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

Executive Summary

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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 S*trengthening Professional Identity: Challenges of the Addiction Treatment Workforce* (U.S. Department of Health and Human Services [DHHS], 2005a).

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

This strategic planning process was designed to examine current weaknesses in efforts to develop and sustain a strong workforce in behavioral health; develop a vision for a future workforce that is

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

Areas of Focus

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

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

Defining the Workforce

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

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

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

Issues of Language

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

A Common Agenda

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

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

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

THE PLANNING PROCESS

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

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

The Annapolis Coalition issued an open call for submission of information and recommendations via the Internet and extended specific invitations to a wide range of groups and organizations through a variety of

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

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

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

THE CURRENT WORKFORCE AND ITS ENVIRONMENT

The Mental Health Workforce

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

The best available estimates indicate that there were slightly more than a half million clinically trained and active mental health professionals in the United States in 2002 (Manderscheid & Henderson, 2004).

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

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

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

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

The Substance Use Disorders Treatment Workforce

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

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

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

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

The Substance Abuse Prevention Workforce

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

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

The Environment of Care

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

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

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

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

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

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

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

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

General Findings

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Seven Strategic Goals: An Overview

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

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

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

TABLE 1
STRATEGIC GOALS AT A GLANCE

BROADENING THE CONCEPT OF WORKFORCE

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

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

STRENGTHENING THE WORKFORCE

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

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

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

STRUCTURES TO SUPPORT THE WORKFORCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FOCUSED TOPICS & THE SEARCH FOR INNOVATION

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

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

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

Next Steps: Leveraging Change

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

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

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

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

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

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

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

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

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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.

CONTRIBUTORS

The Annapolis Coalition Board of Directors

Michael A. Hoge
John A. Morris
Allen S. Daniels
Neal Adams
Gail W. Stuart
Leighton Y. Huey

The Annapolis Coalition Staff

Ann M. McManis

National Steering Committee, Senior and Technical Advisors

Stephen J. Bartels
Sue Bergeson
Joyce Burland
Jane Callahan
Dona Dmitrovic
Joan M. Dodge
Michael Flaherty
Steve Gallon
Tom Hill
Constance M. Horgan
Larke N. Huang
D.J. Ida
Dennis Mohatt
Oscar Morgan
Maria O'Connell
Manuel Paris
Carl E. Paternite
Janice L. Petersen
Pamela Petersen-Baston
David L. Shern
Susan Storti
Mark D. Weist
Jessica Wolf

Expert Panel & Work Group Members

Hoover Adger
Steve Adelscheim
Heather K. Alvarez
Maryann Amodeo
Dawn Anderson-Butcher
Thomas E. Arthur
Jennifer Lauren Axelrod
Nora Barrett
David Bergman
Kinike Bermudez
Esther Betts
Mimi Bradley
Carlos Brandenburg
Leslie Brougham
Ellen Bueschel
Robert Burke
Joanne Cashman
Mary Cesare-Murphy
Timothy Conley
Dan Connor
Wayne Coombs
John J. Coppola
Patricia Deegan
Deborah DiGilio
Paolo del Vecchio
Holly Echo Hawk
Barry Edelstein
Steven W. Evans
Ted Feinberg
Daniel B. Fisher
Paul Flaspohler
Larry Fricks
Rita Gallagher
Martin Gaudiose
Margaret Gatz
Eric Goplerud
Jennifer Green
Neil C. Grogin
Ramiro Guevara
Mary R. Haack
Maureen Halpain
Ardis Hanson
Dianne Harnad
Lori Harris-Stevens
Mario Hernandez
Pablo Hernandez

Expert Panel & Work Group Members (cont'd)

Gregory A. Hinrichsen
Sara Honn Qualls
Mareasa Isaacs
Toni Johnson
Linda Kaplan
Stephanie Pacinella
Edward L. Knight
James Koller
David Lambert
Michael Langer
Michele Laraia
Harriet P. Lefley
Constance M. Lehman
Sally Lloyd
Francis Lu
Bruce Lubotsky Levin
Kim MacDonald-Wilson
Carol MacKinnon-Lewis
Mike Magnusson
Pamela Mattel
Ken Martinez
Lee McCabe
Christine McDonald
Carol P. Meredith
Elizabeth L. Merrick
Hope Merrick
Judith Meyers
Fran Miceli
Jennifer Miller
Joel Miller
Gerald Mohatt
Ed Morris
Randy Muck
Peter L. Myers
Paul D. Nelsen
Michelle Nienhaus
Trina Osher
Geraldine S. Pearson
Karen Perdue
Lawrence Piper
Sheila Pires
Deborah B. Pitts
David Pollack
Russell Poulin
Darlene Prettyman
Stephanie Reed
Shirley Repta
Sharon Reif
Scott Ries
Kay Rietz
Paul Romam
Douglas M. Ronsheim
Anita Rosen
Kaye Rote
Marcia A. Rubin
Marie Sanchez
Pat Sanchez
Mark Sanders
Julie Sarno Owens
Sandra Spencer
Forrest Scogin
Larry Scott
Susan P. Shafer
Helene Silverblatt
Lincoln M. Stanley
Laurie Sutter
Debbie Synhorst
Wilma Townsend
Christopher Tompkins
Tom Trabin
Mary van der Wall
Cynthia Wainscott
Dale Walker
Mona Waslow
Tommie Waters
Karen J. Weston
Josh Wilk
Deborah Wilkerson
Iris Wilkinson
Charles Williams
Daniel Yalisove
Al Zachik
Antonette M. Zeiss