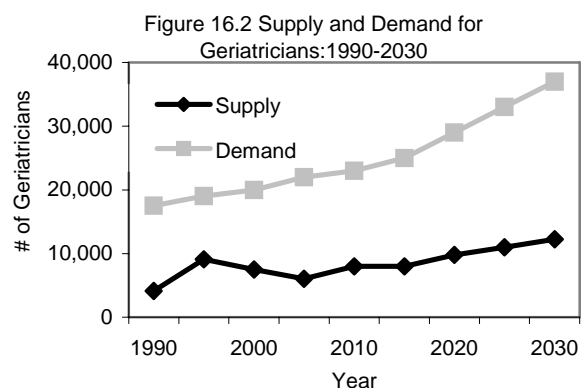
this critical public health need will require an initiative that successfully addresses the following trends and associated challenges.

- Mental disorders in older persons are associated with adverse outcomes, including poorer functioning, increased morbidity and mortality, and increased risk of institutionalization.
- Despite the fact that effective treatments exist, there is substantial unmet need associated with lack of access to services, lack of trained, accessible providers, the stigma of mental illness, and financial barriers.
- Demographic projections predict that there will be an unprecedented increase in the burden of mental illness among aging persons, especially those in the baby boom generation.
- The increase in the numbers of older adults and the prevalence of mental illness is expected to have a major direct and indirect impact on general health service use and costs.
- There is a pronounced shortfall in the current workforce of providers with expertise in geriatrics and mental health and aging, and this deficit is anticipated to worsen as the population ages.
- Recent proposed cuts in the federal budget, including the elimination of Title VII funding for 50 geriatric education centers and cuts in the National Institutes of Health (NIH) budget for research and research training, will ensure a workforce crisis of major proportions in the coming decade unless steps are taken to reverse alarming trends in a lack of capacity and funding for workforce development and sustainability.

Overview of the Professional Mental Health Workforce Issues for Older Adults

The shortage of health care providers with geriatric training is expected to grow as the population of older Americans increases in the coming decades, as the following characteristics suggest.

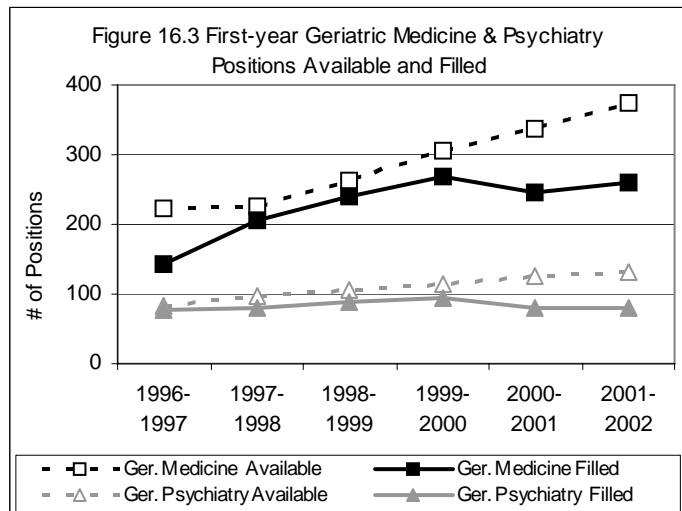
- Approximately 2,500 psychiatrists have received added qualifications in geriatric psychiatry, yet that number is far short of the 4,000 to 5,000 geriatric psychiatrists who are needed to provide patient care (American Psychiatric Association, 2002). At the current rate of graduating approximately 80 new geriatric psychiatrists each year (and an estimated 3% attrition due to retirement), there will be only 2,640 geriatric psychiatrists nationwide by 2030.



- Currently there are 9,000 physicians with geriatric certification, which represents less than half of the current need. By 2030, the need for geriatric physicians is expected to increase to 36,000,

- o with the shortfall of geriatricians projected to reach 25,000 doctors (Alliance for Aging Research, 2002), as Figure 16.2 illustrates.

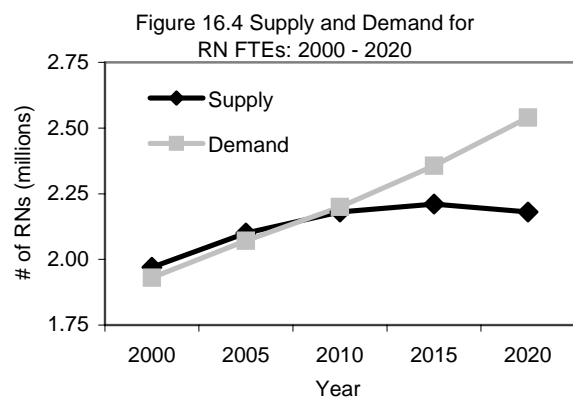
- o In response to a recognized need for physicians with specialized training in geriatrics, medical schools have increased the number of specialty fellowship positions. However, as indicated by an analysis conducted by Warshaw and colleagues (2002), the proportion of filled positions has steadily declined over the last 5 to 6 years. During the 2001-02 academic year, only 69% of geriatric medicine fellowship positions were filled, and only 61% of geriatric psychiatry fellowship positions were occupied. Despite a 67% increase in the number of available training positions in geriatric psychiatry, there has been virtually no overall change in the number of geriatric psychiatry fellows from 1996 (n=77) to 2001 (n=81) (Warshaw, Bragg, Shaull, & Lindsell, 2002), as Figure 16.3 illustrates.



This alarming shortfall in filled training positions in the context of a dramatic workforce shortage indicates that simply adding training programs and opportunities is not enough. In order to recruit physicians (many of whom have substantial student loans to repay) into the field of geriatrics, fundamental changes must occur in the way that psychiatric and medical physician services are organized and reimbursed. Currently, advanced training in geriatrics does not translate into a higher salary compared to general providers, and increased dependence on Medicare reimbursement carries added limitations and constraints.

- o Only 3% of practicing psychologists viewed geriatric patients as their primary professional target (Honn Qualls, Segal, Norman, Niederehe, & Gallagher-Thompon, 2002). The best estimate of currently practicing geropsychologists – 700 – falls far short of the current need for 5,000 to 7,500 geropsychologists (Jeste et al., 1999).

- o Less than 1% of the 2.56 million registered nurses in the United States are certified in geriatric care (American Health Care Association, 2002). In the 10 years between 1991 and 2001, only 4,200 advanced practice nurses (of an estimated 70,000 to 80,000 such



- nurses) were certified as advanced practice gerontological nurses (West, 2001). Training in mental health also is limited. Among the 4,000 members of the American Psychiatric Nurses Association, only 16%, or approximately 640 members, have a subspecialization in geriatrics (American Psychiatric Nurses Association, 2002).
- Sixty thousand to 70,000 full-time social workers will be needed by 2010 to serve the needs of older adults; however, less than 3% of students pursuing a master's degree in social work are specializing in older adults, and less than 2% of other social work students are pursuing graduate course work in gerontology (Browne, Braun, Mokuau, & McLaughlin, 2002; Council on Social Work Education, 2001).

Overview of the Strategic Planning Process

Input and recommendations for workforce development were obtained through a variety of approaches and sources. The Older Adults Expert Panel conducted a literature review of studies, reports, and consensus statements related to workforce issues, policies, and recommendations pertaining to mental health and older adults. The panel also conducted an environmental scan of current efforts by organizations and states to enhance and promote workforce development in geriatric behavioral health care. Recent and current federal legislative initiatives that are aimed at enhancing geriatric workforce development were reviewed, as were workforce policy recommendations and position papers. The recommendations of the New Freedom Commission's Older Adult Subcommittee, particularly the recommendations involving workforce capacity, were reviewed and discussed. The Expert Panel held a presentation and discussion of workforce issues at a White House Conference on Aging listening session titled "The Shortage of an Adequately Trained Geriatric Mental Health Workforce" and held in January 2005. Finally, the Expert Panel conducted telephone inquiries and discussions, and solicited input and reviews of the report through e-mail.

Relevance of the Core Action Plan Goals

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

Self-directed care, illness self-management, and informed shared decision-making are critical components of systems of care that support the role of the individual in achieving optimal independent functioning. Established and empirically supported models for informed shared decision-making in medical health care exist that include the use of decision aids, information portals, interactive video, and electronic systems of decision support for consumers and clinical providers. However, the field of mental health has failed to keep pace with the research and application of these approaches. The development

and implementation of effective models and supports for self-directed care and informed shared decision-making should be a priority in advancing the quality, effectiveness, and core values of mental health care for older adults.

It is also important to recognize the crucial role of family members as the primary service providers in the system of care for older adults with mental disorders. To address the need for effective family roles as care providers, several components of services must be developed and supported. First, reasonable and appropriate mechanisms that help to offset the financial burden of being a family caregiver need to be developed. Such mechanisms include direct payments to families and tax incentives. Second, programs are needed that support a caregiver's decision to simultaneously provide care and continue employment. Finally, implementation, replication, and dissemination of family interventions and caregiver support programs are needed. These efforts should be directed toward providing educational and service programs to both consumers and caregivers. Specific areas of concern include the promotion of mental health and aging, the prevention of late-life mental disorders and disability, improved access to evidence-based treatment, and reducing stigma while increasing public awareness.

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

Effective approaches to promoting behavioral health and wellness for older adults encompass the full array of community services and settings. However, the current system of supports for older adults with mental health needs is fragmented and poorly coordinated. One approach to integrating and coordinating community services and supports consists of the Wrap Around Service Model for Older Adults. The model is built around three core values: (1) Services are person-centered, family-focused, and individually tailored; (2) when possible, services are community-based and provided in the least restrictive setting using natural supports, as opposed to institutional care; and (3) services are provided in a context of cultural competence. Wraparound teams are designed to foster collaborative care between consumers and a variety of service agencies addressing issues of housing, mental health, home health, medical needs, recreational needs, and mental health needs. Examples of critical formal health and social services and other supports are listed in Table 16.1.

Table 16.1

Formal Service Providers and Other Community Resources	
Formal Health and Social Services	Other Resources
<ul style="list-style-type: none"> • Area Agencies on Aging • Mental Health Centers • Health and Primary Care Clinics • Visiting Nurse Associations • Home Care • Residential Care Facilities • Long-term Care 	<ul style="list-style-type: none"> • Family Members • Senior Centers • Fitness and Recreation Centers • Friends and Peer Support • Spiritual and Faith-based Support and Activities • Senior Housing and Residential Services • Other Social Support Networks

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

Critical strategies to address the current and future shortfall in providers who are trained in geriatrics and mental health include 1) exploring incentive programs, including loan repayment programs and increased authorization of graduate medical education payments; 2) expanding required training in geriatrics to long-term care nurses, certified nursing assistants, and other allied professionals in addressing psychiatric disorders and behavioral symptoms of dementia; and 3) developing approaches to increasing the number of providers with geriatric mental health training, including early educational awareness of geriatrics as a potential health care career path; development of multidisciplinary training in aging and mental health; increasing provider competencies through information-technology mechanisms; and increasing the proportion of educational programs with training in late-life mental disorders.

Of particular importance are strategies designed to provide financial incentives and support to professionals interested in pursuing a career related to geriatrics. For example, a bill in Congress, the Geriatricians Loan Forgiveness Act (H.R. 3046), would extend the National Health Service Corps Loan Repayment Program (NHSC LRP) to the fields of geriatric medicine and geriatric psychiatry. To address a shortfall across the entire span of medical professions, it is essential that loan repayment programs also be extended to master's- and doctoral-level training programs for clinical mental health professionals, including psychologists, social workers, and psychiatric nurses, who specialize in practice with older adults.

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

Effective training and education in mental health and substance use disorders services for older adults need to accommodate an array of providers, including primary care physicians, long-term care providers,

home- and community-based care workers, hospital-based providers, substance abuse and mental health providers, and others. Furthermore, approaches to training and education need to move beyond conventional conference and workshop formats in order to achieve real and substantive change. A compelling general literature underscores that education and training are necessary to improving services and provider competencies, but alone are not sufficient. For example, conventional approaches to education and training consisting of distributing treatment guidelines or holding training conferences have limited and transitory impact. Dissemination efforts must be linked to focused strategies that ensure implementation and sustainability over time. Meeting these aims requires measures that promote systems change, service integration, standardized assessment, interactive learning, and decision-support materials supporting evidence-based and promising practices. Skill acquisition by providers is best achieved through a combination of interactive and problem-based learning, decision-support materials, and integrated assessment and service delivery systems.

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

Active support of leadership development is needed at all levels in order to create an effective initiative in expanding the workforce of mental health providers addressing the needs of older adults with mental disorders. Successful efforts to implement evidence-based practices include technical assistance materials and strategies specifically designed for program administrators. Sustained impact requires systems change that includes attention to leadership in financing, organization, recruitment, retention, and training of the workforce. Train-the-trainer approaches also have been effective when combined with continued education, support, and implementation materials to provide training leadership at the ground level.

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

Technical assistance resources are needed that help providers and state service systems in adopting effective, evidence-based practices to meet the needs of older persons with mental health or substance use disorders. Recent examples of helpful educational and technical assistance resources include SAMHSA's Older Americans Substance Abuse and Mental Health Technical Assistance Center (TAC), dedicated to the prevention of substance abuse and mental health disorders within the aging population. The mission of the TAC is to provide technical assistance designed to reduce risk factors for substance abuse and mental health problems late in life through partnerships with state and federal agencies and community health care providers (<http://www.samhsa.gov/OlderAdultsTAC/>). In 2005, SAMHSA also funded an initiative to develop an implementation resource guide for practitioners serving older adults with depression. The guide is modeled after the framework of SAMHSA's six existing guides. The overall learning objective of the *Implementation Resource Guide for Older Adult Depression* is to understand how to support older adult wellness by understanding and properly treating depression in older adults. Target

audiences will include area aging networks, the mental health system, primary care practitioners, and consumers. (<http://ebp.networkofcare.org/adult>).

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

A critical strategy in addressing the current and future shortfall in providers who are trained in geriatrics and mental health consists of a systematic evaluation of the future workforce needs for health care providers in geriatric mental health. A national research agenda on behavioral health workforce development should specifically examine the different needs and capacities of the system of care for older adults. The agenda should include an assessment of the need, projected gap, and estimated economic impact of the workforce shortages on health care, and an identification of factors to improve recruitment into geriatric specialty training programs.

Unique Issues and Recommendations Actions

Anticipating the growing demand for mental health services among older adults and their families will require building an adequate infrastructure by training clinicians to provide the services that will be demanded by older consumers with mental health problems. The following recommendations consist of approaches designed to address the geriatric mental health workforce shortages, including workforce recruitment, retention, and skills training:

Recommendation 1: Develop incentives and mechanisms to support geriatric mental health training across primary health care, mental health, and social service professions. Key strategies include broadening the eligibility criteria for loan repayment programs, dedicating federal funding for training in mental health and aging, and designating geriatric medicine and mental health as an underserved profession. In addition, professional mental health and substance use disorder education programs receiving federal funding should be required to provide a curriculum addressing issues on aging or a rotation for all students that includes promotion of evidence-based and emerging best practices and skills in treating older adults with mental health needs.

The following is a list of examples of loan repayment and training initiatives.

- Passing the Geriatricians Loan Forgiveness Act (H.R. 3046), which would extend the NHSC LRP to the fields of geriatric medicine and geriatric psychiatry. The bill would amend the Public Health Service Act to include each year of fellowship training in geriatric medicine or geriatric psychiatry as a year of obligated service under the NHSC LRP.
- Expanding the Elder Justice Act from the Senate Finance Committee in 2004. The act contains provisions for training grants to increase the number of health care professionals with geriatric training, including mental health professionals.

- Extending repayment programs to master's- and doctoral-level programs for clinical mental health professionals, including psychologists, social workers, and psychiatric nurses who specialize in practice with older adults.
- Renewing and increasing funding for the Graduate Geropsychology Education Program, a part of the Graduate Psychology Education Program in the Bureau of Health Professions within DHHS.
- Specifying social work as a health profession eligible for grants under the health professions training programs administered by DHHS.
- Extending the NHSC scholarship program to include psychologists, social workers, and nursing.
- Encouraging states to revise licensing and continuing education requirements so that training in geriatric mental health, behavioral health, and substance use disorders is required for all licensed health, mental health, and social services professionals.
- Designating geriatric medicine and geriatric mental health as underserved professions in the context of clear population trends that require dramatic workforce development to meet the public health need. Provide loan forgiveness and financial incentives consistent with Public Health Service mechanisms for addressing medically underserved populations.

Recommendation 2: Eliminate disparities in reimbursement rates between geriatric health, mental health, and substance abuse practice and other areas of behavioral health and health care practice (e.g., adult-, child-, and adolescent-focused). Disparities in reimbursement between geriatric health care practice and other areas of health care practice need to be eliminated if the field is to attract and retain providers dedicated to mental health and aging. Several initiatives, some of which are listed below, can help address payment disparities for mental health services that constitute major disincentives for mental health professionals to specialize in geriatrics.

- Enact federal and state legislation to repeal the discriminatory 50% copayment required by many public and private health insurance plans for outpatient mental health services.
- Expand substantive opportunities for psychologists to participate in the GME program.
- Enact federal legislation to permit direct payment under Part B of the Medicare program for clinical social worker services provided to residents of skilled nursing facilities.

- Eliminate the discretion accorded Medicare fiscal intermediaries to arbitrarily deny payments for services to persons with Alzheimer's disease solely because the payments are submitted by a psychiatrist or other mental health provider, rather than a primary care physician or neurologist.
- Provide funding for innovative, comprehensive senior mental health services by enhancing access to such services for the elderly through social service providers and in everyday settings. Also, support initiatives such as the Positive Aging Act that facilitate the integration of mental health services with primary care. (The American Psychiatric Association, American Association for Geriatric Psychiatry, National Association of Social Workers (NASW), CSWE, and other professional organizations are spending time on this needed effort).
- Eliminate regulatory barriers to full participation by advanced practice nurses and certified nurse assistants in the provision of mental health services to older adults.
- Increase rates of reimbursement for providers with advanced training and certification in geriatrics.

Recommendation 3: Training in aging and mental health should be mainstreamed into standard training of health care disciplines. Initiatives to accomplish this include the following:

- Professional mental health and behavioral health education programs that receive federal funding should require geriatric course work or rotation for all students on evidence-based and emerging best practices and skills in treating older adults with mental disorders.
- State and federal education entities should require that all health professionals, health professions students, and direct care workers have the requisite knowledge, skills, and attitudes to provide patient/person-centered, evidence-based, and coordinated interdisciplinary geriatric care and aging services. This care must be available across the continuum in ambulatory, acute, home- and community-based services, assisted living, and long-term care settings.
- States should be provided with incentives to revise licensing and continuing education requirements so that geriatric mental health, behavioral health, and substance use disorders training is required for all licensed health, mental health, and social services professionals.
- DHHS should refine its approach to technology transfer in geriatric mental health and behavioral health evidence-based and emerging best practices. A new approach is needed to ensure that knowledge is translated more rapidly into the content of training curricula; that curricula employ teaching methods of demonstrated effectiveness; and that knowledge about effective education, recruitment, and retention strategies inform all public and private efforts to translate science to

services. DHHS also should spearhead national initiatives in the dissemination and implementation of evidence-based mental health assessment and treatment services for older persons with mental health, cognitive, and substance use disorders.

Recommendation 4: Renew funding of the Geriatric Education Act (Title VII) The recent proposed elimination of Title VII funding for geriatric education centers and training programs in the federal budget will eliminate 50 geriatric education centers across the country and numerous fellowship and other training programs for physicians, nurses, dentists, social workers, psychologists, and other health care providers. It is critical that these funds be restored if the nation is to meet the future health and mental health needs of an aging America.

Recommendation 5: Promote the development of the next generation of geriatric mental health researchers by

- expanding (rather than reducing) the career development K-award mechanism at the National Institute of Mental Health (NIMH) aimed at supporting early career investigators in geriatric mental health research;
- increasing funding initiatives and programs at NIMH, SAMHSA, AHRQ, the National Institute on Aging (NIA), and other federal agencies addressing mental disorders of aging;
- continuing to support and expand innovative mentoring programs modeled after the successful Summer Research Institute in Geriatrics (SRI) program designed to provide training and support in research development in geriatric mental health research careers; and
- reinvigorating funding to head off a projected “research recession” at NIMH associated with a recent budget that effectively has cut funding to the institute for the first time in 30 years. The projected population of older persons with mental disorders will overwhelm the health care system if approaches to prevention and intervention are not identified and proven effective by well-designed research studies.

Conclusion

The proportion of the U.S. population over age 65 will increase from 12.4% in 2000 to 20% by 2030 (U.S. Census Bureau, 2000). In the coming decades, the number of older adults with major psychiatric illnesses will more than double, from an estimated 7 million to 15 million individuals (Jeste et al., 1999). This demographic shift is projected to exacerbate to crisis proportions the current shortfall in health care providers with geriatric expertise. To address this shortfall, state and federal authorities should be directed to support an initiative to develop a workforce with specialized skills in caring for older persons with mental disorders. This will require evaluating national workforce needs, identifying factors that contribute to the failure of geriatric residency programs to fill training slots, and developing recommendations to improve recruitment of providers with geriatric specialization. Incentive programs

should be explored, including loan repayment programs and increased authorization of GME payments. Required training in geriatrics should be expanded for long-term care nurses, certified nurse assistants, and other allied professionals in addressing psychiatric disorders and behavioral symptoms of dementia. Approaches to increasing the number of providers with geriatric mental health training include early educational awareness of geriatrics as a potential health care career path; development of multidisciplinary training environments for aging and mental health; increasing provider competencies through information technology mechanisms; increasing the number of educational programs with training in the identification, assessment, and management of late-life mental disorders; and increasing funding for research on effective approaches to prevention and actions, coupled with research on effective strategies for implementation, training, and workforce development in the area of geriatric mental health services (Bartels, 2003).

Innovation Highlight: Emergency Preparedness for the Elderly

The *Emergency Preparedness for the Elderly Program* was developed by a collaborative of Geriatric Education Centers within the National Association of Geriatric Education Centers (NAGEC) network in response to the lack of training materials on emergency preparedness in aging. Interdisciplinary training enables service providers in more than 30 professions to effectively respond to mental and physical health needs of elders in emergency situations. Programs can be delivered through workshops, distance-learning sessions, or through a train-the-trainers model. Interactive training programs include didactic and video-streamed presentations, tabletop exercises, Web-based resources, games, and experiential healing rituals. This multiple-modality program, designed for urban and rural settings, addresses cultural/language-challenged ethnic elders with chronic mental or physical conditions, and explores federal, state, regional, and local programs and resources on bioterrorism, emergency preparedness, and other public health threats. All teaching materials are available through NAGEC.

Innovation Highlight: The Outcomes-Based Treatment Planning System (OBTP)

The OBTP is a methodology of guided assessment and decision support designed to increase the quality of home- and community-based care of older persons with mental disorders by substantially improving the clinical tools and practices of clinicians who serve them. The OBTP guides a provider through an integrated and systematic process of screening, assessment, identification of treatment targets, guided treatment planning, and feedback on outcomes. The OBTP system has been shown through the Robert Wood Johnson Initiative to be effective in increasing the range and depth of assessments, increasing the breadth of treatment options offered, and improving outcomes as perceived by consumers. It is now being implemented as the standard for all older adults receiving state-supported mental health services in New Hampshire and a proposal is in place to make the OBTP available to mental health clinicians nationwide through a Web-based electronic application and database.

Innovation Highlight: SAMHSA Older Americans Substance Abuse and Mental Health Technical Assistance Center

The *SAMHSA Older Americans Substance Abuse and Mental Health Technical Assistance Center* (<http://www.samhsa.gov/OlderAdultsTAC>) collaborates with the National Registry of Evidence-Based Programs and Practices to identify evidence-based programs for older adults, and provide education, direct training, and technical assistance to state agencies and providers across the country. Through collaboration with the National Council On Aging, TAC staff conduct state planning events, and offer trainings to service providers and program administrators from the aging, substance abuse, mental health, and public health fields. Through exhibits, presentations, technical assistance, direct state trainings, and responses to requests from TAC's e-mail address and 800-number, TAC has responded directly to the needs of 25 states and the District of Columbia. Materials are available in a ready-to-use manual that includes staff education curriculum, fact sheets, handouts, replicable forms, a resources list, depression screening instruments for participants, and a video.

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CHAPTER 17

RURAL ISSUES⁷

IN THE BEHAVIORAL HEALTH WORKFORCE

Introduction

The *Annapolis Coalition* asked the Western Interstate Commission for Higher Education (WICHE) Mental Health Program to provide consultation on the rural content area. The Mental Health Program at WICHE helps its 15 member states improve their mental health systems and enhance the preparation of a qualified mental health workforce. Specifically, the WICHE Mental Health Program is a technical assistance and evaluation center with nearly a half century of expertise in responding to behavioral health systems and issues, and is a recognized leader in the areas of rural and frontier mental health (for more information, please see <http://www.wiche.edu/mentalhealth>).

The WICHE West comprises America's most rural and frontier states, areas that frequently experience professional shortages. These shortages create a critical barrier to effectively meeting the mental health care needs of the region. Throughout the past 50 years, the Mental Health Program has been actively engaged in workforce development activities for the West.

One fifth of America's population lives in rural areas. Rural America includes more than 2,000 counties and 49 million people, and contains 75 percent of the nation's land (<http://www.ers.usda.gov/>). Rural communities are diverse, which makes it difficult for researchers to accept one definition of rural. For example, the issues in a remote community in Alaska may be quite culturally and ethnically different from the behavioral health issues in a geographically isolated town in Montana.

Research indicates that the prevalence rates for mental health and substance use disorders are similar for rural and urban populations, but that rural communities lack availability, acceptability, accessibility,

⁷ Dennis F. Mohatt, M.A., and Mimi M. Bradley, Psy.D., were the authors of this section. The work of the Expert Panel on Rural Issues in the Behavioral Health Workforce informed the contribution.

and applicability of services. Yet rural areas are no different from urban areas in the kinds of services they need, including crisis intervention, substance abuse treatment, family and individual therapy, group therapy, assessment, and medication management. Another factor to consider is that the older population is growing and is expected to double by 2050. Throughout the nation, rural areas generally have a higher proportion of older persons in their total population than urban areas (<http://www.ers.usda.gov/briefing/population/older/>). This imbalance further highlights the need for a competent behavioral workforce to address population trends in rural areas.

Workforce Overview

The American behavioral health workforce is changing. The WICHE Mental Health Program analyzed data (<http://higheredinfo.org/>) involving population projections between 2000 to 2025 for its 15 member states (Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, North Dakota, New Mexico, Oregon, South Dakota, Utah, Washington, and Wyoming). If the projections are accurate, only four states—Alaska, California, Hawaii, and New Mexico—will have more people entering or in the workforce than leaving it by 2025.

Specifically, the 15 WICHE member states will average an 18% increase in persons aged 18 to 64 years (range of 1.4% in North Dakota to 37.8% in Hawaii) between 2000 and 2025. However, during the same period, these states will average a 122% increase in the number of persons who are 65 years old and older and entering their retirement years (range of 72.6% in South Dakota to 159.7% in Utah).

Multiple reports dating from the Eisenhower-era Presidential Commission on Mental Health through today indicate that the behavioral health workforce shortage problem has persisted with little improvement. This is particularly true in rural and frontier areas. Behavioral health workforce shortages have been a fact of life in rural America for decades (Flax, Wagenfeld, Ivens, & Weiss, 1979; Murray & Keller, 1991). The four major concepts that capture a vast majority of the barriers rural Americans face in receiving needed behavioral health treatment are accessibility, availability, acceptability, and applicability of services. Workforce shortages in rural areas are directly related to each of these issues, particularly availability. Many rural states face problems in attracting and keeping behavioral health professionals in rural communities. In addition, evidence-based practices may not be appropriate or feasible for some rural populations, as the practices are generally created and researched in urban populations.

The following statistics from the report of the New Freedom Commission's Subcommittee on Rural Issues (2004) identified several workforce issues specific to rural communities.

- More than 85% of 1,669 federally designated mental health professional shortage areas are rural (Bird, Dempsey, & Hartley, 2001).
- Holzer and colleagues (2000) found that few psychiatrists, psychologists, or clinical social workers practice in rural counties, and that the ratio of these providers to the population worsens as rurality increases.
- For the past 40 years, approximately 60% of rural America has been underserved by mental health professions.
- The National Advisory Committee on Rural Health (1993) noted that across the 3,075 counties in the United States, 55% had no practicing psychiatrists, psychologists, or social workers, and all of these counties were rural.
- The National Advisory Committee on Rural Health (1994) reported that the supply of psychiatrists is about 14.6 per 100,000 people in urban areas compared to 3.9 per 100,000 in rural areas.
- The workforce shortages are even worse within specific areas of the field, such as children's mental health, older adult mental health, and minority mental health.

The New Freedom Commission subcommittee report also describes factors that have impeded workforce development, which generally include an intricate mix of training, professional, organizational, and regulatory issues (<http://www.mentalhealthcommission.gov/papers/Rural.pdf>).

The ratio of behavioral health providers to the population worsens as rurality increases. Holzer and colleagues (2000) studied the availability of health and mental health providers by population density. They found that only about 10% of *frontier*⁸ counties had psychiatrists and less than 1% of *very frontier*⁹ counties had any psychiatrists. The rates of psychiatrists per 100,000 people for frontier and very frontier counties are 1.3 and 0.1, respectively. Additionally, only 13.3% of very frontier counties had psychologists (13 per 100,000), while 43.1% of frontier counties had psychologists (18.1 per 100,000). Among very frontier counties, 18.5% had social workers (12.8 per 100,000), while 23.4% of frontier counties had social workers (9.1 per 100,000). These data show the strong trend of sharply declining ratios of behavioral providers to populations as one gets farther away from urban areas.

Bird, Dempsey, and Hartley (2001) offer other data that support these statistics. For instance, the lack of mental health professionals is a key factor in explaining differences in access to and use of mental health services in rural areas compared to urban areas. Additionally, it is difficult to translate methods for estimating workforce adequacy from general (or physical) health to mental health, as the mental health workforce is characterized by a considerable overlapping of roles.

⁸ The Frontier Mental Health Services Resource Network defines *frontier* as a county with fewer than 7 persons per square mile (it is slightly altered to be 2 to 6.9 persons per square mile, to include the categorization *very frontier*).

⁹ *Very frontier* is a county with 0 to 1.9 persons per square mile.

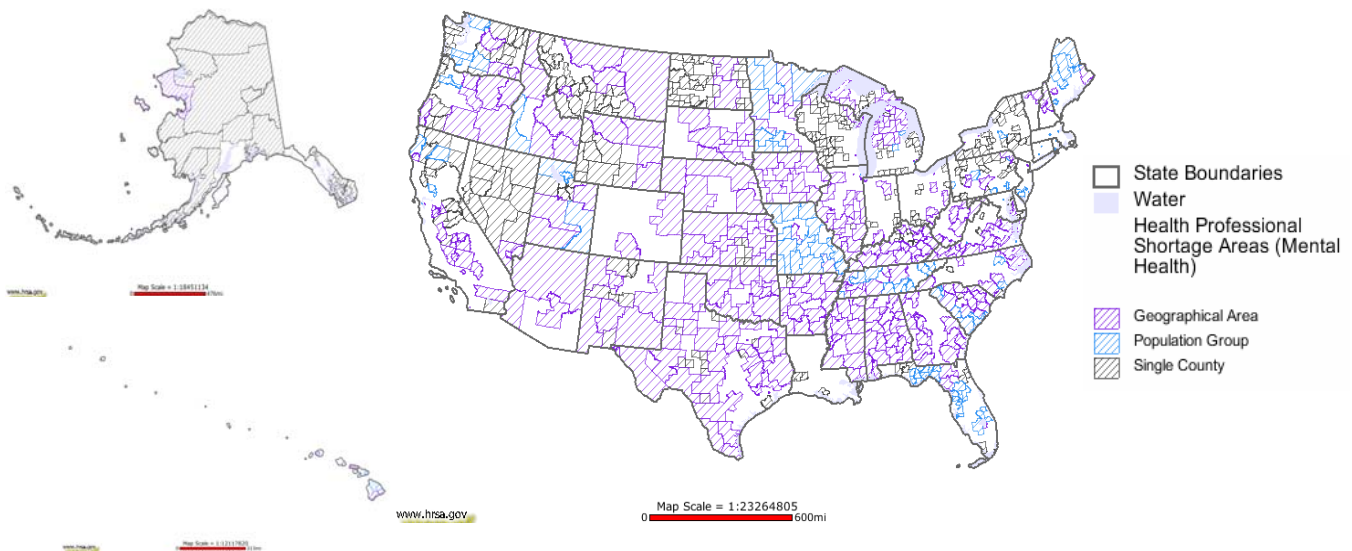
In a National Health Policy Forum Issue Brief, Koppelman (2004) describes the shortage of qualified providers to address children's mental disorders, possible causes, the relationship of managed care to practice patterns, and the difficulties in deciding which providers are most qualified to deliver which kinds of care. The brief characterizes the mental health workforce as "in flux," with practice boundaries among psychiatrists, psychologists, counselors, and other mental health professionals becoming increasingly unclear to consumers and payers.

Frequently, different mental health disciplines require different levels of training, have different areas of expertise, and have different salaries (Koppelman, 2004). The salary issue is especially complex for rural workforce development because of several interacting forces: It takes longer to repay the costs of higher education at the relatively lower wages available in public-sector and safety-net provider organizations, a circumstance that is likely to continue as payers seek to pay lower rates for care, driving organizations to try to do more with lower paid staff.

Behavioral health workforce policy has been focused almost exclusively on doctoral-level providers (i.e., psychiatrists and psychologists). Social service agencies in rural areas are generally staffed by a range of non-doctoral-level providers and typically do not provide any consistent standards or core competencies. Staffing has been influenced more by state practice regulations and insurance reimbursement regulations than by science or competency (New Freedom Commission on Mental Health, 2004).

Rural workforce strategies involve two primary aspects: 1) development of the existing workforce, and 2) expansion of the workforce through recruitment and retention activities. The IOM report *Quality Through Collaboration* (2005) identifies a third strategy, which is to enhance the "health readiness" of rural residents. This involves educating rural residents about the symptoms of mental illness so they can be more proactive in seeking care for possible mental health issues.

Figure 17.1: Designated Mental Health Professional Shortage Areas: Nationally



The troubling reality of behavioral health workforce shortages in rural America is well documented and has persisted for decades. However, it is significant that the New Freedom Commission Subcommittee on Rural Issues report was one of the first reports on the topic to be released. A number of organizations, government agencies, advocacy groups, and policy initiatives have taken up the call to ensure that attending to workforce shortages is a top priority.

Neither the New Freedom Commission report nor this Action Plan is an exhaustive list of the issues that define the workforce shortages in rural America, but the documents provide a good sense of the scope of the problems. They will not be solved immediately; an action plan to counteract some of the behavioral health workforce trends is instrumental to effecting change in this area.

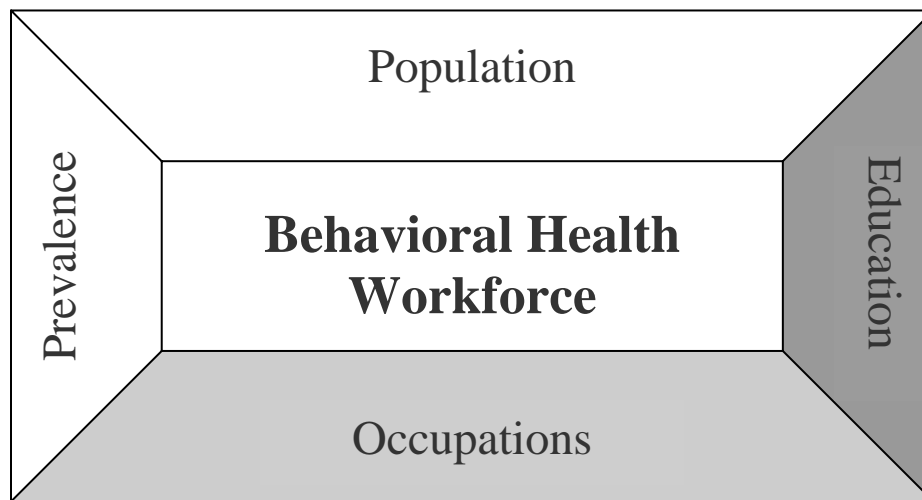
Components of a Strong and Effective Workforce

At any given time, the need for workforce development in behavioral health is determined by the prevalence of behavioral health disorders and the number and location of professionals to provide services. Prevalence rates are based on epidemiological studies of populations, while the number and location of clinicians is based on the interplay of education and occupation trends. Both are estimates, and there are multiple reasons beyond limited availability of services why people who need treatment do not seek it (e.g., lack of awareness of a problem, stigma, etc.). Additionally, a competent and adequate workforce has the right number of experienced and skilled people in the right jobs at the right time.

Thus, establishing and sustaining an effective mental health workforce involves several components. As illustrated in Figure 17.2, the components are

- a profile of present *population* and demographics;
- an estimation of the *prevalence* of mental illness;
- an analysis of the professional *occupations* available to serve the community; and
- a picture of the *higher education* programs designed to supply well-trained professionals.

Figure 17.2



The four components are interrelated, and changes to one component often affect the others. For example, large and rapid increases in population can translate into greater numbers of people with a behavioral health problem (even if percentage remains the same). But it can also mean more people available to enter the behavioral health field as clinicians. Thus, it is important to study previous trends to project future courses. More important, the projections allow decision-makers to identify potential avenues of growth, as well as barriers and means of overcoming them. The model also provides a framework within which specific recommendations will be discussed in a later section.

Behavioral Health Workforce Strategic Planning Processes

Strategic planning for the creation of a rural and frontier behavioral health workforce development strategy has evolved over several years. The work that directly addresses the Annapolis Coalition project occurred at a SAMHSA-sponsored conference held in Mesa, Arizona, in March 2005. The conference was initiated by and the product of a previous conference held in Reno, Nevada, in September 2003.

This section will provide a brief overview of the two conferences, as well as other relevant workforce development activities that have occurred in the interim.

Reno Conference: The Reno conference was funded by HRSA and was facilitated by the WICHE Mental Health Program. The meeting combined leaders in the mental health field and higher education as well as legislators from WICHE member states, with the goal of sharing and gaining perspectives in workforce shortages in the West. The meeting focused on discussing the multilevel contexts in which workforce shortages exist, the implications of these shortages, and possible solutions. The discussions resulted in a broader understanding of the national, regional, and state contexts regarding rural and frontier mental health workforce shortage issues and potential avenues for addressing them. Some of these important issues were

- identifying regional strategies and mechanisms to address critical mental health professional shortages in frontier areas of the WICHE West;
- action planning for cross-sector, interinstitutional, and interstate collaborative action to expand access to professional training to improve the supply of urgently needed mental health professionals in frontier areas; and
- exploring opportunities for regional integration and coordination of funding strategies to support mental health professional training to promote frontier practice.

The Reno conference report can be seen at <http://ruralhealth.hrsa.gov/pub/WicheMH.asp>

Mesa Conference: The WICHE Mental Health Program received funding from SAMHSA to sponsor a second conference to bring together public mental health system stakeholders and higher education representatives to enhance efforts to address rural mental health professional shortages. The conference included speakers who addressed from a number of perspectives workforce development issues related to rural and frontier areas. Specifically, speakers discussed the national context of workforce development issues generally, national activities that have focused on rural and frontier areas (e.g., Rural Healthy People 2010, a publication of the Southwest Rural Health Research Center at Texas A&M University System; and the New Freedom Commission Rural Subcommittee report), and other regional and state-specific workforce initiatives (e.g., integration of higher education, state mental health systems, and provider organizations, such as in Alaska and Arizona). Additionally, an expert panel on cultural competence described issues in rural workforce development that have an impact on diverse populations. Workshop participants identified six priority areas pertinent to rural behavioral health workforce development: 1) resources (i.e., financial and time commitments), 2) evaluation and outcomes, 3) training, 4) grow-your-own workforce (i.e., identify and train potential pools of individuals from rural communities), 5) cultural competence (i.e., attend to the culture and diversity of rural communities), and 6) community collaboration.

Relevance of the Core Action Plan Goals

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

This goal is particularly important because a majority of people in rural and frontier areas look to friends and family first to help them solve their problems; this tendency is amplified by the lack of behavioral health providers and by geographic and transportation barriers. This support system can be instrumental in connecting the individual to available services and educating first responders and medical providers. In addition, peer-to-peer support can be especially effective in addressing the behavioral health needs in rural areas. Peers and other community members can be leaders in advocating for increased treatment options and training opportunities in rural and frontier areas. It is critical to consult communities and stakeholders (e.g., consumers, leaders, schools, churches, service agencies, etc.) about their specific needs as defined by the community.

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

Providing education to rural communities is paramount to achieving this goal. Training, seminars, and community meetings would be helpful in providing basic information on identifying and promoting behavioral health. Using distance technology for these trainings may be an efficient and cost-effective method to reach multiple communities within a state or region. Community members should be informed of the nearest behavioral health services, the contact information, and how to refer someone in need of services. The Community Mental Health Centers (CMHCs) and Community Health Centers can be involved in the provision of training as a way of building a bridge and partnerships between the service providers and rural communities.

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

While there exist some federal and state programs that provide incentives for behavioral health providers to work in rural areas, the programs generally do not succeed in retaining workers in rural communities, especially when workers are recruited from urban areas. Systematic recruitment in rural areas is exemplified by the grow-your-own approach, in which residents of rural areas are offered training opportunities, an articulated behavioral health career path, and incentives to remain in their community. Using distance education for these purposes is a practical way to connect remote areas to higher education institutions and other agencies providing training. Increased financial resources need to be

exclusively earmarked and allocated for the recruitment and retention of behavioral health providers in rural and frontier areas.

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

The majority of behavioral health training programs' curricula (e.g., psychology, psychiatry, social work, etc.) do not provide education on issues in rural behavioral health. Moreover, few training programs offer a specialized track or emphasis in rural behavioral health. Therefore, the majority of behavioral health clinicians are not prepared for the reality of work in rural areas. A bridge between higher education and the public mental health system is essential to addressing this problem. Collaborative relationships between the two systems to unify their training efforts will help close the gap that currently exists.

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

Leaders exist in every rural community and they should be identified and engaged to guide workforce efforts. These leaders can act as liaisons between people in rural communities (e.g., service providers, consumers, families, etc.) and people in metropolitan areas, including federal policy makers. A clear communication pathway will promote partnerships and allow rural communities to be represented in a significant way. Furthermore, current leaders can mentor young professionals entering the field to sustain programs and efforts into the future.

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

Rural behavioral health systems of care typically suffer from limited resources, including money, staff, and facilities. Therefore, behavioral health infrastructure tends to be much more informal and fragmented in rural areas than in urban and suburban areas. Active collaboration among rural service providers, consumers, and state and federal funding agencies is essential in order to strengthen the infrastructure in rural areas and coordinate behavioral health workforce initiatives. Rural communities need a stable mechanism or forum to enhance formal, integrated, and ongoing communication among different systems (e.g., criminal justice, child welfare, etc.).

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

Research on rural behavioral health has been difficult for many reasons. Definitions of rural are inconsistent and the people and places that compose rural areas are diverse (which limits the generalization of research and practice results). However, researchers are coming to the consensus that rural must be viewed on a continuum, and updates to federal definitions (e.g., Office of Management and

Budget; Census Bureau) reflect this. Furthermore, rural research agendas have been proposed over the past 10 years that address these issues and propose similar research foci. Ultimately, a national research and evaluation agenda on the rural behavioral health workforce will need to identify issues that cut across all rural behavioral health systems. An annual national meeting of rural researchers, consumers, providers, and funding agencies would be one way to create and implement a specific agenda with targeted outcomes and timelines. Financial incentives could be provided for research and for identifying and implementing promising practices in rural communities.

Unique Issues and Recommendations

As indicated above, there is no one definition of rural; rural and frontier areas vary in their cultural and economic circumstances. Therefore, although there are universal recommendations for rural behavioral health workforce development, they must be shaped to fit the specific context of a given rural area.

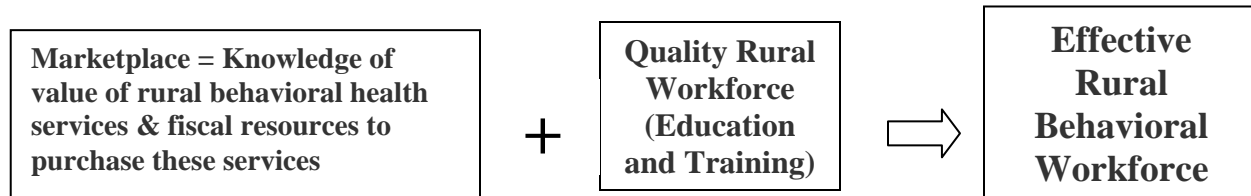
The recommended interventions for rural behavioral workforce development were reviewed and developed by multiple sources with expertise in the workforce and behavioral health service needs of rural communities. Attendees of the Reno and Mesa Conferences, who represented a wide range of professionals and advocates across the behavioral health or health care field, developed initial recommendations and action steps. The Rural Expert Panel and external reviewers provided further input. It should be noted that the recommended interventions are not suggesting that current initiatives or existing coalitions be abandoned. Unwarranted duplication is not productive. Instead, the recommendations are intended to operate in conjunction with the larger strategic plan for workforce development by the Annapolis Coalition.

The framework for the recommendations was provided earlier in the discussion of Figure 17.2. In brief, the four main components of the behavioral health workforce are population, prevalence, occupation, and education. Of these, education is fundamental and, therefore, the primary focus here.

Education refers to two main groups: 1) community members' knowledge of and interest in behavioral health as potential consumers or providers, and 2) providers' clinical knowledge regarding rural culture and issues. Like all Americans, rural residents have the potential to be consumers or providers of behavioral health services, or both. As potential consumers, they must know that a) mental health problems are not uncommon, b) help is available, and c) services are affordable. Rural Americans, including persons in recovery, who are interested in behavioral health as a profession and who want to remain in their communities should have options for receiving quality education so they can train and practice where they desire to live (e.g., via distance learning).

Providers of rural behavioral health services will be competent and effective to the extent that they are appropriately trained in the issues and delivery systems that exist. Training can be accomplished in large part by bridging higher education curricula and the reality of public mental health systems in rural areas, and by distance education and use of technology, and the inclusion of training for primary care providers in rural communities (who often take the place of mental health providers in remote communities). The simple equation below might be considered a logic model for improved workforce.

Figure 17.3: Rural Workforce Logic Model



Within the frameworks presented in Figures 17.2 and 17.3, the following four major recommendations were established, with interventions for each one.

Recommendation 1: Develop initiatives (i.e., policies, resource centers, etc.) that support the delivery of behavioral health education and training to people living in rural and frontier areas. Frequently, training for behavioral health and other available providers in rural areas (e.g., primary care providers) bears little resemblance to the real-world work specific to rural residents and rural and frontier culture and needs. However, there are limited resources to develop a defined training system that clearly articulates and supports the transfer of knowledge and competency to the rural behavioral health workforce.

Actions:

- Establish a national data resource center for rural behavioral health that would
 - a. act as intermediary between training programs and actual practice charged with disseminating information on “what works” in rural areas;
 - b. establish an annual award for exemplary rural behavioral health programs that would provide support from the federal level and some monetary incentive for nominated programs;
 - c. provide updated information on disparities in rural behavioral health;
 - d. provide fellowship programs for workers seeking advanced training in rural areas; and
 - e. facilitate the development and implementation of evidence-based practices for rural communities.
- Catalog model training programs for rural behavioral health.

- Establish ongoing collaborations between state behavioral health and primary health care organizations.
- Execute a national educational campaign on Medicaid policies, reimbursement, and flexibility for behavioral health services in rural areas.
- Educate local coalitions of citizens about behavioral health programs that serve the unique needs of their communities and enlist their help in securing resources to sustain the programs.
- Assess how local and statewide voluntary associations (e.g., Kiwanis, Rotary, Jaycees, etc.) can become informed about innovative mental health programs that serve rural areas.

Recommendation 2: Define and support the development of a midlevel workforce to ensure adequate access to behavioral health services. Developing a midlevel workforce in rural behavioral health requires the development of core competencies in this area. Core competencies are fundamental skills one must possess to effectively treat people with behavioral health problems. Defining a set of competencies in rural behavioral health will ensure basic standards of care, facilitate fluid communication through a common language, and increase collaboration and accountability across provider disciplines. Ultimately, the rural competencies could be linked with licensure and certification of providers and the accreditation of training and education programs.¹⁰

Actions:

- As a first step, train primary care providers and other first responders in rural areas to better identify behavioral health issues, provide proper initial treatment, and make responsible referrals to other professionals when necessary.
- Recommend that SAMHSA issue a grant or grants to an organization to convene stakeholders and constituencies in rural behavioral health to identify a set of core competencies necessary for work in rural behavioral health as a midlevel provider. The initiative would also create a core competency training curriculum to be used in behavioral health, primary care, and other rural provider educational programs.

Recommendation 3: Use technology to effectively support the training of behavioral health professionals (e.g., specialty consultation, education, and training). It is recommended that distance education and technology be used to deliver seamless training across the rural behavioral health care career ladder. An example of an emerging initiative where technology and distance learning are used in this way is the Western Social Work Programs Collaborative. This multistate collaborative proposes an integrated

¹⁰ Current strategies to increase the rural behavioral health workforce, such as loan repayment programs, should not be abandoned. This strategic plan should be viewed as an opportunity to expand participation in programs that serve rural America to best meet the needs of rural communities.

distance-learning plan to address the workforce shortages of master's- and doctoral-level social workers with expertise in rural and frontier practice in the rural and underserved regions of the western United States. The higher education partners are in Alaska, Colorado, Wyoming, Idaho, North Dakota, Nevada, and Utah. Students will be admitted to distance-education programs from these states and will have access to a consortium-delivered curriculum that earns them a graduate certificate in rural and frontier social work practice. Other kinds of actions are presented below.

Actions:

- Encourage state mental health divisions to partner with their departments of education to identify unique needs or capacities for technology and distance learning.
- Identify regulations that govern the use of technology in different systems, and create a plan that increases integration and usefulness of technology in training efforts.
- Identify key persons in regions serving rural areas to manage technology resources for behavioral health purposes (e.g., teleconferences, distance education, electronic mailing lists, Webcasts).

Recommendation 4: Ensure that rural residents, political officials, and consumers are full partners in behavioral workforce development planning and implementation efforts. Consistent with Goal 1 for the Action Plan for behavioral health workforce development, rural residents, political officials, consumers, and other community members should be included in all planning and implementation initiatives. This recommendation underlies all other recommendations set forth in this report. It ensures support at multiple levels and increases the likelihood that individuals will buy in and take ownership of an initiative affecting their rural community. It is also important for workforce planning efforts to consult rural regions to understand and respond to community-specific needs.

Actions:

- Organize on a state-by-state basis a Rural Behavioral Health Consortium that includes behavioral health and primary care providers, representatives from the state office of rural health, state behavioral health and primary care associations, consumers, and political officials.
- Organize county or regional collaborations to serve as local work groups on workforce development that report to the state consortium.
- Change the paradigm from one that keeps consumers dependent on government and health systems to one that promotes empowerment and independence. The knowledge and experience of consumers who have achieved significant recovery can help focus training and workforce development efforts on skills and tasks that are truly clinically effective.

Conclusion

Rural Americans face a unique combination of factors that create disparities in health care not found in urban areas. The national, regional, and state efforts currently underway indicate significant momentum behind behavioral health workforce development, particularly in rural areas. However, among the most critical issues for rural Americans is a lack of behavioral health providers and services. Common sense indicates that significant time and effort be put toward developing an effective behavioral health workforce for rural and frontier America.

Agencies such as SAMHSA and HRSA have shown their commitment to helping rural Americans receive the care they need by offering financial support for these and other efforts. Furthermore, the leadership, scholarship, and support of the Annapolis Coalition have been instrumental in national efforts to develop a behavioral health workforce and the Mesa Conference in particular. Also worth acknowledging is the quiet, often unnoticed, but immensely important work of the individual Americans who are providing services and training, going through recovery, or advocating for persons with behavioral health problems. These are precisely the people and efforts that conferences and meetings seek to include in the process of strengthening the workforce. WICHE will continue to work with the Expert Panel on Rural Issues and other key individuals to further develop and implement an action plan for rural behavioral health workforce development.

Innovation Highlight: Alaska Behavioral Health Workforce Initiative

The *Alaska Behavioral Health Workforce Initiative* (www.uas.alaska.edu/healthscience/ABHWI.htm) is a joint effort of the University of Alaska, the Alaska Division of Behavioral Health, and the Alaska Mental Health Trust Authority to address behavioral health workforce recruitment and retention problems in rural Alaska. With guidance from WICHE, the University of Alaska convened educators from across the behavioral health fields to discuss how to most effectively address workforce shortages. The group examined need, future demand, and current efforts to educate professionals. As a result, the university is focusing on training an indigenous workforce for Alaska that is community-focused and culturally competent. The results include a set of curricula that supports a career ladder to enable Alaska to grow its own workforce.

Innovation Highlight: Lakota Mental Health Care Coordination Certification Program

Lakota Mental Health Care Coordination Certification Program (www.wakanyeja.org), offered by Oglala Lakota College, provides training and education in the delivery of prevention techniques and interventions to treatment mental health needs that are culturally appropriate to the needs of the Lakota people. The certification program was developed out of a grassroots effort to change the way that people with mental and addictive disorders were treated by using Lakota cultural healing as the foundation. Interventions unique to this certification program include the Inipi (purification) ceremony where individuals and their family go through a ceremony where mind, body, and spirit are renewed; the Lakota rites of passage for males and females; and a healing ceremony to “call back” the spirit that has been disconnected from the individual as a result of severe trauma.

Innovation Highlight: UNM Rural Psychiatry Residency Program

The *Rural Psychiatric Residency Program at the University of New Mexico Health Science Center* is designed to enhance training and competencies in special rural practice issues by exposing residents to the significant and unique cultural and class demographics found in rural America. Medical residents spend 1 day a month during their third year, and up to days a week for 6 months to a year during their fourth year at rural sites throughout the state. Residents spend only about half of their time doing clinical work; the rest of the time is spent participating in administrative deliberations, sorting out the role of the psychiatrist in rural CMHCs, and exploring ways to integrate effectively with community resources like schools, the broader medical community, the local police department, tribal councils, and local health care boards. Local supervisors and clinical faculty serve as mentors for this rotation.

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CHAPTER 18

SCHOOL MENTAL HEALTH WORKFORCE ISSUES¹¹

Introduction

In the past two decades, school mental health (SMH) services have undergone substantial development, with movement beyond traditional, and often discipline-specific, practices addressing the needs of identified students. SMH services increasingly reflect more comprehensive approaches involving family-school-community partnerships and a full continuum of mental health promotion, problem prevention, and intervention services for children and youth in general and in special education. These more comprehensive services, reflecting integrated approaches to reducing academic and nonacademic barriers to learning, have received considerable federal support (e.g., New Freedom Commission on Mental Health, 2003; DHHS, 1999, 2000). In fact, the President's New Freedom Commission (2003) emphasized not only that schools offer unparalleled access as points of engagement with children and youth, but also that schools must address students' interrelated academic and mental health needs, leading the commission to make an explicit recommendation (4.2) to "expand and improve school mental health programs." Heightened attention to SMH also relates to the realization that, when done well, SMH services can reduce the stigma of help seeking, promote generalization and maintenance of treatment gains, enhance capacity for prevention and mental health promotion, and offer more natural, ecologically grounded approaches. Effective SMH services also are associated with strong satisfaction by diverse stakeholders, improvement in student emotional and behavioral functioning, and improvements in school outcomes (Robinson, 2004; Weist, Evans, & Lever, 2003; and the full SMH expert panel report). In relation to these findings, effective SMH services offer the potential to substantially address the mandates of the reauthorized Elementary and Secondary Education Act (No Child Left Behind) and the reauthorized Individuals with Disabilities Education Improvement Act (IDEA).

¹¹ Carl E. Paternite, Ph.D., Mark D. Weist, Ph.D., Jennifer Axelrod, Ph.D., Karen Weston, Ph.D., and Dawn Anderson-Butcher, Ph.D., were the authors of this report, written on behalf of the Mental Health – Education Integration Consortium.

Despite substantial progress, comprehensive SMH still is a young and complex field, with a fairly limited knowledge and research base, extreme variability in implementation of programs and practices, and tenuous funding. There are many difficult challenges and exciting opportunities to significantly improve student outcomes socially, emotionally, and academically, reflecting the reality that SMH operates at the intersection of education and mental health knowledge bases, norms, and cultures. Within this evolving context, advancement of strong interdisciplinary workforce training and support is essential. The goal of the Mental Health–Education Integration Consortium (MHEDIC) Expert Panel report is to contribute strategic guidance for further development of an enhanced training agenda for an evolving and effective SMH workforce.

Workforce Overview

Mental health services in schools, and the associated workforce, often have been marginalized and viewed as “add ons” that are not central to the academic interests of schools. On all levels, the education system has not adequately recognized the essential contribution of effective mental health supports to integrated approaches that reduce barriers to student learning, promote student well-being, and enhance desired school-level outcomes. Staff trained to work in and be employed by schools (e.g., school psychologists, school social workers, school counselors, and school nurses) often contend with very high student-to-staff ratios and position constraints that hinder their much-needed central roles in mental health promotion, prevention, and intervention services. Staff trained to work in community settings (e.g., clinical/counseling psychologists, clinical social workers, professional counselors, and child psychiatrists) generally are not adequately trained to work in schools. The majority of schools have far too few mental health providers, whether school or community trained, and there are significant needs for advanced interdisciplinary training that emphasizes high quality, family-driven, culturally competent practices to address the myriad roles that school and community mental health staff provide to children and families in schools.

SMH staff members generally are not adequately trained in implementation of evidence-based practices nor in adaptation strategies and processes that often are necessary to implementing effective practices in schools and classrooms. Similarly, educators generally are not adequately prepared in their training to address the significant mental health issues they encounter in the classroom (Paternite & Johnston, 2005; Stemler, Elliot, Grigorenko, & Sternberg, 2006).

Workforce training should support interdisciplinary mental health practices in schools, yet there are very few examples of effective training that fully engage traditionally school-focused and community-focused mental health disciplines, educators, and families. Efforts to advance such a training agenda are

complicated further by standards for credentialing and licensure that vary across disciplines and states. (See the full SMH expert panel report for a more thorough overview of workforce issues.)

Strategic Planning Process

MHEDIC, a multidisciplinary group, is serving as the school mental health expert panel for the Annapolis Coalition. MHEDIC emerged from a critical issues planning meeting, convened in May 2002 by the Center for School Mental Health Assistance (now the Center for School Mental Health Analysis and Action; CSMHA) at the University of Maryland. The work of MHEDIC evolved initially through a series of conference calls, e-mail exchanges, and meetings at the CSMHA-sponsored annual SMH national conferences (Philadelphia, 2002; Portland, OR, 2003; Dallas, 2004; Cleveland, 2005). Currently, the membership of MHEDIC reflects a broad range of disciplinary backgrounds (clinical psychology, school psychology, social work, school health, public health, child psychiatry, teacher education, educational leadership, mental health administration, and educational administration). In the past 4 years, MHEDIC has been deeply involved in the training agenda for effective mental health practice in the schools, with members making more than 60 professional presentations at diverse training conferences, organizing a number of national and state meetings, publishing 16 articles, organizing a list of core competencies for advanced effective mental health practice in the schools, and helping to develop an emerging SMH Community of Practice (described later). MHEDIC's mission and goals are detailed at the MHEDIC Web site (<http://www.units.muohio.edu/csbmhp/mhedic/index.html>).

The consortium began to develop the Annapolis Coalition report during a two-day meeting in July 2005. A first draft was submitted to the Coalition in September 2005. Subsequently, two full reviews of the paper by additional MHEDIC members took place prior to submission of a revised draft in October 2005. Between October and December, additional feedback on the paper was received from a number of professional organizations representing school-based mental health staff. To assist with responding to recommendations for improving the report, three additional MHEDIC authors, with diverse disciplinary perspectives, joined the core writing team. A revised report then was shared for feedback in early January 2006 within MHEDIC and was submitted to the Coalition on January 17, 2006. Throughout the 6-month period of writing and revision, following the summer 2005 meeting, an active e-mail exchange took place among MHEDIC members, and four conference calls were convened to discuss the report. The current summary report is drawn largely from the full report and has been carefully reviewed, edited, and endorsed by the core writing team.

Relevance of the Core Action Plan Goals

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

Best practice in SMH is grounded in a *shared agenda* philosophy, in which families, schools, mental health, and other child-serving systems work collaboratively, and the contributions of children, youth, and families across diverse cultures are actively engaged, respected, and valued (Axelrod Lowie, Lever, Ambrose, Tager, & Hill, 2003; U.S. Department of Education, Office of Special Education Programs, 2002). Based on the shared agenda philosophy and the research in the field documenting the impacts of family and individual involvement on outcomes, Goal 1 is critical to advancing effective SMH practice. In addition, Goal 1 supports the development of relevant educational information on SMH that is reflective of diverse cultures, promotes dialogue and collaboration on shared decision-making strategies, and prominently involves youth and families in training roles. To support this best practice in SMH, MHEDIC members, and many other groups, actively participated in the development of a national SMH Community of Practice, which places significant emphasis on close collaboration with children, youth, and families in all work. The Community is supported primarily by the IDEA Partnership and by the CSMHA. The SMH Community of Practice is a forum for dialogue and collaboration striving to advance meaningful work related to 10 critical themes by facilitating multiscale learning among localities, states, national organizations, and federal supports. This Community of Practice integrates the key themes of Goal 1 with conscious emphasis and exploration of practices to more effectively involve and engage children, youth, and families in mental health supports.

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

Strong community participation in needs assessment, resource mapping, program planning, program evaluation and continuous improvement, and policy advocacy are foundational to advancement of SMH (Devaney, O'Brien, Resnik, Keister, & Weissberg, in press; Flaspohler, Anderson-Butcher, Paternite, Weist, & Wandersman, 2006). In addition, the SMH field is beginning to enhance connections with initiatives related to school-based health centers, full service schools, and afterschool programs, all of which require strong community participation and provide opportunities for cross-training between schools and community agencies. The core competencies for advanced interdisciplinary mental health practice in the schools (described in the full SMH expert panel report) are intended to promote practice within SMH programs and services that are community driven. There are distinct opportunities to connect enhancement of the SMH workforce (and SMH services) to Goal 2.

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

There are many SMH workforce recruitment and retention challenges. Several objectives embedded in Goal 3 are directly relevant for SMH, especially public relations efforts to address marginalization and promote SMH as a career choice, and career ladders and incentives to facilitate commitment to advanced interdisciplinary mental health practice in the schools. In addition, recruitment into SMH as a profession would be enhanced greatly by state-level efforts to change certification and licensure requirements to include cross-disciplinary tracks for SMH practice.

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

Goal 4 is aligned directly with the mission, goals, and activities of MHEDIC, which since its inception in 2002 has been focused on identifying advanced interdisciplinary skills in SMH and effective pre- and in-service training approaches to promote the acquisition and application of these skills by mental health and education professionals. MHEDIC has developed a set of 32 core competencies for effective advanced interdisciplinary mental health practice in the schools, and a current project is underway to cross walk this set with discipline-specific competencies developed by several professional organizations and certification bodies (e.g., National Association of School Psychologists, School Social Work Association of America, and American Counseling Association). This preliminary set of competencies has been developed through careful review of diverse resources, including findings from a systematic NIMH-funded study on quality assessment and improvement underway at the CSMHA. Identification of the competencies, and associated competency-based curricula and effective training methods, also are informed by the local, state, and national training and research experiences of CSMHA, the Center for School-Based Mental Health Programs at Miami University (Ohio), the Center for Advancement of Mental Health Practices in Schools at the University of Missouri (Columbia), and the Collaborative for Academic, Social, and Emotional Learning. These competencies, and training methods to promote their development, emphasize evidence-based practice and use of diverse, interactive, and effective training methods, including distance learning and methods that capitalize on other technological advances.

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

Fostering strong leadership to promote a connected policy-training-practice-research agenda for the SMH field is a high priority. Leadership in the mental health, education, public health and other systems must effectively address several critical challenges that include: a) implementing meaningful interdisciplinary SMH practices by overcoming barriers, including limitations in pre- and in-service training, confusing

credentialing and licensure requirements, issues related to language and professional jargon, different disciplinary heritages and cultures, and logistical and financial obstacles; b) delivering SMH services that reflect an integrated focus on mental health and academic outcomes, through attention to nonacademic (social, emotional, behavioral) and academic barriers to learning; c) emphasizing commitment to a families-schools-mental health shared agenda in all aspects of SMH work, with effective collaboration between school staff and community staff; d) supporting the leadership of school-employed mental health professionals in the provision and coordination of SMH services, and also emphasizing strong collaboration with community-based mental health professionals in the development and implementation of full continuums of services; e) building strong systems of ongoing quality assessment and improvement for promotion of evidence-based practice, with well-integrated research supports for local practitioners (e.g., ongoing training, coaching, and feedback, technical assistance, and useful resources); f) ensuring that all SMH work is culturally competent; g) building stronger emphasis in SMH services on key transitions in children's lives, from preschool into postsecondary education or work; and h) enhancing public involvement in advocacy strategies to improve policies and firmly establish SMH programs and services as the norm.

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

Substantial recent federal investments in SMH provide opportunities for heightened commitment to a meaningful workforce training strategy. A detailed summary of these commitments is provided in the full SMH expert panel report. Most of these federally supported initiatives also contribute to some level of training in SMH. Workforce issues also are beginning to be prioritized within the context of SMH policy advocacy, service delivery, and technical assistance that are emerging in some U.S. cities and states. In addition, collaborative SMH networks and training initiatives have developed at state, national, and international levels.

Nonetheless, the infrastructure reflected in the above-noted investments and activities remains highly fragmented and not well integrated, with very tenuous funding. The emerging infrastructure at the federal and state levels is not sufficiently reflective of nor engaged with the realities of local-level SMH and educational practice (see Flaspohler et al., 2006). In addition, models of effective SMH, and the collaborative infrastructures that support them, typically are not well understood and implemented at the local level. Meaningful connection across these federal, state, and local initiatives would be enhanced greatly by implementation of Goal 6.

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

Work undertaken by MHEDIC thus far suggests that there are substantial unmet training needs for most current SMH providers (including school- and community-employed), current educators, and preprofessionals in current training programs. There are many important research questions that should be addressed once core competencies for advanced interdisciplinary mental health practice in the schools are identified and competence-based curricula and effective teaching methods are integrated into a proposed SMH workforce training agenda. For example, it will be important to examine a) the perceived value of the advanced interdisciplinary competencies by a variety of professional groups, parent, and family advocacy organizations, and other community partners; b) the extent to which these competencies already are being demonstrated by currently practicing SMH providers from various disciplines; c) the degree to which, and ways in which, the competencies are addressed in university training programs and in continuing education; and d) the impacts that having staff fully trained in and demonstrating the core competencies have on costs and benefits to SMH programs. The workforce training needs associated with critical leadership challenges, reviewed in discussion of Goal 5, also represent important areas for future research.

Unique Issues and Recommendations

Compelling data provide a strong basis for asserting the imperative that SMH programs and services must be improved and expanded (New Freedom Commission on Mental Health, 2003). The data show that between 20% and 38% of children and youth in the United States have diagnosable mental health disorders, and 9% and 13% have serious disturbances. In addition, many more children and youth are at risk for serious disturbances or could benefit from help. The data also show that as few as one sixth to one third of children and youth with diagnosable disorders receive any treatment; and, of those who do, far less than half receive adequate treatment. For the small percentage of children and youth who do receive services, most actually receive them within a school setting. The majority of children and youth benefit from comprehensive, coordinated, evidence-based universal mental health promotion programming in schools (Greenberg et al., 2003; Robinson, 2004; & Weist et al., 2003). In addition, given that more than 52 million children and youth attend 114,000 schools in the United States and that more than 6 million adults work in schools (i.e., over one fifth of the U.S. population in combination), the findings highlight the importance of schools as a key setting for mental health promotion, problem prevention, and intervention. In fact, as described previously, the New Freedom Commission noted that schools offer unparalleled access as points of engagement with children and youth to address their interrelated mental health and academic needs.

However, as described previously, there are many challenges to adequately preparing a SMH workforce and delivering effective services. To reiterate a previous point, many of the challenges relate to the fact that SMH operates in the intersection of education and mental health knowledge bases, norms, and cultures, and there is a pressing need for advancement of strong interdisciplinary workforce training and support.

The writing team for this summary report, and the larger MHEDIC, drew upon diverse sources of information for the development of the recommendations that follow. The sources include review of the published literature, research findings from studies the coauthors are involved in, and guidelines for training, core competencies, and certification published by professional associations for mental health providers from relevant disciplines (e.g., school, clinical, and counseling psychology; school and clinical social work; school counseling). The recommendations are intended to go beyond discipline-specific frameworks to focus on core competencies that are relevant across SMH disciplines and that ideally should be applied to workforce preparation that reflects an interdisciplinary philosophy and is informed by appreciation of the context of schools. Thus, the expert panel strongly recommends the development and implementation of a sequential and iterative SMH workforce training strategy that includes

- systematically identifying and validating the core competencies for *Advanced Interdisciplinary Mental Health Practice in Schools*;
- designing training curricula, methods, and experiences for developing these critical competencies of SMH providers;
- implementing, strategically pilot-testing, and evaluating the curricula, methods, and experiences, within the context of model community-school partnerships that serve as real-world learning opportunities;
- developing a common certification process and mechanism for *Advanced Interdisciplinary Mental Health Practice in Schools*, which requires mastery of the core competencies; and
- influencing university-based mental health training programs and accreditation by reviewing and disseminating to them current exemplary training processes and practices, and involving them in developing and implementing the certification process for *Advanced Interdisciplinary Mental Health Practice in Schools*.

At a minimum, the common core competencies for all SMH providers, to be identified in conjunction with the first recommendation, should ensure a) well-developed cross-discipline knowledge, skills, and abilities to guide practice in schools; b) clear understanding of the background, training, professional identity, and professional standards of the other disciplines; c) strong interdisciplinary and jargon-free communication, collaboration, and consultation skills and abilities uniquely demanded of professionals working in schools; d) firm understanding and appreciation of school culture and education laws and regulations, and related skills and abilities to integrate mental health issues, needs, and services in school terms; e) strong

abilities to engage in and promote ongoing quality assessment/improvement and evidence-based SMH programs and services that reflect and are responsive to the operating realities of schools and reflect best practices of individual and family involvement; and f) well-developed skills, abilities, and commitment to demonstrate support and respect for family and cultural values in all SMH practices.

Strategies for identifying specific competencies associated with these key elements, and for implementing the four additional recommendations are included in the full SMH expert panel report. The goal is to create and sustain a workforce that can facilitate improvement and expansion of school mental health programs and services (New Freedom Commission on Mental Health, 2003), to effectively serve youth with mental health needs and their families, to enable these students to succeed in school, and to promote the mental health and success for all youth.

Conclusion

To achieve desired outcomes for all children and youth, effective mental health promotion, problem prevention, and intervention services are needed in schools. Ultimately, to promote the development of an effective SMH workforce that can meet the mental health needs of children and youth, and to promote improved and expanded SMH practices, there is a basic necessity for a substantial interconnected policy-training-practice-research agenda (Kratochwill, Albers, & Shernoff, 2004; Lever et al., 2003; Weist & Paternite, in press). To ensure effective SMH practices, a critical quality assessment and improvement agenda must be undertaken, which subsumes culturally competent evidence-based practices that are reflective of strong family and community engagement. Infrastructures that reflect effective communication, strong collaboration, and meaningful training underpin the successful development and implementation of such practices. Policies to promote effective SMH practices must be based on a clear understanding of the current status and needs of the field and must inform strategic planning. Such policies and planning are needed to ensure adequate resources (new and reallocated) that are foundational to advancement of the field. Resources must be allocated judiciously to support well-coordinated, non-duplicative SMH services that reflect a common agenda for families and other stakeholders in child-serving systems (education, mental health, health, child welfare, and juvenile justice). These key elements reflect SMH as a cornerstone in the development of a public mental health promotion system in the United States, emphasizing more preventive services for all children and youth “where they are” and consistent with positive experiences occurring in other nations (Rowling & Weist, 2004; Weist, 2005).

Innovation Highlight: Center for the Advancement of Mental Health Practices in Schools

The *Center for the Advancement of Mental Health Practices in Schools* (<http://schoolmentalhealth.missouri.edu/>) is an online graduate-degree program in the area of school-based mental health designed to educate school-based personnel (teachers, administrators, counselors, nurses, etc.) about the numerous mental health disorders that commonly affect school-age children, and how educators can better serve such children in the classroom. Through this program, school-based personnel can obtain a graduate degree accessible through the delivery of online learning and gain invaluable experiences communicating with teachers, administrators, and others from around the world. Educators also have access to professors from across the United States with expertise in specific academic content related to their respective fields of practice. Coursework is designed to provide students with proactive, prevention-focused, evidence-based practices proven effective in the fields of education and mental health. The program also recognizes and addresses the importance of the mental health needs of educators.

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CHAPTER 19

SUBSTANCE ABUSE PREVENTION¹²

WORKFORCE ISSUES

Introduction

The history of the substance abuse prevention field provides an important context for understanding the evolving needs of the substance abuse prevention workforce. The earliest prevention programs relied on unproven strategies or practices that lacked effective evaluation that clearly demonstrated results. For more than a decade, however, prevention science has fostered an expansion beyond these largely unsuccessful approaches by producing an ever-increasing number of evidence-based programs and practices. Current prevention programs, policies, and practices continue to evolve and embrace the science that drives the delivery of evidence-based approaches that address alcohol, tobacco, and other drug (ATOD) problems. With its increasing success in preventing, delaying, and reducing disability from chronic disease and illness, including substance abuse and co-occurring mental illness, the field of substance abuse prevention has developed into a respected, organized discipline and now has a significant role in the fields of behavioral health, public health, and mental health promotion.

Prevention is defined as a proactive, multifaceted, multi-community-sector process involving a continuum of culturally appropriate services. It empowers individuals, families, and communities to meet the challenges of life events and transitions by creating and reinforcing conditions that have an impact on physical, social, emotional, spiritual, and cognitive well-being and promote safe and healthy behaviors and lifestyles. Substance abuse prevention is a planned sequence of activities that, through the practice and application of evidence-based programs, policies, and practices, is intended to inform, educate,

¹² The work of the National Association of State Alcohol and Drug Abuse Directors, Inc, National Prevention Network (NPN) Workforce Development Committee, with Janice Petersen, Ph.D. (Chair), and Jane Callahan, representing CADCA, informed this contribution. Pamela Petersen-Baston, MPA, CAP, CAPP, served as a consultant and was the author of this section.

develop skills, alter risk behaviors, and affect environmental factors in addressing alcohol and other drug problems (adapted from NASADAD/NPN position statements, 2006).

The Center for Substance Abuse Prevention (CSAP) is the sole federal organization with responsibility for improving accessibility and quality of substance abuse prevention services and for providing national leadership for the field. Through its adoption of guidelines to states for the implementation of prevention programs, six major strategies have emerged. Table 19.1 outlines the structure of the strategies and the types of interventions that are highlighted as examples. Over the years, states have incorporated the six strategies into planning processes to support their prevention infrastructure and have expanded the definition of prevention to include an array of prevention activities focused on the life span. Any attention to workforce issues must take these current delivery strategies into consideration.

Table 19.1: CSAP Substance Abuse Prevention Strategies & Interventions

Note: Examples of services to describe the CSAP six strategies were adapted from the Ohio Department of Alcohol and Addictive Services, *Strategic Planning Process, 2006*.

Prevention Service Delivery Strategies
1. Strategy: Information Dissemination
Information Dissemination focuses on building awareness and knowledge of the nature and extent of alcohol and other drug use, abuse, and addiction and the effects on individuals, families, and communities, as well as the dissemination of information about prevention, treatment, and recovery support services, programs, and resources. This strategy is characterized by one-way communication from source to audience, with limited contact between the two.
Services
<ul style="list-style-type: none"> • <i>Print and Electronic Media</i> • <i>Newsletters</i> • <i>Clearinghouse and Other Information Resource Center</i> • <i>Resource Directories</i> • <i>Brochures and Other Publications</i> • <i>Speaking Engagements</i> • <i>Informational Booths and Displays</i> • <i>Information/Resource Lines</i> • <i>Web-based Resources and Information Services</i>
2. Strategy: Alternatives
Alternatives focus on providing opportunities for positive behavior support as a means of reducing risk-taking behavior, and reinforcing protective factors. Alternative programs include a wide range of social, recreational, cultural, and community service/volunteer activities that appeal to youth and adults.
Services
<ul style="list-style-type: none"> • <i>Social and Recreational Prevention Services</i> • <i>Youth-Led Prevention</i> • <i>Youth and Adult Leadership Services</i> • <i>Community Service/Service Learning Activities</i> • <i>Mentoring Programs</i> • <i>Cultural Programs</i> • <i>Community Events</i> • <i>Community Drop-In Center Activities</i>

Table 19.1 continued on next page

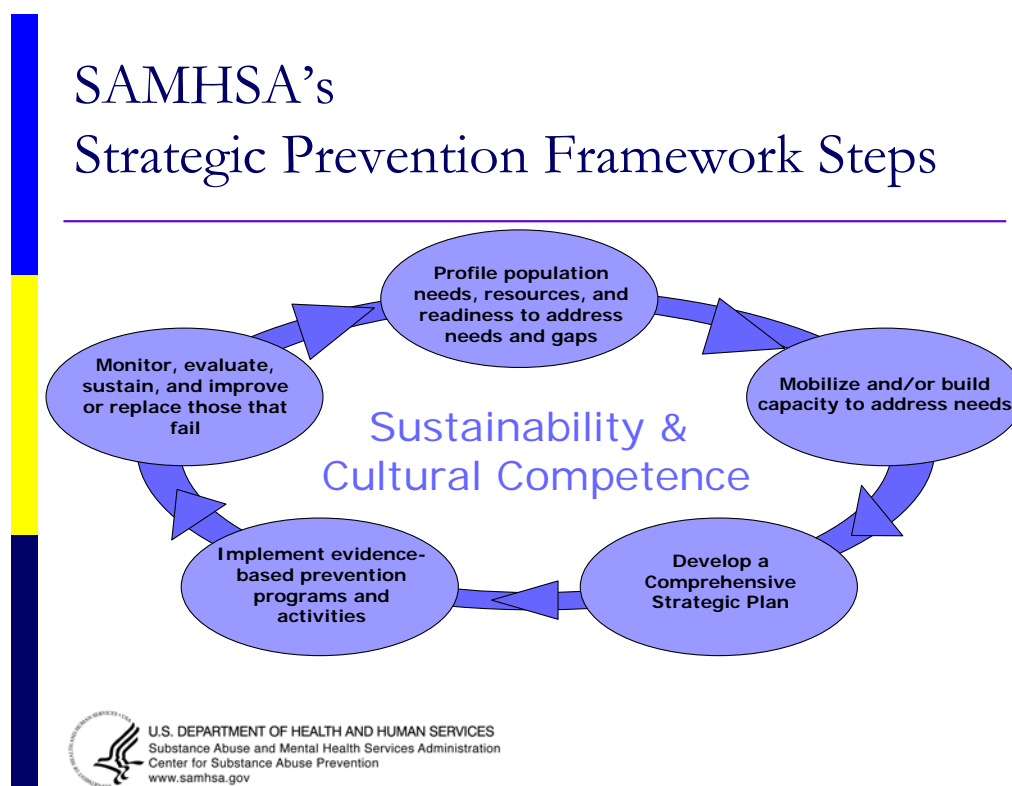
3. Strategy: Education
Education focuses on the delivery of services to target audiences with the intent of affecting knowledge, attitude, and/or behavior. Education involves two-way communication and is distinguished from information dissemination by the fact that interaction between educator/facilitator and participants is the basis of the activities. Activities focus on critical life and social skills, including decision-making, refusal skills, critical analysis, and systematic judgment abilities.
Services
<ul style="list-style-type: none"> • <i>Classroom and Small Group Discussion/Instruction</i> • <i>Parenting and Family Education/Skills Training</i> • <i>Peer Leader and Peer Educator Programs</i> • <i>Education Programs for Youth/Adult Groups</i> • <i>Educational Support Groups</i> • <i>After-School Programs</i> • <i>Mentoring Programs</i> • <i>E-Learning</i> • <i>Workshops/Conferences</i>
4. Strategy: Community-based Process
Community-based Process is an AOD prevention strategy that focuses on enhancing the ability of the community to provide prevention services through organizing, training, planning, interagency collaboration, coalition building, and/or networking and policy development.
Services
<ul style="list-style-type: none"> • <i>Community and Volunteer Training</i> • <i>Strategic Planning</i> • <i>Capacity-Building Activities</i> • <i>Multiagency Coordination and Collaboration</i> • <i>Accessing Service and Funding</i> • <i>Community Team Building</i> • <i>Coalition Building</i> • <i>Technical Assistance</i> • <i>Focus Groups</i> • <i>Surveys</i> • <i>Training/Workforce Development</i>

Table 19.1 continued on next page

5. Strategy: Environmental
Environmental prevention is an AOD prevention strategy that represents a broad range of activities geared toward modifying systems in order to mainstream prevention through policy and law. The environmental strategy establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of alcohol and other drug use and abuse in the general population.
Services
<ul style="list-style-type: none"> • <i>Establish and Review of School Policies</i> • <i>Technical Assistance to Communities</i> • <i>The Review and Modification of Advertising Practices</i> • <i>Product Pricing Strategies</i> • <i>Minimum Purchase-Age Interventions</i> • <i>Deterrence Interventions</i> • <i>Interventions Addressing Location, Restrictions on Access and Density of Retail Outlets</i> • <i>Server/Seller Oriented Interventions</i> • <i>Establishing AOD-Free Policies</i> • <i>Changing Environmental Codes, Ordinances, Regulations and Legislation</i> • <i>Compliance Checks</i>
6. Strategy: Problem Identification and Referral
Problem Identification and Referral refers to intervention-oriented prevention services that primarily target indicated populations to address the earliest indications of an AOD problem. Services by this strategy focus on preventing the progression of the problem. This strategy does not include clinical assessment and/or treatment for substance abuse and dependence.
Services
<ul style="list-style-type: none"> • <i>Screening and Referral Services</i> • <i>Services Coordination</i> • <i>Support Groups</i> • <i>Mentoring Services</i> • <i>Insight Services</i> • <i>Risk Reduction Services</i>

As part of its efforts to reengineer its approach to substance abuse prevention, CSAP is implementing a new approach to substance abuse prevention referred to as the Strategic Prevention Framework (SPF). The SPF is identified in the matrix of SAMHSA cross-cutting principles and priorities as a distinct priority along with workforce development (SAMHSA, 2006). The SPF is a systemic public health and community-based approach that supports the delivery of effective programs and practices to prevent substance use disorders and promote mental health. The SPF sets into place a step-by-step process referred to as the 5 Strategic Steps: assessment, capacity building, planning, implementation, and evaluation. These steps are set forth as a mechanism to empower communities to identify and implement the most effective prevention approaches for their specific needs. It also includes feedback to ensure accountability and effectiveness of the program effort (DHHS, 2006). Figure 19.1 depicts the interaction of the five-step process, highlighting the essential elements of sustainability and cultural competence as central to the implementation of the framework.

Figure 19.1: SAMHSA's Strategic Prevention Framework



The SPF serves as the foundation for prevention programming and is used by states, jurisdictions, and territories to shape prevention systems across the nation. The utilization of this framework brings about an added set of unique challenges for the workforce as the need for advanced skills are required.

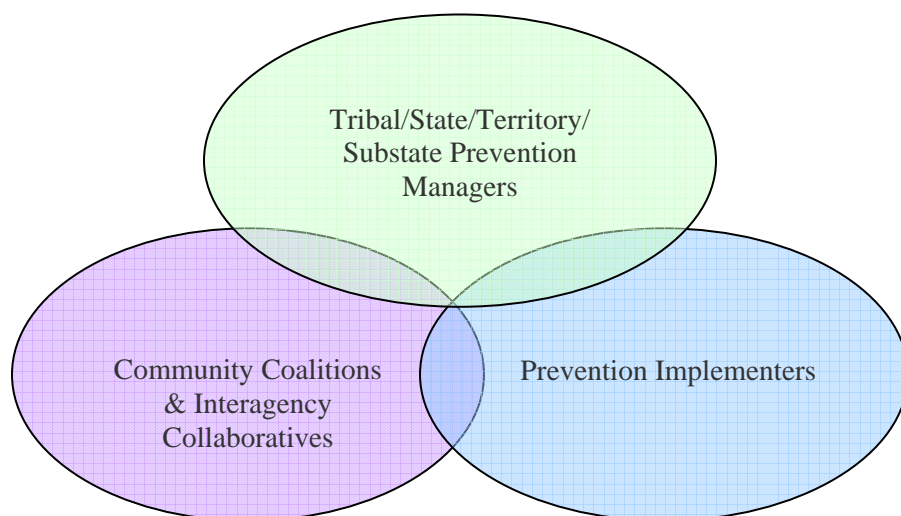
Workforce Overview

The nation's substance abuse prevention workforce now totals nearly ½ million workers. Unfortunately, no industry-wide inventory of the substance abuse prevention workforce exists, nor is there a uniform understanding about the expectations of the workforce. The substance abuse prevention workforce is made up of dedicated individuals who enter the field from a number of different disciplines such as social work, education, psychology, criminal justice, health care, and counseling, and professions such as the clergy. Some of these individuals have participated in a state certification or credentialing process, while others either do not meet the educational requirements for certification or credentialing, do not have access to such a process, or cannot afford the requisite education and training to qualify. Other members of this workforce include parents, teachers, youth leaders, indigenous workers, and representatives from multiple community sectors such as law enforcement, schools, religious or fraternal organizations, civic and volunteer groups, health care, and others who are committed to substance abuse prevention. Some

members of the prevention workforce perform in a professional capacity while others serve in voluntary, supportive, or ancillary roles. Despite their important contributions, many members of the prevention workforce report their work to be less valued than that of their peers who work in treatment settings or other similar professions.

As portrayed in Figure 19.2, the substance abuse prevention workforce typically falls into three distinct, yet overlapping segments: (1) tribal, state, territory, or substate managers of prevention funding and systems, including National Prevention Network (NPN) representatives; (2) direct implementers of prevention programs and activities; and (3) community or coalition members engaged in promoting the behavioral health and wellness of communities. The knowledge, skills, and abilities within each segment are quite diverse.

Figure 19.2: Substance Abuse Prevention Workforce Segments



An extensive array of “workplace” settings exists for the prevention workforce. These settings include schools, community groups and coalitions, businesses, health and welfare systems, justice programs, and faith-based organizations, requiring prevention workers to coordinate their efforts with others working at these sites. Research, cross-system coordination, and a growing emphasis on “behavioral health” has fostered the expansion of the scope of substance abuse prevention to include risk factors such as mental health, delinquency, school drop out, teen pregnancy, child welfare, adverse health conditions, and more. This diversity gives the prevention field a rich array of perspectives and skills, but also requires complex, coordinated approaches to workforce development.

The beneficiaries of substance abuse prevention are diverse and span all sectors, cultures, ethnicities, and age groups, including prenatal populations, school-age youth, young adults, older adults, and

families. The numbers and complexities of substances that put populations at risk are increasing, exemplified by cyclical use of drugs such as methamphetamine, Ecstasy, and Oxycontin. The varied developmental issues, risk factors, and cultural diversity associated with prevention's expanding target populations, and the complexity of emerging drugs and related risks, result in exceptional and ever increasing demands on today's prevention workforce.

While the advances in scientific knowledge and evidence-based practice have enabled prevention to emerge as a focused topic within the behavioral health field, the progress has not been without challenges. The growing emphasis on accountability, performance, and effectiveness have added substantial layers of knowledge, skills, and abilities that require specific competencies and place training demands on the workforce. The associated workforce development strategies and resources simply have to keep up with the growing demand.

Strategic Planning Process

The planning group assembled to represent substance abuse prevention in the strategic planning process included the Workforce Development Committee of NASADAD, Inc., NPN, and a representative of CADCA. NPN, represented by each state alcohol and other drug abuse prevention director or manager, provides a national advocacy and communication system for prevention. State prevention representatives work with their respective state agency directors for alcohol and other drug abuse to ensure the provision of high quality and effective alcohol, tobacco, and other drug abuse prevention services in each state. NPNs located in the states, jurisdictions, and territories manage the prevention portion of SAMHSA's Substance Abuse Prevention and Treatment Block Grant funds, which accounts for 20% of the total allocation. Members of the NPN organization were offered the opportunity to be involved in strategic planning for this Action Plan through phone conferences, face-to-face meetings, or review of work documents developed through this process. Representing the NPN membership, NASADAD's workforce development committee provided opportunities for input and developed reactions to the mission and goals of the strategic plan.

Relevance of the Core Action Plan Goals

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

The substance abuse prevention field has a history of accomplishments in support of this goal, as family members, and particularly parents, have been the "first responders" for substance abuse prevention for more than 3 decades. This history began with the "parent movement," which formed in the late 1970s in

response to the then rapid increase of drug use among America's youth. Parents organized themselves into action groups and began reclaiming their communities by working to close shops that openly sold drug paraphernalia and by closing neighborhood crack houses (DHHS, n.d.). In effect, parents became the drug abuse prevention specialists of the 1970s and 1980s. Strong parent and community coalition activity and advocacy, coupled with increased funding, made a powerful combination that contributed to the decline in drug use among America's youth (DHHS, n.d.).

Peer- and family-support services, shared decision-making, and formal engagement of persons in recovery and family members as educators are important objectives to the prevention field. While peer-led models are well established and consumer involvement is widespread, the needs of the substance abuse prevention field vastly exceed the human resources currently dedicated to this effort. Much work remains to be done to educate individuals and families about the vital prevention roles that they can and should play and to mobilize them into action. In recent years, there has been an increase in youth-led groups and increased adult involvement in mentoring programs, and school-based organizations are taking more of a leadership role in what happens with prevention activities in school settings. However, the involvement of individuals and families in continual efforts to educate the prevention workforce is less frequent than is optimal and provides an opportunity for further growth and development.

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

In the prevention arena, the concept of community generally refers to community coalitions or collaboratives comprising residents, consumers, policy makers, organizations, groups, governments, and agencies. Community involvement in promoting behavioral health and wellness has been a hallmark of the prevention field, originating with the crack cocaine epidemic of the mid-1980s. Many concerned communities organized their own coalitions, and from these grassroot beginnings, the anti-drug community coalition movement grew rapidly. The notion of “community” as the vehicle and catalyst for change has received increasing support as the coalition movement has demonstrated significant achievements in transforming communities in positive ways. Community coalitions, more than any other entity, are poised to connect multiple sectors of the community, including businesses, parents, media, law enforcement, schools, faith organizations, health providers, social service agencies, and the government (<http://cadca.org/AboutCADCA/Mission.asp>). State and federal funding agencies are now asking prevention implementers to measure outcomes at the community level, not the individual participant level, rendering the role of community coalitions even more vital.

“The community is not simply the *site* for the intervention but the *vehicle* for change” (Wagenaar, Murray, Wolfson, Forester, & Finnegan, 1994).

In 1990, with guidance and support from the President's Drug Advisory Council, a new organization, CADCA, became the national public voice for community coalitions (<http://www.cadca.org>). Local coalitions provide a strong foundation on which to further develop community competencies, aligned with evolving prevention science. In 2003, CADCA, in partnership with the World Health Organization Collaborating Centre for Community Health and Development at the University of Kansas, developed core competencies for community planning based on SAMHSA's SPF process (assessment, capacity building, planning, implementation, and evaluation) (<http://www.coalitioninstitute.org/index.asp>.) CADCA provides training and technical assistance to community coalitions seeking to develop or enhance core competencies in community problem solving. While CADCA is off to an ambitious start, greater consensus about and support for these competencies is needed from the many communities that have not yet been exposed to them. Additionally, expanded technical assistance is needed to assist communities in effective adoption of these competencies.

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

Some people might argue that prevention work is less emotionally taxing, less stigmatizing, and, in terms of paperwork, less burdensome than treatment-oriented work in addictions. Nevertheless, the prevention field suffers from many of the recruitment and retention problems experienced throughout the behavioral health field: high workloads, low wages, high turnover, shortages of workers (particularly ethnic minorities, younger workers, and men), and a lack of defined career paths.

It is especially challenging to attract and retain a workforce that is ethnically and culturally diverse and that possesses the necessary skills to provide evidence-based and accountable prevention interventions to increasingly complex populations. The absence of comprehensive educational opportunities and clearly defined entry points into the substance abuse prevention profession results in serious barriers to recruitment.

For many prevention staff, the only opportunity for enhanced wages or upward mobility is to move out of the prevention sector altogether and into the treatment area of the addiction field. The lack of a career ladder within prevention fosters an exodus scenario that siphons off some of the most seasoned and talented prevention professionals, further exacerbating a looming prevention leadership crisis. Implementing a comprehensive public relations campaign at the national, state, and local levels to promote substance abuse prevention as a career choice and formally identifying and promoting centers for excellence in workforce practices are especially relevant objectives for prevention.

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

Current education and training methods are largely inadequate to develop the menu of competencies needed by the current prevention workforce. Typical substance abuse prevention trainings are offered in single-event workshops. Participants leave the session or workshop with new information or increased awareness about a particular topic, and may even obtain an introduction to new skills and strategies that they might employ when they return to their jobs. However, participants generally have few opportunities to practice new skills and knowledge and have little support for trying new techniques in their work settings. Moreover, many prevention staff members do not have access to the available technologies needed to take advantage of the increasing number of Web-based education and training opportunities.

CSAP has developed or sponsored the development of prevention training courses, some of which are available online through its Prevention Pathways initiative (<http://pathwayscourses.samhsa.gov/>). At this time, however, the course work is not specifically tied to a set of widely accepted competencies. In 2000, the International Certification and Reciprocity Consortium identified five performance domains that contain the core areas of training and experience needed by substance abuse prevention professionals (International Certification and Reciprocity Consortium, 2001). While this is a good foundation, much work remains to be done to ensure that these, or other comparable competency sets, reflect the optimal and evolving skill sets and knowledge requirements of the prevention workforce as it tackles the increasing complexities and multidisciplinary nature of prevention work.

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

Funding limitations within prevention contribute to the considerable challenges of recruiting and keeping skilled prevention managers, as many prevention programs cannot pay salaries that are competitive with other areas of health care and the private sector. Leadership development within the prevention system is hampered by the absence of formal systems for developing management and leadership skills among people with strong prevention experience. CSAT's ATTC has supported the Southern Coast Addiction Technology Transfer Center's (SCATTC's) first Addiction Leadership Institute, piloted in October 2003. The program's components include 1) independent pre-course assignments; 2) a 360-degree assessment of each participant's job strengths; 3) five intensive days of training; and 4) a six-month follow-up program, during which time protégés work with mentors and complete a project based on their leadership goals. In the 2004 and 2005 Institutes, the first prevention protégés were accepted for enrollment. This example has shown promise and has led the way for others to evolve including the Prevention Leadership Academy funded by SAMHSA's CSAP.

CSAP developed the Prevention Leadership Academy as a sustainability model for the NPN representatives (SAMHSA-CSAP, 2005). The first Academy, held in February 2005, gave the NPN leaders a chance to map out their strategic plan for workforce development and set the pace for continued leadership training. A second Academy was held in 2006, and plans call for future ones to focus on state-level leadership skills.

In response to the advanced leadership skills now required of state prevention leaders and the rapid turnover in prevention leadership experienced by many states, the Academy is designed to build these skills in order to sustain the leadership in the field. CSAP considers the Prevention Leadership Academy to be part of an ongoing workforce development/leadership effort. Its purpose is broader than building specific knowledge and skills for NPNs. It builds the capacity and relationships that will nourish and sustain continuous self-development and peer learning.

Goals of the Prevention Leadership Academy include

- enhancing the CSAP/NASADAD/NPN partnership;
- fostering professional growth in the prevention field;
- enhancing state capacity;
- enhancing NPN as a leadership organization; and
- bringing to NPNs the latest leadership information and newest skills

Since the development of the Prevention Leadership Academy, CSAP has also sponsored the development of a Prevention Fellowship program. Prevention fellows are recruited to assist NPNs, which serve a mentoring function in their respective states, territories and jurisdictions, to address internal workforce development issues (SAMHSA-CSAP, 2006). The CSAP Prevention Fellowship project is currently the only one of its kind to focus on the substance abuse prevention workforce on a national level. It should be used as a model in other fields to address the issue of prevention.

The Prevention Fellowship program promotes the SPF as the overarching vehicle for planning, development, and delivery of prevention services. Through the fellowship program, participants enhance their knowledge, skills, and competencies in all components of the SPF. Upon completion of the Prevention Fellowship program, participants are expected to become stewards of effective prevention practices in the future.

While promoting the SPF for planning, development, and delivery of prevention services, prevention fellows are exposed to myriad activities specific to prevention. These areas include substance abuse prevention across the life span; community prevention planning and service delivery at the state and community levels, including coalition building; data, evaluation, and alcohol and drug epidemiology;

environmental prevention strategies, systems change, and service delivery; and social marketing as it relates to prevention. Development in these competency areas equips the fellows with the necessary skills to become valuable partners in the practice of substance abuse prevention.

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

Similar to its addiction treatment counterparts, the organizational and administrative infrastructure of many prevention programs in States, tribes and territories lack adequate resources to help them maintain stability. Increasing educational and credentialing demands, escalating operational costs, and funding constraints or reductions have caused many programs to discontinue services, resulting in a diminished workforce. As well, prevention networks and associations that have historically offered needed infrastructure support to the prevention field have ceased functioning. While infrastructure requirements such as performance measurement, quality improvement, uniform standards development, data collection and management information systems, evaluation, credentialing, certification, and accreditation are being increasingly required, they are essential to accountability and crucial to quality management. However, they are also typically implemented with limited support to prevention programs that have already been stretched and under-funded in existing prevention systems. Strengthening the infrastructure to support prevention services and related workforce development efforts is a high priority. The responsibility for these essential elements needs to be recognized at all levels by any professional that is interested in the advancement of the prevention field.

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

While considerable research and evaluation has been conducted in the substance abuse prevention field on evidence-based practices and programs over the past decade, scant research and evaluation has been conducted for the benefit of understanding and improving the prevention workforce. A national research and evaluation agenda on strengthening the prevention workforce is sorely needed. The creation of a federal, interagency research collaborative is one key step towards increasing the quantity and quality of prevention workforce-related research informing subsequent technical assistance delivered to the field. A specific research agenda should be set in collaboration with prevention practitioners and providers that incorporates some of the tenants of the service to science academies model (www.samhsa.gov) that is currently being supported by SAMHSA. This research agenda for prevention should help direct the adoption of evidence based programs, policies and practices that should prove to advance the field and offer opportunities for the development of competencies for the workforce.

Unique Issues and Recommendations

A key problem in the prevention field is the lack of surveys specific to the substance abuse prevention workforce. While many states have conducted workforce surveys, most have been focused on counselors in the treatment field. The dearth of information specific to the needs of the prevention workforce is a significant impediment to planning meaningful remedies. System-wide prevention workforce data collection and assessment is needed to identify the unique issues, and to track, evaluate, and manage key prevention workforce issues.

The absence of comprehensive educational opportunities and clearly defined entry points into the substance abuse profession has directly contributed to recruitment and retention problems. While an increasing number of colleges and universities offer addiction studies programs, few have a prevention specialty. The prevention field would strongly benefit from greater partnerships with colleges and universities, through which consistent academic preparation programs for the prevention specialty can be developed.

The prevention field supports the creation of a more permanent infrastructure at the national level to improve recruitment, retention, education, and training that is central to strengthening and sustaining a vital prevention workforce. Efforts to remove economic barriers and create financial incentives for a strengthened prevention workforce, including more competitive salaries and expanded use of student loan repayment programs, are urgently needed throughout state, territory, and tribal sectors. More systemic retention activities need to be put in place, such as mentoring and the promoting of a learning culture in the field so that prevention workers, including those embedded in treatment agencies, will want to continue to work in this area. More formal leadership development strategies that include traditional instructional venues, Web-based interactive modules, supervision, mentoring, peer consultation, and apprenticeship programs are also needed.

SAMHSA has a number of current initiatives that provide important funding and technical assistance resources to meet some of the prevention workforce development needs. These initiatives include CAPT (www.capt.org), the State Incentive Grants program, and new capacity expansion grants to assist states, tribes, and territories in strengthening services, infrastructure, and the use of best practices. Additionally, state agency prevention offices and substance abuse provider associations offer or support training and serve as important dissemination vehicles. Still, more resources are needed to develop the competencies of the workforce and to sustain previous gains.

The limited resources available for workforce development must be concentrated on building a strong workforce of multiskilled preventionists, supervisors, and leaders. This means program planners at the

national, state, tribal, and community levels must critically evaluate the knowledge, skill, and competency development strategies and delivery systems they currently use. Prevention workforce competency sets should be significantly updated and expanded. The value of these prevention competencies, however, is realized only if they are systematically incorporated into curricula used to train the workforce, which is not currently occurring on a broad scale. Therefore, ensuring the availability and adoption of model training curricula for these prevention competencies is also critical.

Conclusion

The problems and needs within the substance abuse prevention workforce are dramatically increasing and evolving due to rapid and continuing advances in the field, changing conditions in communities, and the growing expectation that the prevention workforce address the broader behavioral health context and multiple risk factors for substance abuse. The prevention workforce must not only be knowledgeable about current research, but also it must possess the skills needed to apply that research in practical, culturally competent, and accountable ways with diverse populations. Addressing these challenges will require an increased and sustained focus and commitment to workforce development in the substance abuse prevention field.

Innovation Highlight: Core Competencies for Communities

In collaboration with the World Health Organization Collaborating Centre for Community Health and Development, the Community Anti-Drug Coalitions of America (www.cadca.org) has developed core competencies and a curriculum for training members of coalitions in community problem-solving. These competencies are tied to the steps in the Strategic Prevention Framework: assessment, capacity building, planning, implementation, and evaluation. The model emphasizes systems and environmental change with a focus on achieving measurable, community-level results. The curriculum comprises training manuals and videos, participant workbooks, and the capacity to deliver training via video-conferencing and Web-assisted learning. Trainers are formally trained and certified.

Innovation Highlight: Nebraska's Community Academy

Nebraska's Community Academy (www.nebraskaprevention.gov) is a series of educational modules that enable community decision makers and members to identify and address their priority substance abuse issues through assessment, mobilization, planning, implementation and evaluation processes at the local level. By building capacity at the local level, communities can successfully identify and address their priority substance abuse issues and advance community readiness for positive social change in community policies, practices, and norms. The Community Academy combines comprehensive capacity-building with facilitated networking and emphasizes "systems thinking." Communities are engaged in collective, objective analyses of the ways community members and organizations can work together to coordinate leadership, build capacity and adopt the effective practices needed to solve complex, shared social problems.

Innovation Highlight: North Carolina Governor's Academy for Prevention Professionals

The North Carolina Governor's Academy for Prevention Professionals (www.gapp.unc.edu) is a rigorous, highly structured, 2-week immersion curriculum in prevention designed to provide the building blocks of prevention education to a broad range of students. Offered through the University of North Carolina, at Chapel Hill, Division of Student Affairs, Center for Healthy Student Behaviors, the Governor's Academy is the first of its kind in the nation to prepare individuals as "prevention specialists." The Academy provides a core curriculum of 110 hours that can be applied to prevention certification through a rigorous, highly structured, educational venture using didactic, experiential, interactive, and participatory learning modalities. Students come to the Academy either with grassroots experience in the field and a minimum of a high-school diploma or as a Ph.D/M.D. professional within the health care system. All materials are prepared in manual form for participants and a training manual is available for mentors.

The Academy is sponsored by the North Carolina Department of Health and Human Services, Division of MH/DD/SAS.

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CHAPTER 20

SUBSTANCE USE DISORDERS TREATMENT

AND BEHAVIORAL HEALTH WORKFORCE DEVELOPMENT¹³

Introduction

SAMHSA reports that on any given day more than 1 million Americans are enrolled in substance abuse treatment somewhere in the United States (SAMHSA, 2005). That figure represents less than 20 percent of the people currently suffering from a treatable substance use disorder (SUD). To address the gap in accessibility of treatment, the federal government is currently committing \$1.6 billion to support state efforts to build and expand their capacity for substance abuse treatment and to improve treatment systems.

SUDs are no longer considered to be disorders separate from the existence of other life problems. Professionals increasingly recognize that more than 7 million people who suffer from at least one serious mental disorder also have a substance abuse problem (DHHS, 2003). Over 65 percent of those incarcerated in prisons and jails are estimated to suffer from an SUD (Karberg & James, 2005). The number of patients treated in emergency rooms and trauma centers each year who have a SUD is now thought to exceed 1.2 percent or more than 535,000 cases (SAMHSA, 2003). To effectively address individual patient needs, a diverse multidisciplinary workforce is required (DHHS, 2000; Haack & Adger, 2002; Hall & Hall, 2002; Institute of Medicine [IOM], 2001, 2006; Pincus, 2003).

Workforce Overview

Professionals from a broad cross-section of health, criminal justice, substance abuse treatment, mental health, social service disciplines, and recovery support advocates provide care for people with substance use disorders. Their number exceeds 67,000, and they work in outpatient, residential, medical,

¹³ Michael Flaherty, Ph.D., and Steve Gallon, Ph.D., were the authors of this section. The work of the Expert Panel on Substance Use Disorders (Treatment/Recovery Workforce) informed the contribution.

detoxification, correctional, and a variety of specialty service and community settings. Patients in those settings often suffer from not a single disorder but a variety of physical, psychological, legal, and social problems. The current workforce is struggling to meet the multiple needs of patients. Staff turnover rates are high (McLellan, Carise, & Kleber, 2003); it is difficult to recruit and train a sufficient number of qualified professionals to meet current needs (Gallon, Gabriel & Knudsen, 2003; Northeast Addiction Technology Transfer Center [NeATTTC], 2005); many agencies are understaffed and cannot meet treatment demand (DHHS, 2000; Therapeutic Communities of America, 2005); and the number of people actually receiving treatment represents only about 20 percent of those who need it (DHHS, 2000; NeATTTC, 2004).

As federal and state programs move to increase the availability of substance abuse prevention, intervention, treatment, and recovery services, the need for adequately and fairly paid, qualified professionals to fill positions on all levels significantly increases. While many existing professionals in different fields can be trained to perform screenings, brief interventions, referrals to treatment, and, in some cases, less intensive treatment, it is becoming increasingly difficult to find qualified addiction specialists to fill staff vacancies in treatment facilities. There are three aspects to this problem. First, the rate of new professionals seeking entry into the field needs to increase. Recruitment of second career and recovering individuals entering the field from related backgrounds needs to be intensified. The number of graduates from academic and field-based training programs needs to increase in order to keep pace with clinical need. Second, there is a need to reduce staff turnover rates in community agencies, estimated to be 20 to 25 percent annually (Knudsen & Gabriel, 2003) or more. Third, there is a need for uniform standards in the education and training programs that prepare substance abuse prevention and treatment specialists (DHHS, 1998, 2000). Such programs exist in community colleges, 4-year institutions, graduate schools and in community agencies, but there is no agreement as to program standards, curricula, and how much, if any, supervised field work is required before the graduate is eligible for employment in a prevention or treatment position.

Strategic Planning Process

To develop a set of recommendations specific to SUDs, SAMHSA and the Annapolis Coalition recruited two senior advisors, both directors of regional addiction technology transfer centers, to lead the process. The co-chairs assembled a panel of 16 national experts to assist them. The panel included representatives from addiction prevention, intervention, treatment and recovery provider associations, medicine, social work, nursing, health policy, state governments, research, and academic institutions.

The planning process evolved as input was solicited at meetings and conferences, and selected literary materials were reviewed during winter and spring 2005. Special meetings of SUD experts including

recovery leaders were organized; regional workforce development groups contributed their priorities; and numerous individual suggestions were taken into account before the expert panel was convened in July 2005. The panel focused its effort on reviewing a 2005 SAMHSA CSAT draft document entitled “Strengthening Professional Identity: Challenges of the Addiction Treatment Workforce.” That manuscript, built through a national consensus process, clearly highlights the historical context of today’s workforce challenges and includes a detailed list of recommendations to address them. The panel used the report to guide discussion and development of recommendations for an action plan. Information from the Workforce Issues Panel report within the CSAT National Treatment Plan Initiative (DHHS, 2000) was also valuable and was incorporated into a comprehensive set of SUD workforce development recommendations.

Relevance of the Core Action Plan Goals

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

This is a significant strength of the SUD workforce. Historically, over 50 percent of the people delivering direct treatment services are in recovery from an SUD. The foundation of the current treatment system was built by those in recovery, and the lessons available to other areas of behavioral health care are many. Chief among them is the value that a peer in recovery brings to others who are just starting the recovery process. They serve as sources of hope, empowerment, and understanding to those who are often overwhelmed with feelings of failure, helplessness, and discouragement. The current workforce, faced with increasing education and credentialing requirements, is challenged to maintain the role of people in recovery in the behavioral health workforce. Various models for providing peer recovery support services need to be examined to determine which approaches are most effective. In addition, specific roles within the treatment and recovery systems need to be expanded for those whose recovery experience can augment the success of those in earlier stages of change.

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

Indicators of SUDs in communities across America are well established. Adult and juvenile arrest records, domestic violence and child abuse reports, hospitalizations, death statistics, and national and state household surveys all provide needs information. Promoting behavioral health is another issue. Often the people at highest risk are not adequately assessed to determine the extent of their substance use. Professionals in disciplines like medicine, nursing, social work, counseling, and psychology are either insufficiently trained or are hesitant to engage in assessments that might reveal SUDs.

One community whose needs are not well monitored is the professional SUD workforce. Turnover rates are high, recruitment of qualified direct service providers is difficult, and health and wellness issues within the provider community have not truly been studied. Needs assessments that focus on workforce retention, development, and wellness issues are needed.

To enhance treatment and recovery services, the SUD workforce needs to build partnerships with many other systems and professionals, such as schools, primary care, mental health, justice, the business community, and community groups. Networking in the community is crucial to expand needed treatment and recovery resources, as well as to increase referrals to treatment and recovery services.

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

Qualified SUD professionals are in extremely short supply. The numbers of SUD specialists graduating from counselor education, human services, and related fields are not keeping up with the annual staff turnover rate in community agencies. SUD professionals leave the field for a variety of reasons: Retirement, career advancement, administrative burden, and job dissatisfaction all contribute to the problem. Interestingly, a modest 10 percent increase in treatment capacity would require an additional 6,800 clinicians above the annual number currently required to replace staff leaving clinical practice (Lewin Group, 2004). Strategies for both recruitment of new professionals and retention of the existing workforce are needed. The strategies must accommodate the dynamic nature of the treatment field, including increased demand related to new types of funding for treatment services, linkage with and training for peer recovery supports, the need to keep pace with scientific advances, staff turnover, leadership and interdisciplinary collaboration and education – and the required training time for staff. Additionally, thought must be given to find ways to address the need for a racially and ethnically more representative workforce. The development of enhanced education in all disciplines, including medical and all professional schools, must be considered.

A key issue is compensation. Salary and benefits for certified or licensed SUD professionals are significantly lower than for related fields like mental health and nursing (U.S. Department of Labor, 2003). To remedy that situation, decision makers at all levels are encouraged to examine a variety of strategies to make entering the SUD profession more attractive. Loan forgiveness in exchange for public service, tuition assistance, salary and compensation research, and clarification of career ladder options in the treatment and recovery field all could be promoted as part of a comprehensive recruitment and retention strategy.

Another important issue includes the special needs of rural providers. SUD problems exist throughout the entire country. Rural areas need access to effective SUD services, yet recruitment and retention of

qualified staff are particularly difficult in more sparsely populated areas of the country. Special strategies tailored to the unique characteristics of frontier and rural communities are needed to recruit, train, and support SUD professionals for working in those areas.

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

The establishment of model competency-based addiction professional preservice and in-service education and training standards is of paramount concern. Curricula, instruction, and faculty development standards need to be updated continuously to reflect current best educational practices for preparing and updating prevention, intervention, treatment, and recovery support professionals and advocates. Standards should be developed with consumer input (clinicians, researchers, educators, recovery support advocates) and serve as a guide for the development of accreditation standards for academic and behavioral health practitioner development programs that focus on SUD. Scholarship, loan-forgiveness, and recruitment programs targeted to needed populations are a second high priority. An adequate behavioral health workforce, skillful in managing patients with SUDs, will be maintained only when a sufficient number of needed professionals graduate from quality education and training programs regularly. The current shortage of qualified behavioral health professionals is partially due to the absence of quality education and training standards and partially due to inadequate recruitment of new professionals.

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

Leadership initiatives that build the skills of existing leaders and prepare promising professionals for future administrative and clinical leadership positions need to be developed, delivered, and sustained for the foreseeable future. Existing leaders need to be prepared to establish and support nationally accepted clinical¹⁴, supervisory, and administrative standards and competencies for SUD services across the entire continuum of care (prevention, intervention, treatment, and recovery supports). Leaders need to be cultivated from a variety of health care disciplines in order to better integrate SUD prevention, intervention, and recovery services with primary care at the community level. New positions will need to be created in the future to provide recovery management and support, and the entire continuum of care deserves to be reimbursed for services in a way that enhances access to quality care. To meet these leadership needs, developers will need to assure that research informs practice and that practice informs research in a way that will assure the continued development of effective interventions and strategies in managing SUDs.

¹⁴ This also includes standards and competencies for services provided outside of traditional SUD clinical settings and among all who may provide services to potential SUD clients.

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

The infrastructure necessary to facilitate the kind of workforce development efforts discussed here and in other Annapolis Coalition reports will operate at a national level. To this end, SAMHSA is encouraged to establish a national Workforce Development Office to oversee ongoing infrastructure development. That office could sponsor initiatives focused on the professional and apprenticeship educational, clinical services¹⁵, and organizational development needs throughout the entire SUD continuum of care. The office could also serve as the basis for collaboration among other federal agencies such as the Departments of Labor, Education, and Justice that have a stake in addressing workforce problems. The office could develop partnerships between public and private organizations in order to enhance the clinical, education, and organizational infrastructure necessary to a coordinated, cost-effective system of care. Having a national coordinating and resource center that provides leadership in infrastructure development is essential if the behavioral health care workforce envisioned here is to become a reality and if the care of all patients having mental and/or substance use disorders is to become more accessible, cost-effective, and helpful.

Of special importance is the need to upgrade the reimbursement rates for addiction treatment and recovery support services, and to establish fair compensation for workers in settings that provide SUD treatment and recovery support services. Historically, the rates paid for assessment, intervention and ongoing care of SUDs do not cover the actual costs of delivering services. States, managed care entities and insurers who pay for SUD treatment have not based reimbursement rates on research-based provider costs. In addition, treatment providers have not typically understood how to calculate their unit costs for providing care. Expenses such as clinical supervision, administrative overhead, and employee benefits, and concepts like profit margin may not be included in the setting of rates. As a result, SUD treatment services often are underfunded and the staff is poorly compensated. These circumstances do not support a viable career ladder for addiction professionals. Instead, they present barriers to both the ongoing development of a professional workforce and services that yield increasingly positive outcomes for clients and patients. Ultimately a lack of career advancement opportunities, all too often, precipitates a move to positions outside addiction treatment in an effort to meet personal career development goals.

¹⁵ Clinical services would also include a range of services outside of the traditional SUD clinical setting, including recovery supports, primary care, other specialty medical care, etc.

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

The behavioral health workforce has never been a unified group of professionals. Mental health and substance use disorders professionals historically have been trained separately and subscribe to different practices and values. However, with an emerging national interest in recovery, recognition that co-occurring mental and substance use disorders are common, and an increasing emphasis on the adoption of empirically tested cost-effective practices, the two fields are beginning to collaborate and even merge in some states. To facilitate the growth and improvement of recovery-oriented services, there is a need for research on how best to foster development of the workforce. The empirical investigation of key issues is needed. Here are a few priority questions that need to be studied:

- What is the importance of supervisory observation, feedback, and coaching to the successful adoption of empirically supported treatment interventions?
- What is the relationship between level and type of service, provider education and training and behavioral health treatment outcomes?
- How do clinician and patient cultural and demographic characteristics affect treatment outcomes?
- What clinician characteristics enhance the therapeutic alliance and lead to improved outcomes?
- What is the impact of reimbursement rates, salary levels, and working conditions on treatment providers and how do those conditions affect client care?

Unique Issues and Recommendations

Developmental Priorities within the Existing SUD Workforce. The existing SUD workforce consists of dedicated professionals with diverse education, training, and vocational backgrounds. System improvement and continuing education initiatives are typically not well planned but are left to agencies and individual professionals to manage. At the same time the treatment community is marked by relatively high staff turnover rates and a general lack of clinical supervision. There is a need to establish national programs that will promote the ongoing development of the existing behavioral health workforce – with all levels (federal, state, and local) working in concert. To that end, the following recommendations are made for enactment on a national level:

- Develop innovative workforce development initiatives that cross federal agency boundaries.
- Promote prevention, intervention, treatment, and recovery organizations as learning communities and encourage direct care providers to adopt empirically supported interventions to improve quality of care and treatment outcomes.

- Provide training for clinical and recovery support supervisors who serve as technology transfer agents for the latest research- and consensus-based recommended practices.
- Cross-train existing substance use disorders, mental health, criminal justice, health, and social service providers in effective SUD practices which offer all clients and families the opportunity to achieve wellness and recovery.
- Develop continuing education programs for professionals in disciplines that are allied with SUD treatment (e.g., medicine, nursing, social work, criminal justice, psychology, dentistry, child welfare, and vocational rehabilitation).
- Identify and disseminate to state and local agencies best practices in staff retention, including compensation and benefits, clinical supervision, and stigma reduction for addiction professionals.
- Encourage development of human resources policies at the agency level that promote health and prevent physical and behavioral health problems. Such policies should both prevent workers from entering into the cycle of substance use disorders and avert relapse for workforce members in recovery from a mental, substance use, and/or physical health disorder.

Preservice Professional Development Priorities. Preservice preparation of SUD professionals has never been standardized. There is no unified national professional credential and no recognized national or regional accreditation of apprenticeship, undergraduate, or graduate SUD education and training programs. To create consistently high standards for preservice preparation of behavioral health professionals, the following recommendations are offered:

- Facilitate the development of a unified set of national credentials that verify the recipient's knowledge and skill in providing care, supervision, and/or management in SUD service settings.
- Develop and adopt national or regional competency-based accreditation standards for preservice education and training of SUD professionals at all post-secondary levels of education.
- Promote articulation and portability of academic credits from associate's- through graduate-level studies, thus establishing a clear educational pathway for persons wanting to further their professional development.

Recruitment Priorities. The behavioral health workforce is not large enough to keep pace with demand. Turnover is relatively high, the population needing care is much larger than can be currently served, and

the number of new professionals graduating from training programs each year is not sufficient to meet the needs of existing agencies. There is a need for both first and second career professionals to fill a variety of positions in corrections, substance abuse, primary care, mental health, and child protective service settings. To that end, a national recruitment strategy is needed to accomplish the following objectives:

- Recognize the diverse backgrounds of individuals entering the behavioral health workforce (e.g., recovering populations, workers seeking a second career, youth) and create model career ladders to establish ways for new professionals to advance through positions of gradually increasing responsibility during their careers.
- Develop and implement recruitment strategies for preservice education and training that attract students and professionals from related fields with needed diverse ethnic, gender, age, culture, and/or recovery characteristics to specialized SUD training programs.
- Continue national efforts to reduce stigma associated with working in addiction treatment and prevention fields by developing public information campaigns and promoting the economic and social benefits of recovery and SUD prevention, intervention, and treatment to the general public, insurance companies, health care providers, and public safety officials.

Conclusion

The goals of the behavioral health workforce strategic development plan are ambitious. Within the SUD treatment area the needs are great. Leadership and a vision for unifying and enhancing workforce development programs are needed at the national level and supported by the states and the many professional associations that represent the dedicated and diverse workers that make up the field currently. Proposed in the pages above are sweeping improvements that will grow the workforce, create more consistency in preservice education, and build avenues for continued professional development. The behavioral sciences and specifically the addiction/co-occurring disorder treatment field have grown to the point that new discoveries and treatment interventions need to be integrated more efficiently into common practice. In addition, SUDs have become so ubiquitous in both behavioral health and primary care settings that professionals from a variety of disciplines need to be prepared to assess and manage SUDs effectively. Without a strategic plan and leadership at the national and local levels, the vision of accessible treatment and utilization of science-based treatments by a diverse and well-prepared workforce is not likely to be realized.

Innovation Highlight: Leadership Institute

Developed by Southern Coast Addiction Technology Transfer Network (ATTC), United States Department of Agricultural Graduate School, and SAMHSA/CSAT Partners for Recovery, the *Leadership Institute* (<http://www.nattc.org/leaderInst/index.htm>) is a six-month leadership preparation program for potential leaders in the addictions field that provides a combination of in-depth assessment, traditional training seminars, distance education, and field experience in conjunction with guidance from a specially selected mentor. Selected by agency directors and supervisors, participants are identified as having demonstrated a realistic potential to become leaders, commitment to their agencies, and a career commitment to the addictions field, in general. The ATTC Leadership Institute provides training and growth opportunities that not only increase leadership knowledge and skills, but also reinforce critical retention variables such as fitting into one's workplace, getting along with coworkers, and aligning with organizational values.

Innovation Highlight: Project Mainstream

Project Mainstream: An Interdisciplinary Project to Improve Professional Education in Substance Abuse (www.projectmainstream.net) is a project designed to overcome the lack of substance abuse prevention services in generalist health care through strategic planning, interdisciplinary faculty development program, and national and regional electronic and training infrastructure. The disciplines targeted by the Project were future dentists, dieticians, nurses, nurse midwives, nurse practitioners, occupational therapists; pharmacists, physical therapists, physician assistants, physicians, public health professionals, psychologists, social workers, and speech pathologists and audiologists. The Project featured interdisciplinary collaboration, mentoring, training meetings, and Internet-based instructional materials.

Innovation Highlight: Taking Action

Taking Action to Build a Stronger Workforce-Facilitating and Implementing Workforce Development is an initiative to develop and implement strategic plans in New York, New Jersey, and Pennsylvania to address state needs in the area of addictions workforce development through Workforce Committees in each state. Workforce Committees were specifically designed to deal with workforce development and incorporate specific task groups in the following areas: compensation, marketing, administrative relief, credentialing, and organizational culture and best practices. States were encouraged to learn from national experts and the experiences of other states while working to build a plan, implement that plan, and study and evaluate that implementation over time.

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CHAPTER 21

FINANCING ISSUES

IN THE BEHAVIORAL HEALTH WORKFORCE¹⁶

Introduction

The essential yardstick by which to judge the overall adequacy of the mental health and substance abuse treatment systems, and prevention and health promotion activities, is how fully and efficiently they address the behavioral health needs in the population (IOM, 2006; New Freedom Commission on Mental Health, 2003). Though surely a complex determination, relative success requires a workforce that is accessible and equipped with the necessary skills to deliver high quality services. In turn, mobilizing and supporting the behavioral health service delivery system requires the interest and actions of purchasers, including employers and various levels of government, through a range of insurance products and programs. These stakeholders interact through the marketplace for behavioral health services, the labor market for behavioral health workers, and educational systems.

For a variety of reasons, need for behavioral health services does not necessarily translate into demand that is actualized in the marketplace, nor does demand for specific services always coincide with what is available. First, a large gap exists between the level of clinical need in the population and the funding available for services. The gap consists of two parts. A significant portion of the population needs but does not receive treatment, while other individuals receive some treatment, but not in adequate amounts or types of services. This leaves many provider organizations underfunded and overextended as they try to address the needs of individuals seeking care. Second, an accompanying suppression of wages and salaries for behavioral health workers hampers recruitment and retention and degrades the workforce in terms of the credentials, skills, and experience needed to meet extensive and diverse needs in the population.

¹⁶ Christopher P. Tompkins, Ph.D., Elizabeth L. Merrick, Ph.D., M.S.W., Sharon Reif, Ph.D., and Constance M. Horgan, Sc.D., were the authors of this section. This report was partially supported by the Brandeis/Harvard Center on Managed Care and Drug Abuse Treatment, NIDA grant # P50 DA010233.

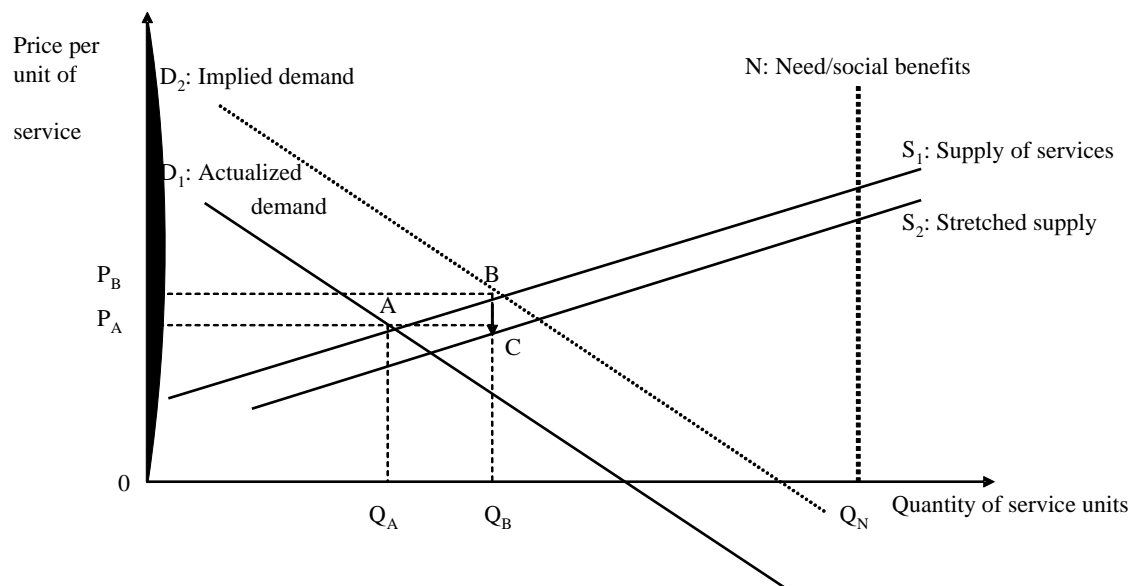
This article examines the extent to which there could be problems for the behavioral health care workforce that are rooted in certain market failures or other equity considerations. It identifies and considers possible improvements that could be instigated or mediated through the relevant financing and reimbursement systems.

Market Problems

In economics, the marketplace can answer questions such as “What quality of services is adequate?” and “How many services should be provided?” through the normal interactions of supply and demand. However, economists also recognize that conditions leading in a straightforward manner to desirable outcomes may be lacking in certain markets. In the case of mental health and substance abuse treatment markets, the population or demand-side shortcomings include 1) reluctance on the part of individuals to seek treatment due to stigma or undervaluation of the benefits of treatment; 2) difficulty of having purchasers recognize or internalize many benefits to treatment (e.g., productivity for employers); and 3) insufficient income or insurance to finance services. The provider or supply-side factors include 1) a historical lack of evidence-based treatments, allowing for a heterogeneous array of services that range greatly in quality; 2) an overloaded treatment system with relatively high rates of staff burnout and turnover; and 3) underutilization of peer, family, and potential community supports.

Figure 21.1 illustrates some of the market issues with the common economic picture of supply and demand. The expected result of the market overall would be Point A, which is the intersection of demand curve (D_1 , labeled actualized demand) and supply curve (S_1), with a resulting price (P_A) and quantity output (Q_A).

Figure 21.1: Market for Behavioral Health Services



However, several issues illustrated in the figure could warrant concern, including:

- Unmet needs in the population. Aggregate population needs are well beyond the reach of current systems, as illustrated by the hypothetical quantity of services truly needed in the population, Q_N .
- Underfunded services even for clients in treatment. Even the people who actualize some demand for services (i.e., receive some treatment) often have additional needs beyond what is paid for, as shown in the implied demand curve, D_2 . Meeting that demand with the normal supply curve, S_1 , would result in more services, Q_B , but at higher cost and price, P_B (Point B).
- A workforce that is stretched and impoverished. In many settings, provider organizations attempt to deliver many of the needed but underfunded services, which has the effect of “stretching” their supply toward Q_B (Point C). Stretching is not intended to convey simply working longer hours or compelling efficient production. Rather, these pressures on the treatment system may cause provider organizations to rely on staffing patterns that consist of a lower mix of professional skills and experience than would be required to produce optimal care. Implications for the labor market could include suppression of provider incomes and driving many workers away from or out of the profession (e.g., burnout and turnover).

Redressing Problems of the Workforce

Improvements in financing the mental health and substance abuse treatment and prevention workforce need to be considered and chosen in light of the workings and failings of the markets for services and for workers. The options presented here are directed at the market for services.

- *Provide more and better private behavioral health insurance coverage.* Private third-party purchasers such as employers may reflect a modest or ambivalent demand for insurance benefits for behavioral health services. The general problem of uninsured and underinsured workers has been growing nationally. Also, an increasingly common method of holding down increases in premiums is to raise the out-of-pocket payments for services, in the form of higher deductibles, coinsurance, and copayments. However, increasing the proportion of people with insurance benefits for behavioral health, and covering more services, would help to shift the actualized demand toward the level of need and to lessen the need for providers to compensate for inadequate resources.
- *Increase public funding for services.* Mirroring private insurance, Medicaid empowers clients by associating the funding for services with the individual’s entitlement. Currently, there is a public debate at the federal and state levels about spending cuts for the Medicaid program; protecting funding for behavioral health may be an important strategy within that context (e.g., supporting

behavioral health set-asides with actuarially supported funding levels). The other public funding for mental health and substance abuse treatment involves direct support (e.g., through state mental health and substance abuse agencies) for a safety net of providers who serve individuals and families who lack insurance and other resources to pay. Increasing such funding could raise supply capacity and quality, helping to meet overall demand and need.

- *Reform provider payments and payment mechanisms.* Existing systems could be more supportive of innovations and improved efficiency if providers were able to fund aftercare, peer-support programs, family involvement, and wellness or self-care training programs. Funding such services could be an enhanced method of “extending” resources, and they even may be extended in a direction that offers better outcomes and longer term sustainability and efficiency. Approaches might include financial risk-sharing models in which providers and purchasers benefit from savings induced through better management of care, and bonuses linked to achieving or improving quality standards (Horgan & Garnick, 2005; Shapiro, 2004). Shaping behavioral health services more closely to evidence-based practice will inevitably increase the need for some skills and services, while perhaps deemphasizing others.
- *Invest in technology.* Major investment in information technology infrastructure appears essential if performance measurement is to reach more fully its potential in driving quality. Computer-based information technology also may provide treatment protocols, algorithms, and guidelines to support provider decision-making, thus improving the performance of workforce.

When demand for services exceeds supply, market-based and regulatory mechanisms exist by which to increase the supply of the labor force. Similar mechanisms also can be used to increase the quality and training of workers. Market-based mechanisms to increase labor supply are based on the assumption that the market can be self-regulating if sufficient incentives are offered to draw new workers into the field or to encourage workers to transition from one field to another. Government and regulatory interventions consider the fact that markets may not be self-regulating and demand continues to exceed supply, though it would be in the public’s interest to bring supply and demand more in line with each other. Interventions in consideration of the public good seek to ensure that certain goals are being met to improve or stabilize the market; in this case, the goal would be to ensure an adequate supply of qualified workers. In behavioral health, this kind of intervention is often required. For example, it is used to assure supply in certain geographic market areas (e.g., rural communities), specialties across disciplines (e.g., geriatric mental health), or specialties within disciplines (e.g., child psychiatrists). The options presented here are directed at the markets for education and labor.

- *Raise workers' income and benefits.* The mental health and substance abuse workforce tends to be paid less, on average, than comparably educated or skilled workers in other fields (U.S. Department of Labor, 2004). Improving compensation may occur only after other problems have been redressed, such as funding levels and administrative technological supports. Meanwhile, tuition remission or paying for certification and licensure programs would provide staff with incentive to receive additional training; these actions also send a message that the provider organization values higher qualifications. Investment in quality training on an ongoing basis, such as by reimbursing the costs of continuing education or providing staff seminars, may reduce staff turnover.
- *Diversify the recognized labor pool.* Public and private payers of behavioral health services could include effective peer-support and peer-operated services in the spectrum of options (IOM, 2006).
- *Subsidize education and training.* When market-based interventions are insufficient, intervention by outside forces may be necessary to ensure sufficient quality and numbers of workers within the field overall or within specific areas of particular need. Tuition subsidies are provided in some fields as a way to encourage potential career tracks. Subsidies or waivers also could be used to encourage specific additional qualifications, such as cultural competence training.
- *Regulate staffing levels and qualifications.* Government and industry can use licensure, accreditation, and certification requirements to ensure that treatment facilities meet certain levels of staffing and qualifications. Requirements may be phased in; perhaps 25% of staff would be required to reach a set goal within the first year, 50% would be required to reach it within the second year, and so on. Similarly, curriculum requirements could ensure that education and training incorporate relevant areas such as cultural competency, geriatrics, co-occurring conditions, and children's issues.
- *Offer conditional public funding.* Regulations and requirements can be built into the application and distribution processes for federal Block Grant programs, Medicaid, and/or state and local programs. For example, grants to specific programs could be contingent upon an appropriate staffing plan.

Discussion and Conclusions

The advancement of social policy and social justice requires thoughtful analysis of market performance and potential market failures or other shortcomings. The behavioral health workforce operates in the context of a market for services that is likely to be underperforming due to several factors. First, there are

problems associated with insufficient information. People needing services often do not recognize their need or know how to get proper care. Also, it is difficult to evaluate, codify, replicate, and enforce best practices in a field so diverse and multifaceted. Second, the benefits of treatment are difficult to measure in many cases, and purchasers often do not perceive the benefits to be worth the investment. The cumulative results likely are understated demand and suboptimal funding in the market and, in turn, low incomes and difficult working conditions for providers.

Redressing problems for the workforce could begin with rectifying shortcomings on the demand-side of the market for services. Private insurance and government-sponsored coverage could be expanded to encompass more people and to include in the covered benefits the full range of behavioral health services. Patient and purchaser education also could increase awareness of problem levels and potential benefits of improved access to treatment. Current funding as well as any future increases could be used more efficiently by reshaping the mix of workers, for example. This could involve retaining workers who have gained knowledge and experience and investing in peer-support activities to help fill the gap between professional workers and enhanced self-care. Educational programs might better anticipate population needs by expanding curricula related to specialized needs and co-occurring disorders.

There also may be need and opportunity for greater public involvement. Already, public funding pays for the majority of substance use disorder treatment in this country, and for behavioral health treatment overall. The government could invest more money in prevention and education efforts, and it could subsidize education related to behavioral health, which could lessen the burden of personal debt against educated workers entering the field and attract more talent to the field.

Finally, it might be most promising to view reforms not only as stand-alone activities, but also as part of a grander design. These reforms could be mutually dependent and reinforcing, and include performance measures and contractual requirements for providers; increased funding from private and public sources, partly conditional on meeting performance standards; flexibility in payment systems to allow providers to invest in improved processes and outcomes; and investment in information and other technologies to support improved practices and performance reporting. For better or worse, economic incentives can play a major role in shaping the entire system as well as individuals and provider organizations.

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SECTION IV

CONCLUSION



CHAPTER 22

NEXT STEPS: LEVERAGING CHANGE

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

Despite the breadth and depth of input into this plan, it undoubtedly has imperfections. Those who did not participate in the planning process and are reviewing these ideas for the first time will have other ideas or alternative strategies to propose. The Annapolis Coalition views the Action Plan, in its current form, as a departure point for immediate actions to strengthen the workforce and for continued dialogue and refinement of the recommendations that will guide those actions.

There is a compelling need for stakeholders throughout the field to take significant action to stem the growing workforce crisis. The major concern is that such action will not occur. The problems and issues identified in this report are not new, as they have been documented in the literature and other reports and, for decades, have been the nemesis of managers and administrators throughout prevention and treatment systems. In a recent report, the Institute of Medicine Committee on Improving the Quality of Health Care for Mental and Substance-Use Conditions concluded that workforce issues "...have been the subject of many short-lived, ad hoc initiatives that overall, have failed to provide the sustained leadership, attention, resources, and collaborations necessary to solve these multifaceted problems" (IOM, 2006, p. 286). The IOM Committee detailed 20 initiatives that have addressed workforce issues since 1956, and argued that a more sustained, multiyear collaborative is necessary to bring about major change.

Translating recommendations into action requires significant attention to the levers of change, those seemingly small forces that can exert enormous influence on a much larger mass. This metaphor borrows directly from the concept of a lever in physics: Properly placed, balanced, and utilized, a lever creates a mechanical advantage that produces significant movement beyond what could be expected if the same amount of force were applied in less strategic ways. These ideas are embedded, to some extent, in the book *The Tipping Point* by Gladwell (2002), and speak clearly to the need for well-considered tactics when attempting to bring about large-scale system change.

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

As to levers of change that can have a positive impact on the workforce, a number have been identified by the IOM in its report on Health Professions Education: A Bridge to Quality (IOM, 2003) and the recent report on mental/substance use conditions (IOM, 2006). Suggested levers of change include the following:

- Identify the specific **core competencies** that all mental and substance use providers should possess. The committees authoring the IOM reports have argued that there can be no accountability in workforce training and development and no dialogue or effective collaboration among various sectors of the workforce unless core competencies and common measurement strategies to assess those competencies are crafted (IOM, 2003).
- Incorporate the core competencies into **licensing and credentialing** standards, with a move toward development of national standards to overcome the current state-by-state variation. Licensing and credentialing standards and exams are widely viewed as drivers of the educational content in training programs.
- Incorporate the core competencies into **accreditation standards**. Training program accreditation standards are similarly viewed as a major lever of change for the curriculum in professional education programs, while workforce-related standards in provider accreditation processes, such as those managed by Joint Commission on Accreditation of Healthcare Organizations and the Commission on Accreditation of Rehabilitation Facilities, have a heavy influence on workforce practices in delivery systems.

- **Financing** is another potent lever that can shift workforce development practices and workforce behavior. Private and public payers can exert enormous influence through their contracts that support training and education and the provision of services. Public payers and foundations can create demonstration funds and other incentives to support the development and evaluation of innovative workforce practices.
- **Faculty development** is a key lever of change, given that faculty members influence a constant stream of young professionals entering the workforce. Advanced educational opportunities for faculty members and financial incentives to support the development of innovative educational programming are two examples of interventions designed to influence this lever and to hasten the translation of new science into daily practice.

Other potential levers have been suggested. **Advocacy** by persons in recovery and their families will likely have an increasing role in changing workforce practices as these individuals become more vocal about workforce problems and increasingly demand care that is more humane and effective. The IOM (2006) has argued that Congress should establish a permanent **Council on the Mental and Substance-Use Health Care Workforce** as a catalyst to change. This council would be charged with monitoring the workforce, advising the federal government on workforce issues, and implementing a comprehensive plan to strengthen the workforce, just as such congressionally mandated councils currently function for medicine and nursing. **Public and private partnerships** also are viewed as levers of change, potentially capable of surmounting the obstacles to change encountered when either the public or private sector acts alone.

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

- Develop a personal, professional development plan, designed to strengthen your own skills. Pursue it with fervor. Revisit it and update it often.
- Ensure that the organization in which you work has a written workforce development plan that addresses the seven strategic goals. Pursue it with fervor. Revisit it and update it often. Collect workforce data to evaluate progress.
- Learn from persons in recovery, youth, and their families. Seek them out as full partners in all efforts to strengthen your workforce.

- Reconnect with the community that surrounds you. Build its capacities. Offer it support. Accept support from it.
- Become a mentor. Encourage young people to join the workforce. Extol the virtues of caring for others and of changing lives.
- Convey hope about the future to all whom you encounter.

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

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SECTION V

APPENDICES



APPENDIX A: PRELIMINARY IMPLEMENTATION TABLES

GOAL 1

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

Objectives, Actions, & Levers of Change	Stakeholders
Objective 1: Provide information and education to individuals in care or recovery and their families¹⁷ to enable them to maximally participate in or direct their own care and to assist and support each other.	
Action 1: Identify and make available to people in care and their families a body of peer-reviewed, scientifically sound, culturally and linguistically relevant materials in a variety of formats (text, video) and languages, and make these materials accessible to people with different educational levels.	
a. Create or identify a central clearinghouse to which consumers and families could be directed to obtain materials on a range of conditions. The clearinghouse could provide the information directly or refer to existing sources (such as national or local advocacy organizations). Provisions will need to be made for individuals and families for whom computer access is problematic.	Consortium of National Organizations, supported by Federal Government
b. Initiate a grant program to foster the development of new educational materials to reflect current and emerging science and to respond to changing demographics, ensuring accuracy and cultural appropriateness.	Federal Government; Foundations
c. Identify or develop and widely disseminate curricula for educating professionals about optimal ways to communicate core information about mental health and substance use disorders. (This is a two-part intervention, as development and dissemination are distinct but interrelated tasks.)	Foundations; Advocates; Education & Training Programs

¹⁷ *Individuals in care or recovery* is always intended to include both adults (including elders) and youth; the term *families* refers to primary caregivers (including foster parents or other parent surrogates) for minors as well as people who are actively involved in the treatment of another family member by invitation of the adult or young adult.

d. Create a consumer-friendly, searchable database (or other accessible retrieval mechanisms) of research findings. This resource provides summaries, in layman's language, of current research on the effectiveness of treatment options available to individuals in care and their families, with special reference to cultural relevance and availability in a range of languages.	Federal Government or Foundations through grants to consumer/family organization(s)
e. Advocate that insurers, including Medicare, Medicaid, and private insurers, use these materials from intervention (d) above to inform, educate, and support their customers, especially those who receive behavioral health services or who have children who may experience behavioral health problems.	Payers; Oversight Organizations; Advocates
f. Advocate for changes that will result in insurers routinely reimbursing the use of science-based psychosocial education and supports as a part of diagnosis and treatment of behavioral conditions as a means to enhance adherence to recovery plans and yield improved outcomes.	Payers
Action 2: Routinely provide families and other natural caregivers and supporters information about optimal ways to help and support loved ones with behavioral health conditions; this information is developed and provided by consumers, family members, educators, researchers, and providers working in partnership(s) and reflects the range of cultural and linguistic differences of the country.	Advocates
a. Identify resources and contact information in every state for national, state, and/or local organizations that can provide information, training, or support to individuals in care, families and other natural supporters (e.g., referral sites on state mental health authority and governor's Web sites). These sites indicate special relevance for minority communities, communities of color, and for persons who do not use English as their primary language.	Professional & Trade Associations
b. Link insurers, including Medicare, Medicaid, and private insurers, to each state's primary Web sites for behavioral health information resources that are consumer and family friendly.	Payers
c. Create mechanisms through which states demonstrate that consumer/family/recovery educators are on staff within provider systems that are funded with Block Grant dollars, regardless of the amount.	Federal Government
Action 3: Routinely engage persons in recovery and family members in teaching providers how best to work with persons seeking recovery from the perspective of the lived experience of mental or substance use conditions.	
a. Make available funding to provider education programs that add to their curricula training about the lived experience from persons in recovery.	Federal Government
b. Develop demonstration programs to create and test training of current providers about the lived experience from persons in recovery, children, youth, and families; these demonstrations are designed to be tested in a variety of cultures and languages.	Federal Government

LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 1	
a. Modify scoring practices of accrediting and licensure standards for provider organizations to include scoring for routine provision of referral to information and support organizations (NAMI, DBSA, CHADD, Federation of Families for Children’s Mental Health, etc.)	Oversight Organizations
b. Fund set-asides in every Block Grant to implement and support Network of Care Web sites for behavioral health; these Network of Care sites connect consumers to comprehensive information on services, research, and policy within distinct localities and communities.	Federal Government
Objective 2: Develop shared decision-making skills among individuals receiving care and their families and service providers.	
Action 1: Expand the knowledge base about shared decision-making.	
a. Fund research that adapts to behavioral health settings shared decision models currently available to patients living with diabetes and breast cancer.	Federal Government
b. Widely disseminate results of research, including cost and outcome data.	
Action 2: Make person-centered (or family-focused or youth-guided) treatment planning the norm in behavioral health interventions.	
a. Devise reimbursement strategies (e.g., incentives) to connect to patient survey results confirming that treatment and service planning processes are based on shared decision models.	Payers; Federal Government
b. Develop and disseminate standards for documentation in patient/client records of the use of shared decision-making.	Oversight Organizations
c. Include documentation of the use of shared decision-making in the recommended recovery-oriented patient record being developed by CMHS.	Federal Government
d. Make courses in shared decision-making available online or through other readily accessible media, such as Web sites, where consumers and families go for information.	Federal Government; Advocates
e. Include shared decision-making as a required skill in all provider curricula.	Technical Assistance Organizations; Education & Training Programs
f. Include language and definitions of shared decision-making in licensure standards for professional providers of behavioral health services.	State, County, & Local Governments
Action 3: Make consumer, family, and provider education a part of every provider interaction – no matter how often the provider has seen the consumer or family.	
a. Build in educational elements as a mutual expectation of client and clinician as a foundation for recovery dialogue.	Service Providers; Oversight Organizations
b. Use routine consumer evaluation of provider competencies on the educational dimension to determine provider compensation.	Payers

LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 2	
a. Create mechanisms in performance measurement strategies to insure that individuals in care and family members routinely evaluate individual providers and services on the degree of effectiveness of their shared decision-making.	Providers & Provider Associations
b. Set reimbursement levels high enough to allow providers to take the time to use shared decision-making models; use consumer evaluations of the providers' competencies in using shared decision-making methods to determine provider compensation.	Payers
c. Create model templates for licensure reflecting shared decision-making.	Technical Assistance Organizations
d. Dedicate federal funds to support and sustain the use of shared decision-making.	Federal Government
e. Include scoring for evidence of the use of shared decision-making approaches in accreditation standards.	Oversight Organizations.
Objective 3: Significantly expand peer- and family-support services and routinely offer them in systems of care.	
Action 1: Implement certified peer specialist¹⁸ (CPS) services as Medicaid reimbursable in all states by 2010.	
a. Advocate that CMS issue guidance to regional offices that CPS services are appropriate for reimbursement under Medicaid.	Federal Government
b. Develop CPS program descriptions and related regulations and include them in state Medicaid plans in all states.	State, County, & Local Governments
c. Allocate or reallocate funding to employ CPSs in all programs receiving state or federal funding, with special attention to ensure that CPSs reflect the diversity of communities being served.	Provider organizations; State, County, & Local Governments
d. Identify a single set of competencies and a core curriculum for CPSs, and make training available.	Federal Government
e. Provide continuing education and support to CPSs once they are employed.	Provider Organizations; Education & Training Programs
f. Require every state- and federally funded service to employ CPSs in order to receiving funding.	Federal Government
g. Fund additional research on CPSs and disseminate the findings widely.	Federal Government
h. Make available federal funding to train and certify peer specialists to work within state systems.	Federal Government

¹⁸ This model has been demonstrated as effective with consumers who have mental health conditions; the substance use conditions community is considering this model, but is also exploring program accreditation and provider certification as other models potentially more suited to their segment of the larger recovery community.

i. Implement strategies at the provider level to ensure that peer supports (paid and volunteer, family, or provider to provider) are integrated into service models and administration.	
Action 2: Expand the use of volunteer and grant-funded peer-support programs where indicated.	
a. Identify federal, state, or foundation grants for the express purpose of increasing consumer/volunteer participation.	Federal Government; State, County, & Local Governments; Foundations
b. Educate providers about the potential for improving outcomes by directing energy and resources toward recruiting consumer/volunteer peer-support initiatives.	Professional & Trade Associations
Action 3: Expand family support services (such as the NAMI Family to Family program and similar programs) in all provider settings, and adapt these programs to meet the needs of diverse communities (based on race, class, sexual orientation, geographic isolation, and language).	
a. Include state and local NAMI chapters and other family support organizations with trained family-to-family facilitators (using models such as NAMI's or CHADD's or the work of the Johnson Institute) in a central resource directory for providers.	Advocates
b. Encourage provider associations to endorse programs that assist families with peer supports (e.g., Family to Family), and to make information or links available to their members.	Professional & Trade Associations
Action 4: Continue to build the evidence base on peer-support practices.	
a. Replicate and test existing research on the use of peer supports and peer-operated services in a variety of settings.	Federal government.
b. Create incentives for providers to have their practice settings serve as sites for research, and use the findings from research to improve services.	State, County, & Local Governments; Provider Organizations
Action 5: Create opportunities for peer support for providers. (The emotional demands of these jobs are intense, and peer support from provider to provider would be an excellent way to build resiliency.)	Provider Organizations; Professional & Trade Associations
a. Build support for peer supports by having providers (including persons not identified as consumers or otherwise in recovery) model the value of peer supports by creating mechanisms for provider/peer supports.	Provider Organizations; State, County, & Local Governments
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 3	
a. Add or expand requirements to offer peer and family support in provider accreditation standards and processes.	Oversight Organizations
b. Expand federal mental health and addiction Block Grant set-asides to include support development of certified peer support specialists.	Federal Government
c. Monitor and report publicly on progress within states and local communities on these objectives.	Advocates
d. Dedicate funding set-asides to support continuing research on peer supports.	Federal Government; Foundations

Objective 4: Increase the employment of individuals in recovery and family members as paid staff in provider organizations.	
Action 1: Develop mandates and standardized reporting mechanisms for self-identified consumers and family members employed as providers in non-peer-support positions, as well as in peer-support positions.	
a. Establish national benchmarks for the employment of self-identified individuals in recovery as part of the workforce. This includes attention to issues of diversity in the workforce.	Technical Assistance Organizations
Action 2: Advocate for CMS endorsement of the use of appropriately trained individuals in recovery or family members as providers under state Medicaid plans.	
a. Recognize the lived experience of individuals in care and their families as a desirable component of preservice preparation or credentialing.	Federal Government
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 4	
a. Expand and/or focus SAMHSA TACs' existing capacity in a more targeted way around technical assistance on the integration of individuals in care into the workforce.	Federal Government
b. Create a peer-support dissemination infrastructure to support employment of self-identified users of care and their families.	Federal Government
c. Assist with collaborations to support recognition and integration of individuals in care in the workforce.	Technical Assistance Organizations
Objective 5: Formally engage persons in recovery and family members in substantive roles as educators for other members of the workforce in every provider training and education program.	
Action 1: Propose that national oversight bodies for each of the major behavioral health disciplines endorse inclusion of individuals in recovery and family members on the faculties of their preprofessional training programs.	Oversight Organizations
Action 2: Propose that national educational oversight organizations that accredit residencies and practica endorse the use of individuals in recovery and family members as preceptors or consultants to preceptors.	Oversight Organizations
a. Report and score training that reflects a priority for inclusion and involvement of users of care in training of professional candidates.	
Action 3: Include individuals in recovery and family members in the design, oversight, delivery, and evaluation of all state-sponsored training.	Professional & Trade Associations
Action 4: Include individuals in recovery and family members in the design, oversight, delivery, and evaluation of all federally sponsored training.	Federal Government

Action 5: Include a course led by consumers and family members regarding recovery from the consumer and family member perspective in all provider-sponsored continuing education programs.	Federal Government
Action 6: Encourage providers, states, and organizations to use teams of consumers and providers to offer continuing education.	Professional & Trade Associations
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 5	
a. Lead the coordination of existing and proposed Technical Assistance infrastructure and the development and dissemination of action steps.	Federal Government
b. Endorse the inclusion of faculty with lived experience of behavioral conditions.	Oversight Organizations.
c. Endorse full equity for persons self-identified as users of care as members of the professional communities to which they belong.	Professional & Trade Associations
d. Reinforce state policies and procedures that foster inclusion of individuals in care or recovery as integral to all continuing education activities.	Professional & Trade Associations



APPENDIX B: PRELIMINARY IMPLEMENTATION TABLES

GOAL 2

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

Objectives, Actions, & Levers of Change	Stakeholders
Objective 1: Support communities in their development of the core competencies of assessment, capacity building, planning, implementation, and evaluation.	
Action 1: Increase the level of consensus and support for utilizing SAMHSA’s Strategic Prevention Framework and CADCA’s related competencies as the basis for competency development with communities.	
a. Engage an organization with expertise in community capacity development to manage implementation of this objective.	Federal Government
b. Devise and implement a strategy to broadly disseminate information and build consensus around the SPF and the CADCA competencies as tools for community capacity-building.	Technical Assistance Organizations; Professional & Trade Associations
Action 2: Identify and further develop competency-based curricula, training models, and technical assistance toolkits for use in building community capacities.	
a. Convene an expert panel in community development to identify, catalog, and review existing curricula, training models, and technical assistance toolkits, and to create an action plan for further development and deployment of such resources.	Federal Government; Foundations
b. Engage organizations with expertise in community capacity-building and development of curricula and related resources to fill identified gaps in curricula, training models, and technical assistance.	Federal Government; Foundations
c. Develop and field-test additional curricula, training models, and technical assistance materials.	Technical Assistance Organizations; Education & Training Programs; Professional & Trade Associations
Action 3: Implement training and deliver technical assistance to communities.	
a. Identify existing funding streams and evaluate potential financing mechanisms to increase support for training and technical assistance to communities.	Federal Government; State, County, & Local Governments; Foundations

b. Organizations with responsibility for delivering behavioral health training and/or technical assistance include community capacity-building when designing their annual implementation plans and deliver these services/assistance.	State, County, & Local Governments; Technical Assistance Organizations; Education & Training Programs; Professional & Trade Associations
Action 4: Evaluate the efficacy of the competencies, curricula, training models, and toolkits used to increase community capacity.	
a. Engage an organization with expertise in the evaluation of workforce and community competencies.	Federal Government; Foundations
b. Select survey tools and evaluate efficacy.	Technical Assistance Organizations; Professional & Trade Associations; Education & Training Programs
c. Use evaluation findings to guide revision or further development of curricula, training models, and technical assistance approaches.	Federal Government; Foundations; Technical Assistance Organizations; Professional & Trade Associations
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 1	
a. Expand or interpret SAMHSA policies and SAPT Block Grant regulations and implementation guidelines to specifically require or create incentives for community capacity-building.	Federal Government
b. Require population-level outcomes in SAMSHA's National Outcomes Measures.	Federal Government
c. Strengthen the emphasis on community-related workforce activities within the standards of provider accreditation organizations.	Oversight Organizations
Objective 2: Increase the competency of the behavioral health workforce to build community capacity and collaborate with communities in strengthening the behavioral health system of care.	
Action 1: Identify the core competencies needed by the behavioral health workforce to build community capacity and collaborate with communities.	
a. Convene an expert panel of federal, tribal, state, community, and behavioral health leaders to (1) develop a set of core workforce competencies related to capacity building and collaborating with communities, and (2) develop an implementation plan regarding curricula development and training delivery.	Federal Government; Foundations
b. Circulate draft competencies for public comment, and revise and finalize them.	Expert Panel
Action 2: Develop competency-based curricula and training models.	
a. Engage organizations to develop competency-based curricula and training models.	Federal Government; Foundations
b. Develop, field-test, and finalize curricula and training models.	Technical Assistance Organizations; Education & Training Programs; Professional & Trade Associations
Action 3: Provide training and staff development to the behavioral health workforce in community capacity-building and collaboration.	

a. Incorporate competencies and curricula into the preservice training and education of diverse professional groups.	Education & Training Programs; Oversight Organizations
b. Incorporate competencies and curricula into the continuing education and staff development of the existing workforce.	Education & Training Programs; Technical Assistance Organizations; Service Providers
Action 4: Evaluate the efficacy of the training approaches in developing the competency of the behavioral health workforce to support and collaborate with communities.	
a. Engage organizations with expertise in the evaluation of workforce competencies.	Federal Government; Foundations
b. Design and complete evaluations of the efficacy of training approaches in building workforce competencies, and revise or further develop them guided by the findings.	Technical Assistance Organizations; Professional & Trade Associations; Service Providers
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 2	
a. Modify provider grants or contracts to mandate or provide incentives for demonstrated workforce competency in working with communities.	Federal Government; State, County, & Local Governments
b. Expand or interpret SAMHSA policies and Block Grant guidelines to specifically require or create incentives for workforce competencies in working with communities.	Federal Government
c. Strengthen requirements for competencies in community capacity-development and collaboration in training accreditation standards, certification and licensing standards, and provider organization accreditation standards.	Oversight Organizations
Objective 3: Strengthen existing connections between behavioral health organizations and their local communities.	
Action 1: Provide technical assistance to behavioral health organizations in assessing and strengthening community ties.	
a. Develop and disseminate technical assistance resources that detail model approaches to assessing and strengthening the interface between behavioral health organizations and their communities.	Federal Government; Technical Assistance Organizations.
Action 2: Encourage behavioral health organizations to develop and implement plans to strengthen their connections to local community coalitions, organizations, groups, governments, and agencies.	
a. Behavioral health organizations reassess current connections to local community coalitions, groups, agencies, and organizations, and develop a plan to further strengthen those connections.	Service Providers
b. Behavioral health organizations seek and/or allocate resources to support this initiative and proceed with implementation.	Service Providers
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 3	
a. Modify provider grants or contracts to mandate or provide incentives for demonstrated workforce competency in working with communities.	Federal Government State, County, & Local Governments
b. Include community collaboration activities as a reimbursable activity for behavioral health providers.	Payers
c. Expand or interpret SAMHSA policies and Block Grant guidelines to specifically require or create incentives for collaboration with communities.	Federal Government



APPENDIX C: PRELIMINARY IMPLEMENTATION TABLES

GOAL 3

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

Note: Recruitment and retention of persons in recovery and family members into the workforce is an essential objective that is addressed in Goal 1.

Objectives, Actions, & Levers of Change	Stakeholders
Objective 1: Disseminate information and technical assistance in effective recruitment and retention strategies.	
Action 1: Collect, analyze, and summarize descriptive information and outcome data on recruitment and retention strategies on a routine basis.	
a. Funding to support this initiative is obtained and/or allocated.	Federal Government; Foundations
b. Initial review of strategies and their effectiveness is completed, using a standardized format and updated biannually.	National Workforce TA Structure
Action 2: Provide information and technical assistance in recruitment and retention to behavioral health organizations.	
a. Broadly disseminate the systematic descriptions and reviews to behavioral health organizations and make them publicly available via the Internet.	National Workforce TA Structure
b. Provide additional technical assistance on recruitment and retention through individualized consultation and learning collaboratives.	National Workforce TA Structure
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 1	
a. Funding to support the completion of the systematic reviews and provision of technical assistance.	Federal Government; Foundations
Objective 2: Select, implement, and evaluate recruitment and retention strategies tailored to the unique needs of each behavioral health organization.	
Action 1: Identify the recruitment and retention needs of each behavioral health organization.	
a. Every behavioral health organization will implement a data-driven continuous quality improvement process using a data set that incorporates variables on recruitment and retention.	Service Providers

b. Routinely survey the demographics and other characteristics of the population served and recruit a workforce of similar composition.	Service Providers
c. Use a quality improvement process, identify recruitment and retention needs, and select interventions to address those needs.	Service Providers
Action 2: Implement and evaluate interventions designed to address the unique recruitment and retention needs of each organization.	
a. Implement and evaluate the effectiveness of selected strategies and modify the interventions using a continuous quality improvement process.	Service Providers
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 2	
a. Organization leaders prioritize this objective and allocate necessary resources.	Service Providers
b. Strengthen requirements in provider organization accreditation standards for organizations to apply continuous quality improvement to recruitment and retention issues.	Oversight Organizations
Objective 3: Expand financial incentives, such as training stipends, tuition assistance, and loan forgiveness, to increase recruitment and retention.	
Action 1: Convene an expert panel to propose the funding sources, priority areas, and target recipients of increased federal and state financial incentives.	
a. Identify and review (1) federal and state incentives that historically have supported or potentially could support recruitment and retention in behavioral health, and (2) initiatives that provide curriculum, mentoring, and paid internships for high-school, postsecondary, and undergraduate students.	Federal Government; State Governments; Expert Panel on Incentives; National Workforce TA Structure
b. Recommend sources of increased federal financial incentives, and identify geographic priority areas, population priority groups, and target recipients (e.g., mechanisms such as the federally funded minority fellowship program).	Expert Panel on Incentives
Action 2: Increase federal and state financial incentives and evaluate their effectiveness.	
a. Establish priorities, allocate funding, and award support for increased federal and state incentives.	Federal Government; State Governments
b. Rigorously evaluate the degree to which these incentives are successful in recruiting professionals into and retaining them in the behavioral health field.	Education & Training Organizations; Professional & Trade Associations; National Workforce TA Structure
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 3	
a. Conduct advocacy with federal agencies, Congress, state behavioral health agencies, and state legislatures.	Advocates; Professional & Trade Associations; Service Providers
Objective 4: Provide wages and benefits commensurate with education, experience, and levels of responsibility.	
Action 1: Develop partnerships with federal and state departments of labor focused on employment, wage, and benefit issues.	

a. Establish a standing partnership between behavioral health agencies and departments of labor at the federal and state levels.	Federal Government; State Governments
b. Develop information through these collaborations on labor markets, “living” wages in diverse geographic areas, and benchmarks on wages and benefits within the behavioral health field. Also, develop information by comparing behavioral health positions with other jobs requiring comparable education, experience, and levels of responsibility.	Departments of Labor
Action 2: Use data generated through collaborations with departments of labor to adjust wages and benefits.	
a. Use wage and benefit data to adjust funding and reimbursement levels to service organizations.	Federal Government; State, County, & Local Governments; Payers
b. Wages and benefits are adjusted within behavioral health organizations to ensure a living wage; wages and benefits also are commensurate with education, experience, and levels of responsibility. Wages should be based on the true costs of services provided, efficiencies, best practices, and the inclusion of related and necessary administrative costs. Wages also should support a clinical career ladder, thereby keeping clinical practitioners in the field and within the scope of their expertise.	Service Providers
Objective 5: Implement a comprehensive public relations campaign to promote behavioral health as a career choice.	
Action 1: Engage a national marketing firm to develop the campaign.	
a. Develop proposed specifications for the public relations campaign, which will include marketing strategies targeted to a diverse range of communities in a variety of languages.	National Workforce TA Structure
b. Obtain and allocate funding and select a marketing firm through a competitive bid process to manage the campaign.	Federal Government; Foundations
Action 2: Develop and implement comprehensive marketing campaigns at the national, state, and local levels.	
a. To advise the contracted marketing firm, convene a Public Relations Advisory Panel with diverse representation from the behavioral health field.	National Marketing Firm; National Workforce TA Structure
b. Identify and define target audiences of the campaign, with special emphasis on outreach to communities of color and to young people of high-school age or younger.	National Marketing Firm
c. Craft key messages of the campaign that will be most influential with target audiences.	National Marketing Firm
d. Design strategy for campaign execution at national, state, and local levels.	National Marketing Firm
e. Develop messaging and products for the national level campaign (e.g., produce and negotiate airing of public service announcements, execute media relations campaign, develop national-level events, etc.).	National Marketing Firm

f. Develop products for adoption and adaptation at the state and local levels. Disseminate them broadly and offer technical assistance to behavioral health organizations for implementing local public relations campaigns (Note: local implementation will place considerable emphasis on employee-to-peer recruitment strategies that have been effective in the developmental disabilities arena).	National Marketing Firm; National Workforce TA Structure
Action 3: Create a Web portal that is a comprehensive resource for people recruiting for or seeking positions and careers in behavioral health.	
a. Establish and manage a Web site on behavioral health careers modeled after the Johnson and Johnson, Inc.-sponsored site, <i>Discover Nursing</i> (www.discovernursing.com).	National Workforce TA Structure
b. Establish or link to a Web site that facilitates job placement in behavioral health through employer postings of opportunities and job seeker postings of resumes.	National Workforce TA Structure
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 5	
a. Federal funding to support development of campaign and offer public relations materials (e.g., brochure templates, public service announcements, etc.) to behavioral health organizations at no charge.	Federal Government; Foundations
b. Strengthen requirements in provider accreditation standards and processes for organizations to effectively recruit and retain a workforce.	Oversight Organizations
Objective 6: Develop career ladders.	
Action 1: Conduct a review of career pathways through educational, certification, and licensing systems.	
a. Map the career ladder of progressive steps in education, certification, and licensure in each state. Identify gaps in the educational, certification, or licensing systems that impede career movement from entry-level, paraprofessional positions to terminal degrees and licensure as an independent professional.	State Behavioral Health Partnerships; State, County, & Local Governments; Education & Training Programs; Professional & Trade Associations; Oversight Organizations
b. Identify the special challenges of and barriers to incorporating persons in recovery and persons of diverse cultural backgrounds into traditional career ladders.	Advocates; Education & Training Programs; Professional & Trade Associations
Action 2: Develop additional curricula, training programs, and certification or licensure procedures to address gaps in the career ladders.	
a. Create curricula and training programs to address gaps in the educational system that prevent advancement.	State Behavioral Health Partnerships; Academic & Training Organizations; Professional & Trade Associations
b. Create additional certifications or licensure processes to ensure that each major educational advancement is accompanied by an associated reward or recognition of that advancement.	State Government; Oversight Organizations; Education & Training Programs
c. Develop curricula and other mechanisms designed specifically to support people in recovery and people of diverse cultural backgrounds in achieving success.	Advocates; Education & Training Programs; Professional & Trade Associations

LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 6	
a. Funding to conduct review, curriculum, and credentialing development.	Federal Government; Foundations
b. Changes in state law and regulation.	State Government
Objective 7: Expand the use of “grow-your-own” recruitment and retention strategies focused on residents of rural areas, culturally diverse populations, and consumers and families.	
Action 1: Develop and distribute technical assistance in existing initiatives to recruit these priority populations into entry-level positions and foster their continued professional development through a career ladder.	
a. Identify and assemble descriptive information, and review evidence of outcomes on existing “grow your own” initiatives.	National Workforce TA Structure
b. Disseminate this information via printed and Web-based media and through direct technical assistance.	National Workforce TA Structure
Action 2: Increase the use of this recruitment and retention strategy with these priority populations.	
a. Increase the number of entry-level training programs targeted to these populations and focused on skills such as case management, outreach and engagement, and interpretive services. Provide or enhance ongoing training, education, apprenticeship, and mentoring opportunities.	Federal Government; Foundations; State Behavioral Health Partnerships; State, County, & Local Governments; Education & Training Programs; Service Providers
b. Provide financial incentives to support individuals in priority populations as they enter the field and progress through the career ladder.	Federal Government; Foundations; State, County, & Local Governments; Service Providers
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 7	
a. Funding for curriculum and program development and support of the people in training.	Federal Government; State, County, & Local Governments; Foundations
b. Advocacy with federal and state governments and educational institutions.	Advocates; Professional & Trade Associations; Service Providers
Objective 8: Increase the cultural and linguistic competence of the behavioral health workforce.	
Action 1: Initiate broad dissemination of standards and tools for culturally competent practice.	
a. Develop and implement a comprehensive dissemination strategy to promote widespread adoption of standards for cultural competence and related tools.	Federal Government; Foundations
b. Implement the CLAS recommendation to develop an Internet-based national clearinghouse and dissemination center containing information on model strategies and programs, assessment tools and techniques, and interpreter and language services.	Federal Government; Foundations
c. Incorporate cultural competencies into the core competency models of all professions and other sectors of the workforce.	Education & Training Programs; Professional & Trade Associations; Oversight Organizations
Action 2: Increase the cultural competence of interpreters used in delivering services through the development of standards, training models, and reimbursement strategies.	

a. Implement the CLAS recommendations to develop national standards in the areas of training, skills assessment, certification, and codes of ethics for interpreters.	Federal Government; Foundations; Professional & Trade Associations; Education & Training Programs
b. Provide sufficient compensation for services to facilitate the provision of culturally competent interpreters and language assistance services in routine clinical care.	Payers; Federal Government; State, County, & Local Governments
Action 3. Create workplace environments that are conducive to a diverse workforce.	
a. Ensure a “critical mass” of diversity in hiring practices (avoid hiring only a single individual as a representative of an ethnic or linguistic group).	Service Providers; Professional & Trade Associations; State, County, & Local Governments
b. Provide and support ongoing training and supervision of all staff in culturally competent practice.	Service Providers Professional & Trade Associations State, County, & Local Governments
c. Revise personnel policies to reflect a value for diversity and incentives or rewards for special skills (e.g., multiple languages, knowledge of alternative healing practices used by persons seeking services, etc.).	Service Providers; Professional & Trade Associations State, County, & Local Governments
Action 4: Expand the pipeline of culturally and linguistically competent professionals who are entering the behavioral health field.	
a. Increase funding and support for professional development of faculty from diverse cultural backgrounds to create a critical mass of faculty capable of serving as mentors and role models for students interested in providing culturally and linguistically sensitive behavioral health services.	Federal Government; State, County, & Local Governments; Foundations; Professional & Trade Associations; Education & Training Programs
b. Allocate funds to support multicultural undergraduate, graduate and postgraduate training and educational opportunities (e.g., diversity courses, practicum placements, externships, and internships, etc.) that will create a critical mass of students who will enter the behavioral health field and provide culturally and linguistically sensitive services.	Federal Government; State, County, & Local Governments; Foundations; Professional & Trade Associations; Education & Training Programs
c. Rigorously evaluate the degree to which these initiatives are successful in recruiting and retaining professionals into the behavioral health field.	Federal Government; State, County, & Local Governments; Foundations; Professional & Trade Associations; Education & Training Programs
d. Adopt strategies drawn from the CLAS recommendations to foster the recruitment and credentialing of foreign-trained professionals.	Federal Government; Professional & Trade Associations; Oversight Organizations
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 8	
a. Modify Block Grant requirements to require demonstrated progress on achieving cultural diversity and competence within each state’s workforce.	Federal Government
b. Identify financing incentives for the provision of culturally and linguistically competent treatment services and interpretive services.	Payers; Federal Government; State, County, & Local Governments
c. Strengthen requirements in provider accreditation standards and processes for organizations to demonstrate the cultural competence and diversity of their workforces.	Oversight Organizations



APPENDIX D: PRELIMINARY IMPLEMENTATION TABLES

GOAL 4

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

Objectives, Actions, & Levers of Change	Stakeholders
Objective 1: Identify core competencies and focused competencies for behavioral health practice.	
Action 1: Establish a Competency Collaborative that links organizations developing behavioral health competencies and provides technical assistance.	
a. Identify organizations currently engaged in competency development and assessment.	National Workforce TA Structure
b. Convene these organizations to participate voluntarily in the collaborative, share information on competency development and assessment, and receive technical support related to these activities.	Organizations developing competency models
c. Develop a set of consensus standards for evaluating competency models and competency assessment methods on rigor and relevance.	Competency Collaborative, with consultation with the Center for Psychiatric Rehabilitation at Boston University
d. Summarize and broadly disseminate information on best practices in competency development and assessment through written and Web-based materials and the provision of technical assistance.	National Workforce TA Structure; Competency Collaborative
e. Conduct self-evaluations of competency models and assessment methods on a biannual basis using these standards. Voluntarily make the results publicly available.	Organizations developing competency models
f. Produce and disseminate biannually a compendium of current competency development and assessment methods and their status.	Competency Collaborative National Workforce TA Structure
Action 2: Develop a model set of core mental health competencies.	
a. Review available competency models and related documents, with special attention to the wealth of information contained in the Addiction Counseling Competencies (TAP 21).	Competency Collaborative
b. Craft a draft model containing core competencies relevant to almost all aspects of mental health practice, broadly disseminate the draft model, and finalize it.	Competency Collaborative

c. Broadly disseminate the final model to the field.	National Workforce TA Structure
d. Periodically review and update the core competency model.	Competency Collaborative
Action 3: Identify and further develop focused competencies relevant to specific areas of behavioral health practice.	
a. Identify the locus of activity on competency development and assessment in each sector of the behavioral health field to ensure that an organized continuous effort to advance this work is in process. The competency models should evolve into tiered levels of competency, tied to levels of experience and/or responsibility.	Federal Government; Professional Associations; Competency Collaborative; and other organizations
b. Identify gaps in current competency models and launch additional development and assessment initiatives.	Federal Government; Professional Associations; Competency Collaborative; and other organizations
c. Review and incorporate core competencies and other critical practice competencies (described below) into focused competencies.	Organizations developing competency models
d. As described above, conduct a self-evaluation of competency models and assessment methods on a biannual basis using the consensus standards. Voluntarily make the results publicly available.	Organizations developing competency models
e. Periodically review and update focused competencies.	Organizations developing competency models
Action 4: Identify and further develop competencies in critical practices that include (a) person-centered planning, (b) culturally competent care, (c) development of therapeutic alliances, (d) shared decision-making, (e) evidence-based practice, (e) recovery- and resilience-oriented care, (f) rehabilitation, (g) interdisciplinary and team-based practice, (h) advocacy, (i) use of informatics, and (j) continuous quality improvement.	
a. Identify or convene an expert panel for each of these critical practices.	National Workforce Technical Assistance Structure
b. Identify, review, and summarize existing competencies related to these practices.	Expert Panels
c. Develop, circulate for public comment, and finalize a recommended set of competencies for each of these practices.	Expert Panels
d. Broadly disseminate the recommended sets of competencies.	National Workforce Technical Assistance Structure
e. Incorporate these competencies into other competency models, curricula, and accreditation, certification, and licensing standards.	Competency Collaborative; Education & Training Organizations; Professional & Trade Associations; Oversight Organizations
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 1	
a. Federal funding.	
b. Accreditation standards and processes require demonstration of individual competency.	
c. Certification and licensing standards incorporate core and specialty competencies.	

Objective 2: Develop and implement competency-based curricula.	
Action 1: Develop model, portable curricula for entry-level, direct care staff based on the core competencies.	
a. Convene a panel of experts in the training and development of entry-level, direct care staff in mental health and co-occurring disorders treatment, prevention, and health promotion.	National Workforce TA Structure; Competency Collaborative
b. Review existing curricula that are relevant to the work of entry-level direct care staff in mental health.	Expert Panel on paraprofessional training
c. Develop a model curriculum based on the core competencies.	Expert Panel on paraprofessional training
d. Circulate the curriculum for public comment, revise, and finalize.	Expert panel on paraprofessional training
e. Develop print and Web-based mechanisms to make the curriculum publicly available without cost to users.	Contracted Organizations
f. Implement this curriculum or a comparable alternative to ensure that each direct care staff person has received competency-based training.	Provider Organizations
g. Develop continuing education curricula to supplement the core curriculum on an ongoing basis.	Expert Panel on paraprofessional training; Contracted Organization; National Workforce TA Structure
h. Evaluate the effectiveness of the curriculum in developing competencies. Revise the curriculum based on evaluation findings.	Expert Panel on paraprofessional training; National Workforce TA Structure
Action 2: Develop a set of consensus standards for evaluating curricula on relevance and effectiveness.	
a. Convene a panel of experts to develop draft standards for curriculum evaluation and relevance.	National Workforce TA Structure; Competency Collaborative, with consultation with the Center for Psychiatric Rehabilitation at Boston University
b. Subject the proposed standards to review by the Competency Collaborative and the proposed National Council on the Behavioral Health Workforce, and incorporate their recommended revisions.	Expert Panel on curriculum standards; Competency Collaborative; National Council on the Behavioral Health Workforce
c. Circulate the revised draft standards for public review and comment and finalize the standards based on feedback received.	Expert Panel on curriculum standards
d. Disseminate the standards to training and education organizations.	National Workforce TA Structure
Action 3: Identify or further develop competency-based specialized curricula, relevant to specific areas of behavioral health practice.	
a. Identify the locus of activity on curriculum development and assessment in each sector of the behavioral health field to ensure that organized, continuous efforts to advance this work are in process. The curricula should be based on the tiered levels of competency.	Federal Government; Professional Associations; Competency Collaborative; and other organizations
b. Identify gaps in curricula and launch additional curricula development as needed.	Federal Government; Professional Associations; Competency Collaborative; and other organizations

Action 4: Require education and training programs routinely to review and update their curricula and conduct self-evaluations using the consensus standards.	
a. Review and update curricula at intervals of no greater than 2 years.	Training & Education Organizations
b. Conduct self-evaluations of curricula at least every 2 years using the consensus standards. Voluntarily make the results publicly available.	Training & Education Organizations
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 2	
a. Accreditation standards for educational program.	
b. Prospective students seek access to self-evaluations of curricula.	
c. Consumer and family members and advocacy groups seek access to self-evaluations of curricula.	
Objective 3: Adopt evidence-based training methods that have been demonstrated as effective through research.	
Action 1: Identify effective teaching methods through a systematic review of available research.	
a. Convene an expert panel of experts on education and training effectiveness from all behavioral health disciplines.	National Workforce TA Structure
b. Identify and review available research, produce a summary of findings, and identify teaching methods that have empirical support.	Expert Panel on effective education
c. Develop and disseminate a tool for use by training and education organizations in conducting self-evaluations on the effectiveness of their current teaching methods.	Expert Panel on effective education; National Workforce TA Structure
Action 2: Employ evidence-based teaching methods in training and education organizations.	
a. Conduct self-evaluations of training and teaching methods and voluntarily make the findings publicly available.	Training & Education Organizations
b. Replace methods without empirical support with those that are supported by evidence.	Training & Education Organizations
Action 3: Require (through accreditation standards for preservice and continuing education) the use of evidence-based teaching methods.	
a. Review and revise accreditation standards applicable to training organizations to strengthen requirements regarding the use of evidence-based teaching methods.	Training & Education Accreditation Organizations; Professional Associations
b. Provide training organizations information on the new standards, followed by time to address the standards, after which standards implementation occurs.	Training & Education Accreditation Organizations; Professional Associations
c. Cease accreditation or other sanctioning of preservice training or continuing education programs that rely on teaching methods proven ineffective through research.	Training & Education Accreditation Organizations; Professional Associations
Action 4: Identify and adopt conference and meeting models that have demonstrated impact on participant learning and behavior.	
a. Develop and disseminate a technical assistance package of alternative conference and meeting models for ensuring demonstrated participant learning and behavior change and/or other measurable outcomes.	Expert Panel on effective education; National Workforce TA Structure

b. Adopt new conference and meeting models and routinely measure and report on outcomes.	Federal Government; State Behavioral Health Agencies; Professional Associations; Continuing Education Providers; and other conference/meeting conveners.
c. Require clear and measurable objectives and demonstrated outcomes from conferences and meetings. Reduce or eliminate funding for conferences and meetings that do not meet this standard.	All Conference & Meeting Funders
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 3	
a. Accreditation standards for educational program.	
b. Prospective and current students seek access to self-evaluations of teaching methods.	
c. Consumer and family members and advocacy groups seek access to self-evaluations of curricula	
d. Prospective and current students seek access to self-evaluations of teaching methods.	
Objective 4: Use technology to increase access to and effectiveness of training and education.	
Action 1: Provide technical assistance to training and education organizations on best practices in the use of technology for learning.	
a. Convene an expert panel on technology-assisted instruction.	National Workforce TA Structure
a. Identify model or best practices in computer-assisted instruction, Web-based learning, distance education, simulated patients, and other technology-assisted training methods.	Expert Panel on technology-assisted instruction
b. Review and summarize the evidence-based on these practices.	Expert Panel on technology-assisted instruction
c. Develop technical assistance materials on best practices and disseminate through print and electronic media, as well as direct consultation.	Expert Panel on technology-assisted instruction; National Workforce TA Structure
d. Develop a self-evaluation tool for use by training and education organizations in assessing their conformance with best practices and evidence-based practices in technology-assisted education.	Expert Panel on technology-assisted instruction; National Workforce TA Structure
Action 2: Employ best practices in the use of technology-assisted instruction.	
a. Conduct self-evaluations of technology-assisted training methods and voluntarily make the findings publicly available.	Training & Education Organizations
b. Replace methods without empirical support with those supported by evidence or identified as best practices.	Training & Education Organizations
Action 3: Fund demonstration initiatives in technology-assisted instruction.	
a. Allocate and award funding to support comprehensive demonstrations of technology-assisted instruction, such as Web-based distance-learning certificate or degree programs based on competency-based curricula.	Federal Government
b. Evaluate the effectiveness of these demonstrations.	Contracted Organization
c. Disseminate information to the field on the demonstration models and their outcomes.	National Workforce TA Structure

LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 4	
a. Accreditation standards for training and education programs require use of best practices in technology-assisted instruction.	
b. Prospective and current students seek access to self-evaluations of technology-assisted instruction methods.	
c. Federal funding to stimulate innovation and development.	
Objective 5: Launch a national initiative to ensure that every member of the behavioral health workforce develops basic competencies in the assessment and treatment of substance use disorders and co-occurring mental and addictive disorders.	
Action 1: Incorporate addiction and co-occurring competencies into all competency models, preservice and continuing education curricula, training accreditation and program accreditation standards, and certification and licensure requirements.	
a. Convene a Commission on the Adoption Competencies for Substance Use Disorders and Co-Occurring Disorders with representatives of training and education organizations, training accreditation and provider accreditation organizations, professional associations, and certification and licensing bodies.	Federal Government
b. Identify the historical barriers that have impeded the incorporation of addiction and co-occurring related competencies into competency models, curricula, standards and requirements, despite the overwhelming evidence that individuals with these disorders frequently present in and receive services in virtually all behavioral health settings.	Commission on Adoption of SUDS and Co-occurring Disorder Competencies
c. Identify and implement strategies to overcome the identified barriers, effectively incorporating these competencies into other competency models, curricula, standards, and requirements (e.g., developing a consensus standard that a minimum percentage of certification and licensure exam questions will address the assessment and treatment of substance use disorders or co-occurring disorders).	Commission on Adoption of SUDS and Co-occurring Disorder Competencies; Federal Government; State Behavioral Health Agencies Training Organizations; Accreditation Organizations; Certification & Licensure Bodies
d. Prepare and disseminate an annual report to the nation on progress in achieving this critical objective, supported by data on the competence of the workforce in treating persons with these disorders.	Commission on Adoption of SUDS and Co-occurring Disorder Competencies
Action 2: Implement or expand training and staff development on the assessment and treatment of substance use disorders and co-occurring mental and addictive disorders throughout pre-service and continuing education.	
a. Identify training and staff development needs regarding these competencies. Devise and implement a staff development plan.	Provider Organizations
b. Expand continuing education programming on these competencies.	Provider Organizations; Continuing Education Providers; Professional Associations; State Behavioral Health Agencies

c. Systematically evaluate progress on this national agenda through formal evaluations of the workforce on these competencies.	Provider Organizations; Continuing Education Providers; Professional Associations; State Behavioral Health Agencies
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 5	
a. Provider and training accreditation standards, as well as certification and licensing procedures, require demonstration of these competencies.	
b. Data-based evaluation of actual workforce competencies.	
Objective 6: Educate prospective students about best practices in training and education to inform their selection of a training program or training provider.	
Action 1: Develop and disseminate a <i>Guide to Selecting Relevant and Effective Training</i> designed for prospective students.	
a. Convene a work group comprising (1) selected members of the expert panels on competencies, curriculum, and effective training, (2) current students in professional preservice programs, and (3) current users of continuing education.	National Workforce TA Structure
b. Distill consensus standards regarding competencies, curricula, and training methods into a draft guide to aid prospective students in evaluating potential training programs and training providers.	Work Group on guide development
c. Distribute the draft guide to prospective students, education and training programs, and clinical training providers for field review and comment.	Work Group on guide development
d. Finalize and broadly disseminate the guide.	National Workforce TA Structure
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 6	
a. Federal funding to support initiative.	
b. Prospective student's use of guide influences responsiveness among educators and trainers to the best practices.	
Objective 7: Identify and implement strategies to support and sustain the use of newly acquired skills in practice settings.	
Action 1: Identify strategies proven to be effective in supporting and sustaining newly acquired skills and behavior change within organizations.	
a. Convene a panel of experts on the structuring and modification of organizational environments and processes to support and sustain new learning and behavior change.	National Workforce TA Structure
b. Review and summarize the evidence on effective interventions.	Expert Panel on impact of organizational factors on behavior change
Action 2: Adopt organizational interventions to support and sustain newly acquired skills and measure sustained behavior change among the workforce.	
a. Provide technical assistance to the field on these interventions through written and Web-based communications and direct consultation.	National Workforce TA Structure
b. Adopt recommended interventions and systematically monitor outcomes in terms of sustained behavior change.	Provider Organizations

LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 7	
a. Provider accreditation standards require demonstration of measurable and sustained changes in workforce behavior as a result of organizational efforts to improve practices.	
b. Requirements for demonstrated and sustained outcomes in federal, state, and foundation grants that support training or service development.	



APPENDIX E: PRELIMINARY IMPLEMENTATION TABLES

GOAL 5

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

Objectives, Actions, & Levers of Change	Stakeholders
Objective 1: Identify leadership competencies tailored to the unique challenges of behavioral health care.	
Action 1: Conduct a comprehensive review of available leadership competency models.	
a. Select and fund a technical assistance organization to manage this scope of work.	Federal Government; Foundations
b. Identify and review effectiveness data, and summarize leadership competency models relevant to this field.	Technical Assistance Organizations; Professional & Trade Association
Action 2: Develop a leadership core competency model tailored to behavioral health.	
a. Convene an expert panel on leadership with representation from diverse sectors of the field and reflecting cultural and linguistic diversity to develop a leadership competency model for behavioral health.	Expert Panel on leadership
b. The draft competency model is released for field review and then finalized.	Expert Panel on leadership; Technical Assistance Organizations
Action 3: Finalize development of supervision competencies tailored to behavioral health.	
a. Finalize the CSAT-sponsored Competencies for Substance Abuse Treatment Clinical Supervision, which currently are under development.	Expert Panel on supervision competencies
Action 4: Disseminate broadly the core leadership and supervision competencies.	
a. Develop and distribute printed materials and technical assistance resources on these competencies.	Technical Assistance Organizations
b. Web sites and other methods for electronic distribution are established.	National Workforce Technical Assistance Structure
Action 5: Adapt the core leadership competency model and supervision competencies to the needs of diverse sectors of the field.	
a. Identify and implement a strategy to review and adapt the core competencies and supervision competencies for each stakeholder group (e.g., substance abuse prevention; persons in recovery; etc.).	Education & Training Programs; Professional & Trade Associations; Technical Assistance Organizations

LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 1	
a. Funding supports competency review, development, and dissemination.	Federal Government; Foundations
Objective 2: Identify effective leadership curricula and programs and develop new training resources to address existing gaps.	
Action 1: Identify existing leadership curricula and programs and evaluate them using selected criteria.	
a. Convene a culturally and linguistically diverse expert panel to develop a standardized evaluation protocol for reviewing the effectiveness of leadership curricula and programs.	Federal Government; Foundations; Professional & Trade Associations
b. Existing leadership curricula and programs, including those focused on supervision, mentoring, and learning collaboratives, are identified through an open call and polling of experts and evaluated using the protocol.	Expert Panel on leadership; Technical Assistance Organizations
Action 2: Develop and disseminate a catalog of available leadership curricula and programs.	
a. Compile a compendium in which curricula and programs are described using the following criteria: training objectives, scope/focus, cultural competence, experiential components, entry criteria, length/duration, number of participants, and evidence of effectiveness as determined via protocol.	Technical Assistance Organizations Professional & Trade Associations
b. Develop and distribute the compilation via print and electronic media.	Technical Assistance Organizations; Professional & Trade Associations
Action 3: Identify gaps in leadership curricula and training models and develop resources to close the gaps.	
a. Analyze the inventory of curricula and programs to identify areas requiring expansion or improvement.	Expert Panel on leadership; Technical Assistance Organizations; Professional & Trade Associations
b. Develop recommendations and priorities for further curricula and training model development.	Expert Panel on leadership
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 2	
a. Funding supports curricula and program development.	Federal Government; Foundations
b. Accreditation standards and processes place increased focus on leadership development and demonstrated competencies of leadership.	Oversight Organizations
Objective 3: Increase support for formal continuous leadership development with current and emerging leaders in all segments of the workforce.	
Action 1: Allocate funding to support the expansion or development of competency-based leadership development initiatives.	

a. Establish and finance grant programs, with special incentives for developing leadership capacities among individuals who are in recovery; family members; racial/ethnic/cultural minorities; residents of rural areas; working with children or older adults.	Federal Government; State, County, & Local Governments
b. Implement and evaluate leadership development initiatives.	Federal Government; State, County, & Local Governments; Professional & Trade Associations; Education & Training Programs; Advocacy Organizations
Action 2: Allocate funding and time to support the participation of individuals in leadership development initiatives.	
a. Establish or expand leadership development as an integral part of staff development and training initiatives.	Service Providers
b. Provide leadership development scholarships and grants to individuals, with a special emphasis on those who are in recovery; family members; racial/ethnic/cultural minorities; residents of rural areas; working with children or older adults. Outreach is made to engage such persons in leadership initiatives.	Federal Government; State, County, & Local Governments; Foundations; Professional & Trade Associations; Service Providers
Action 3: Establish mentorship programs.	
a. Fund and establish mentoring initiatives, with a special emphasis on people who are: in recovery; family members; racial/ethnic/cultural minorities; residents of rural areas; working with children or older adults. Outreach is made to engage such persons in leadership initiatives.	Federal Government; State, County, & Local Governments; Foundations; Professional & Trade Associations; Education & Training Programs; Service Providers
b. Create leadership excellence networks to identify and prepare existing leaders who are interested in serving as mentors.	Professional & Trade Associations; Education & Training Programs; Service Providers
Action 4: Provide competency-based training to all supervisors.	
a. Provide formal competency-based supervision training for all current supervisors who have not been trained in supervision.	State, County, & Local Governments; Service Providers; Professional & Trade Associations
b. Provide formal competency-based supervision training to all individuals who are becoming supervisors as they assume these responsibilities.	State, County, & Local Governments; Service Providers; Professional & Trade Associations
c. Incorporate supervision as an essential element of all ongoing, continuing professional development activities.	Service Providers; Education & Training Programs; Professional & Trade Associations
Action 5: Provide incentives, recognition, and rewards for participation in leadership development programs.	
a. Identify existing certifications for leadership development and develop additional certifications if necessary.	Oversight Organizations; Professional & Trade Associations; State, County, & Local Governments; Education & Training Programs
b. Create salary incentives and promotional opportunities for participation in leadership development.	Service Providers; State, County, & Local Governments

LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 3	
a. Public and private funding to support competency and curricula development and delivery.	Federal Government; State, County, & Local Governments; Foundations
b. Require formal leadership training for supervisory, managerial, and administrative positions.	Service Providers; Oversight Organizations
Objective 4: Formally evaluate leadership development programs based on defined criteria and revise the programs based on outcomes.	
Action 1: Apply data-based continuous quality improvement methods in all leadership development initiatives.	
a. Incorporate variables identified in the standard evaluation protocol described above into CQI efforts of leadership development programs.	Education & Training Programs; Professional & Trade Associations; Service Providers
Action 2: Commission independent evaluation of leadership development initiatives.	
a. Establish methods for independent review, drawing on the evaluation protocol identified above, and complete periodic external review and evaluation of leadership initiatives.	Federal Government; State, County, & Local Governments; Foundations; Professional & Trade Associations
Action 3: Develop, maintain, and routinely disseminate a summary of findings from the evaluation of leadership programs to support ongoing quality improvement of leadership development efforts.	
a. Routinely update and broadly disseminate the catalog of leadership programs, described above, with a focus on evaluation findings.	National Workforce Technical Assistance Structure
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 4	
a. Accreditation standards and processes place increased focus on leadership development and demonstrated competencies of leadership.	Oversight Organizations
b. Organizations funding leadership development require demonstrated outcomes as a requirement of continued funding.	Federal Government; State, County, & Local Governments; Foundations



APPENDIX F: PRELIMINARY IMPLEMENTATION TABLES
GOAL 6

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

Objectives, Actions, & Levers of Change	Stakeholders
Objective 1: Create a National Technical Assistance Structure that coordinates and provides information, guidance, and support on workforce development to the behavioral health field and advises the federal government.	
Action 1: Develop the specifications for a National Technical Assistance Structure on workforce development.	
a. Submit proposed specifications to SAMHSA (this is an existing deliverable in a current contract).	Annapolis Coalition
b. Finalize specifications and obtain and/or allocate funding.	Federal Government
Action 2: Establish the National Technical Assistance Structure.	
a. Contract with an organization to establish and maintain the technical assistance structure.	Federal Government
b. Establish administrative structures, recruit staff, identify a network of workforce experts, and launch communication vehicles (e.g., LISTSERV, Web site). The structures are designed to ensure significant participation by persons in recovery, children, youth, families, and experts who reflect the cultural and linguistic diversity of the communities served.	National Workforce Technical Assistance Structure
c. Establish links with other organizations providing technical assistance and support.	National Workforce Technical Assistance Structure
d. Establish collaboratives to coordinate and support workforce development with selected stakeholder groups, such as provider accreditation organizations, state behavioral health agencies, organizations developing competencies.	National Workforce Technical Assistance Structure; State, County, & Local Governments; Oversight Organizations; Education & Training Programs; Professional & Trade Associations; Advocates
Action 3: Establish a National Council on the Behavioral Health Workforce to monitor workforce status, set national workforce development priorities, and advise the federal government on workforce policy (as recommended in the IOM's 2006 report).	
a. Establish the National Council through legislative or executive action.	Federal Government
b. Select experts in workforce development, including consumer and family advocates, to serve on the National Council.	Federal Government in consultation with other organizations

c. Staff and support the National Council administratively through the proposed National Technical Assistance Structure.	National Workforce Technical Assistance Structure
d. Establish a set of workforce priorities and communicate these to federal agencies and to the proposed National Technical Assistance Structure on an annual basis.	National Council on the Behavioral Health Workforce
e. Report biannually to Congress and the nation on the status of the workforce.	National Council on the Behavioral Health Workforce
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 1	
a. Federal funding to support the technical assistance structure and National Council.	Federal Government
b. IOM report, which calls for establishment of a National Council.	Institute of Medicine
c. Advocacy with federal agencies and Congress to establish the National Council.	Advocates; Professional & Trade Associations; Education & Training Programs
Objective 2: Create a federal Behavioral Health Workforce Partnership, led by a SAMHSA Workforce Team.	
Action 1: Establish a standing SAMHSA Workforce Team with representatives from CMHS, CSAT, and CSAP to coordinate SAMHSA activities on workforce development.	
a. Establish a cross-center SAMHSA Workforce Team charged with (1) ensuring that workforce efforts are coordinated across SAMHSA's portfolio of activities, (2) coordinating federal interagency efforts on workforce development, and (3) managing the contract with the proposed National Technical Assistance Structure.	Federal Government
Action 2: Convene a standing federal Task Force on Workforce Development to prioritize, coordinate, and implement interagency collaborations.	
a. Include the creation of a standing interagency workforce task force as part of the agenda for federal Fiscal Year 2006 for the Federal Partners work group.	Federal Government
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 2	
a. Existing relationships and collaborations within federal agencies and the mandate to implement New Freedom Commission recommendations.	Federal Government
Objective 3: Finance workforce demonstrations through a National Workforce Development Fund and foundation-sponsored initiatives.	
Action 1: Establish a National Workforce Development Fund.	
a. Establish the Fund and allocate monies.	Federal Government
b. Establish demonstration priorities.	Federal Government; National Council on the Behavioral Health Workforce
c. Make awards through a competitive process. Summarize and disseminate findings from evaluations of funded projects.	Federal Government; National Workforce TA Structure
Action 2: Encourage foundations to prioritize support for workforce development initiatives.	
a. Establish within foundations their priorities and mechanisms for funding workforce innovation.	Foundations
b. Make awards, complete evaluations, and disseminate findings.	Foundations; National Workforce TA Structure

LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 3	
a. Advocacy with federal agencies, Congress, and foundations to establish a National Workforce Development Fund.	Advocates; Professional & Trade Associations; Service Providers
b. Availability of funding stimulates and supports innovation.	Federal Government; Foundations
Objective 4: Change the economic market for services to create conditions that improve the quality of care and strengthen the workforce.	
Action 1: Increase parity with other health care in coverage for behavioral health services.	
a. Support state and national efforts to establish parity in insurance coverage for behavioral health conditions.	Federal Government; State Government
b. Create set-asides and actuarially derived funding levels for behavioral health services to avoid further erosion in coverage.	Federal Government; State Government; Payers; Private Employers
Action 2: Improve provider payment systems to create incentives for consumer satisfaction, effectiveness, and efficiency and to reduce levels of undercompensated care.	
a. Divert existing resources from demonstrably costly and ineffective programs to services that have a stronger evidence base.	Federal Government; State, County, & Local Governments; Payers
b. Create incentives through strategies, such as pay for performance, that reward providers for consumer satisfaction, innovation, efficiency, and effectiveness, while avoiding perverse incentives that may arise through these payment mechanisms.	Federal Government; State, County, & Local Governments; Payers
c. Revise reimbursement models and levels to minimize undercompensation of care, which results in workforce “stretch” to meet unfunded demand.	Federal Government; State, County, & Local Governments; Payers
Action 3: Create an Advisory Panel on Workforce Economics to develop financing and performance monitoring strategies to improve workforce practices and quality of care.	
a. Appoint a panel of experts on behavioral health financing and economics.	Federal Government; National Council on the Behavioral Health Workforce; National Workforce Technical Assistance Structure

b. Develop detailed recommendations and implementation plans regarding workforce financing that will (1) more accurately define and measure service demand and supply in an effort to better predict workforce demand; (2) effect improved distribution of the workforce into underserved areas and for underserved populations; (3) benchmark the wage and benefits levels of the behavioral health workforce with work groups of comparable education, experience, and responsibility; (4) improve recruitment and retention through changes in the financing of services, the financing of education and training, wage and benefit packages, and other nonmonetary factors; (5) finance peer and family interventions, including self-help; (6) and increase the incentives and flexibility in financing methods so as to improve consumer and family satisfaction, increase the use of evidence-based practices, and improve provider performance and efficiency.	Advisory Panel on Workforce Economics
c. Review and recommendations of the Advisory Panel and prioritize selected recommendations for implementation.	Federal Government; National Council on the Behavioral Health Workforce; National Workforce Technical Assistance Structure
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 4	
a. Research demonstrating the impact of financing on quality of care.	Researchers
b. Advocacy with Congress, state legislators, CMS, and purchasers.	Advocate, Provider, Professional & Trade Associations; Service Providers
Objective 5: Increase the use of data to track, evaluate, and manage key workforce issues.	
Action 1: Encourage professional associations and states to adopt in their workforce surveys the employee-specific Human Resources Data Set developed by the Alliance of Mental Health Professions. (Note: This set captures data on the individual practitioner, such as professional discipline, level of education, medical specialties, employment status, employment setting, hours per work week, etc.) [Note 2: This recommendation requires further review to determine the current availability of and mechanisms for collecting data on the substance use disorders treatment and prevention workforce.]	
a. Circulate Version 3 of the Human Resources Data Set developed by the Alliance of Mental Health Professions for field review and comment. Finalize and disseminate.	Alliance of Mental Health Professions
b. Formally adopt and utilize the finalized data set in all efforts to survey the workforce.	Professional & Trade Associations; State, County, & Local Governments
c. Implement a common biannual survey calendar.	Professional & Trade Associations; State, County, & Local Governments; Alliance for Mental Health Professions
d. Fund and conduct a national census of the behavioral health workforce.	Federal Government; National Workforce TA Structure

Action 2: Develop an organization-specific, standardized, Human Resources Data Set for recommended use by all organizations that employ a behavioral health workforce. (Note: This set will capture data on organizational variables, such as employee vacancy and retention rates, reasons for turnover, use of temporary staff, cultural composition of the workforce, staff satisfaction, investment in training and development, etc.)	
a. Develop a proposed work plan and allocate funding.	National Workforce TA Structure; Federal Government
b. Convene an Expert Panel to develop a proposed data set. Circulate the set for public comment, revise and finalize.	National Workforce TA Structure
c. Adopt and utilize the data set in all organizations that employ a behavioral health workforce.	Service Providers; State, County, & Local Governments; Department of Veteran Affairs; State Agencies; Provider Organizations.
Action 3: Implement a data-driven continuous quality improvement process on workforce development in every behavioral health organization.	
a. Utilize data in every behavioral health organization to formally (a) identify, assess, and diagnose workforce problems, (b) design and implement interventions to strengthen the workforce, and (c) evaluate the effects of those interventions, creating feedback for re-assessment and further intervention. (Note: Process improvement in provider organizations should focus on their local recruitment, retention, training, and development needs. The focus at the national, federal, and state levels should encompass such concerns, while more broadly examining issues such as workforce supply and demand and workforce distribution.)	Federal Government; State, County, & Local Governments; Service Providers
b. Create a written workforce development plan and fully update at least biannually in every behavioral health organization.	Service Providers
Action 4: Collect and disseminate benchmarking data on human resources.	
a. Submit workforce data voluntarily and anonymously to a central repository.	State, County, & Local Governments; Service Providers
b. Routinely analyze data to create benchmarking information that is disseminated through Web-based and print media.	National Workforce TA Structure
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 5	
a. Federal funding to create the data set and to collect and disseminate benchmarking data.	Federal Government
b. Provider accreditation organizations require the routine collection of human resources data.	Oversight Organizations
Objective 6: Strengthen the human resources and training functions, staffing, and levels of expertise in behavioral health organizations.	
Action 1: Provide technical assistance in evaluating and strengthening human resources and training functions.	

a. Develop technical assistance resources on HR and training functions, organization, and staffing.	National Workforce TA Structure
b. Provide technical assistance through Web-based dissemination of toolkits and through other educational interventions.	National Workforce TA Structure
Action 2: Develop and implement a plan in each behavioral health organization to strengthen human resources and training functions.	
a. Evaluate human resources and training capacities as a key element of continuous quality improvement efforts.	Service Providers
b. Implement interventions to strengthen these capacities (e.g., increasing the allocation of funding and staffing for HR and training functions; upgrading senior HR and training positions; continuing education of HR and training staff; obtaining consultation on HR issues; and creating an agency task force on workforce quality improvement).	State, County, & Local Governments; Service Providers
Action 3: Provide training and technical assistance in workforce development best practices to human resources and training personnel.	
a. Develop and implement technical assistance and workforce development strategies targeted to human resources and training personnel.	National Workforce TA Structure
b. Deem human resources and training personnel as priority groups in behavioral health leadership development initiatives.	Federal Government; State, County, & Local Governments
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 6	
a. Accreditation standards and processes require demonstration of adequate and effective human resources and training capacities.	Oversight Organizations
Objective 7: Promote the increased availability and use of information technology to support the workforce during training and service delivery.	
Action 1: Finalize an action plan for strengthening the behavioral health information infrastructure, drawing on recommendations from the National Summit on Behavioral Health Information Management.	
a. Finalize recommendations from the summit.	Software & Technology Vendors Association; Federal Government
b. Review the recommendations to consider the workforce implications and expand the recommendations, as necessary, to include workforce-related information management strategies.	Software & Technology Vendors Association; Federal Government; National Workforce TA Structure

<p>c. Develop a final action plan, which should address, but not be limited to</p> <ul style="list-style-type: none"> (1) incorporation of behavioral health into the NHII; (2) adoption of electronic health records; (3) establishment of common data standards, including implementation of the IOM (2004) recommendation on the adoption of standards for data that support patient safety; (4) access to secure platforms for the exchange of protected health information; (5) increased use of decision support, including algorithms; (6) increased use of technology for performance management of workforce activities; (7) financing of information technology development, infrastructure, and provider capacity; (8) mechanisms for the provision of technical assistance on information technology; (9) competency-based staff training and development in information management; and (10) infrastructure needs to support the expansion of computer, Web-based, and distance learning. 	<p>Software & Technology Vendors Association; Federal Government</p>
<p>Action 2: Reduce the burden of needlessly variable or purposeless data-reporting requirements for the workforce.</p>	
<p>a. Systematically reassess all data-reporting requirements to determine their demonstrated value and eliminate or improve those of questionable value.</p>	<p>Federal Government; State, County, & Local Governments; Payers; Oversight Organizations</p>
<p>b. Increasingly standardize data requirements to reduce the burden of variable reporting requirements on identical variables. This will occur through voluntary collaborations of similar organizations (e.g., third-party payers) and through the establishment of national data standards.</p>	<p>Federal Government; State, County, & Local Governments; Payers; Oversight Organizations</p>
<p>Action 3: Provide information-management and decision-support tools to the workforce.</p>	
<p>a. Provide grant funding and reimbursement levels adequate to support the financing of basic information management systems and decision-support tools within service organizations.</p>	<p>Federal Government; State, County, & Local Governments; Payers</p>
<p>b. Provide basic information management tools, such as hardware and decision-support software, as well as related training to the workforce to support efficient and effective practice.</p>	<p>Service Providers; State, County, & Local Governments</p>
<p>Action 4: Increase the use of information technology to track and manage workforce performance.</p>	
<p>a. Implement or refine information systems to accurately track workforce activities.</p>	<p>State, County, & Local Governments; Service Providers</p>
<p>b. Increasing the use of data to track, monitor, and manage performance of the workforce.</p>	<p>State, County, & Local Governments; Service Providers</p>
<p>LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 7</p>	
<p>a. Federal and state funding to support planning, development, and implementation.</p>	<p>Federal Government; State, County, & Local Governments</p>
<p>b. Federal NHII initiative to address this issue in health care.</p>	<p>Federal Government</p>
<p>Objective 8: Identify Magnet Centers in workforce best practices, drawing on the “Magnet Hospital” concept from the field of nursing.</p>	
<p>Action 1: Create standards and accreditation procedures for</p>	

Magnet Centers in behavioral health.	
a. Propose standards and accreditation procedures that draw on the existing literature and evidence on workforce development.	National Council on the Behavioral Health Workforce
b. Circulate draft standards for field review and comment, and finalize.	National Council on the Behavioral Health Workforce; National Workforce TA Structure
Action 2: Implement an accreditation process for Magnet Centers in behavioral health.	
a. Establish the structures to support and sustain the accreditation process.	National Workforce TA Structure
b. Organizations seek voluntary accreditation as a Magnet Center.	Service Providers
c. Recognize publicly those organizations accredited as Magnet Centers through a Web-based registry and other media.	National Workforce TA Structure
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 8	
a. Federal funding to support the accreditation process.	Federal Government
b. The drive for competitive advantage in workforce recruitment and retention among behavioral health organizations.	Service Providers
c. Consultation on the Magnet Hospital standards and procedures.	American Nurses Credentialing Center



APPENDIX G: PRELIMINARY IMPLEMENTATION TABLES
GOAL 7

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

Objectives, Actions, & Levers of Change	Stakeholders
Objective 1: Increase the quantity and quality of workforce-related research through creation of a federal interagency research collaborative.	
Action 1: Establish a standing federal Research Collaborative on Workforce Development with representatives of NIMH, NIDA, NIAAA, NINR, HRSA, AHRQ, SAMHSA, and other selected federal agencies.	
a. Negotiate participation of the federal agencies.	Federal Government
b. Convene the federal Research Collaborative, clarify charge, select leadership, and establish routine meeting schedule.	Federal Government
Action 2: Convene a panel of workforce experts, including persons in recovery and family members, to assist in identifying priority research topics and questions.	
a. Nominate potential experts and finalize list of participants.	Federal Research Collaborative
b. Issue report on recommended research topics and questions.	Expert Panel on workforce development research
Action 3: Identify and fund research priority areas and issue an annual report on funded studies and their outcomes.	Federal Research Collaborative
a. Develop consensus on collective research priorities and individual agency priorities on workforce-related research.	Federal Research Collaborative
b. Develop and implement a plan for securing and allocating funds to support these priorities and for stimulating interest among experienced researchers.	Federal Research Collaborative
c. Generate an annual report detailing (a) the priority areas, (b) progress in supporting workforce-related research, and (c) the findings of relevant studies supported by the participating agencies.	Federal Research Collaborative
d. Review and revise the priorities annually.	Federal Research Collaborative
Action 4: Summarize and disseminate research findings routinely to foster their impact on training curricula; licensing, certification, and accreditation standards; and provider workforce practices.	

a. Create and implement an action plan for summarizing and disseminating the findings of workforce-related research.	Federal Research Collaborative
b. Establish or expand federal linkages with academic, training, accreditation, licensing, certification, and provider organizations to facilitate the flow of research findings to the field.	Federal Research Collaborative
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 1	
a. Existing collaborations among federal agencies on behavioral health issues, exemplified by the federal action agenda on mental health.	Federal Government
b. Advocacy with federal agencies and Congress urging their support of this agenda.	Advocates; Professional & Trade Associations
c. Congressional mandates and budgetary support.	Federal Government
Objective 2: Increase the quantity and quality of formal evaluations of workforce development practices by providing technical assistance to the field.	
Action 1: Develop technical assistance materials and methods for delivery.	
a. Select an organization or consortium of organizations to develop technical assistance materials on evaluation methods.	Federal Government
b. Survey states, provider agencies, and professional associations on their evaluation needs.	Technical Assistance Organizations
c. Develop the technical assistance packages, and field-test and finalize them.	Technical Assistance Organizations
Action 2: Build evaluation capacity in the field through the provision of technical assistance.	
a. Devise and implement multiple methods of technical assistance delivery, including Web-based distance learning; organization of learning collaboratives; and ongoing training and consultation that is initiated at the annual meetings of providers, educators, and state behavioral health agencies.	Technical Assistance Organizations
b. Develop and maintain a publicly accessible, Web-based archive of key findings from field evaluations of workforce practices.	National Workforce TA Structure
LEVERS OF CHANGE TO ACHIEVE OBJECTIVE 2	
a. Modify federal Block Grants to the states to include requirements regarding workforce interventions and evaluation.	Federal Government
b. Modify state, county, and local government contracts with providers to include requirements regarding workforce interventions and evaluation.	State, County, & Local Governments
c. Include requirements for evaluation of workforce practices in education and provider accreditation standards.	Oversight Organizations



APPENDIX H

CONTRIBUTORS TO THE NATIONAL STRATEGIC PLAN

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The Annapolis Coalition on the Behavioral Health Workforce is focused on improving workforce development in behavioral health (<http://www.annapoliscoalition.org>). It serves as a neutral convener of those concerned about the future of the workforce, conducts strategic planning, identifies innovation, and provides technical assistance to governments and private organizations on workforce issues. The Coalition was founded by the American College of Mental Health Administration and the Academic Behavioral Health Consortium.

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APPENDIX I

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AACAP: American Academy of Child and Adolescent Psychiatry
AHRQ: Agency for Healthcare Research and Quality
AOD: Alcohol and Other Drug
APA: American Psychological Association
ASAM: American Society of Addiction Medicine
ATOD: Alcohol, Tobacco, and Other Drug
ATTC: Addiction Technology Transfer Center
CADCA: Community Anti-Drug Coalitions of America
CAPT: Centers for the Application of Prevention Technologies
CHADD: Children and Adults with Attention Deficit/Hyperactivity Disorder
CLAS: Culturally and Linguistically Appropriate Services
CMHS: Center for Mental Health Services (within SAMHSA)
CMS: Centers for Medicare and Medicaid Services
CMHCs: Community Mental Health Centers
CPS: Certified Peer Specialist
CQI: Continuous Quality Improvement
CSAP: Center for Substance Abuse Prevention (within SAMHSA)
CSAT: Center for Substance Abuse Treatment (within SAMHSA)
CSMHA: Center for School Mental Health Analysis and Action at the University of Maryland.
CSWE: Council on Social Work Education
DHHS: U.S. Department of Health and Human Services
DBSA: Depression and Bipolar Support Alliance
DSM-IV: American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (4th ed.)*, published in 1994
DSM-IV-TR: Text revision to the *DSM-IV*, published in 2000
GME: Graduate Medical Education
HR: Human Resources
HRSA: Health Resources and Services Administration
IOM: Institute of Medicine
IT: Information Technology
LRP: Loan Repayment Program
MHEDIC: Mental Health—Education Integration Consortium
NAADAC: National Association of Alcoholism and Drug Abuse Counselors
NAMI: National Alliance on Mental Illness (formerly National Alliance for the Mentally Ill)
NASADAD: National Association of State Alcohol/Drug Abuse Directors
NASMHPD: National Association of State Mental Health Program Directors
NASMHPD RI: National Association of State Mental Health Program Directors Research Institute
NCHL: National Center for Healthcare Leadership
NHII: National Health Information Infrastructure
NHSC: National Health Services Corps
NHSC LRP: National Health Services Corps Loan Repayment Program

NIA: National Institute on Aging
NIAAA: National Institute on Alcohol Abuse and Alcoholism
NIDA: National Institute on Drug Abuse
NIH: National Institutes of Health
NIH LRP: National Institutes of Health Loan Repayment Program
NIMH: National Institute of Mental Health
NINR: National Institute of Nursing Research
NMHA: National Mental Health Association
NPN: National Prevention Network
SAMHSA: Substance Abuse and Mental Health Services Administration
SAPT: Substance Abuse Prevention and Treatment (Block Grant)
SMH: School Mental Health
SPF: Strategic Prevention Framework
SUD: Substance Use Disorder
TA: Technical Assistance
TAC: Technical Assistance Center
TAP: Technical Assistance Publication
WICHE: Western Interstate Commission on Higher Education