THE ANNAPOLIS COALITION
ON THE BEHAVIORAL HEALTH WORKFORCE

Innovative Practices in Behavioral Health Workforce Development

Round 3 National Action Plan Final Report

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A Project of the Annapolis Coalition on the Behavioral Health Workforce

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Executive Summary

The Substance Abuse and Mental Health Services Administration engaged the Annapolis Coalition to develop the national *Action Plan on Behavioral Health Workforce Development*, which can be accessed at www.annapoliscoalition.org. The development of the plan was guided by eight expert panels comprised of leaders in workforce development from diverse sectors of the field. Each panel was charged with reviewing available research and reports on workforce problems and strategies relevant to their area of focus and obtaining broad input on these issues from stakeholders from their sector of the behavioral health field. As part of this process, the panels were asked to identify innovative workforce practices using the criteria developed during prior national searches for innovation by the Coalition. Those criteria focus on an innovation's significance, novelty, transferability, and effectiveness (see Appendix A). The selected innovations were highly relevant to the strategic goals and objectives identified in the national *Action Plan*.

The following report provides descriptive information about 20 nominated programs, presented by topic area (listed in alphabetical order).

In the Core Area of **Children and Adolescents**, two programs are highlighted:

- *Choices, Inc. Technical Assistance Center for Systems of Care and Evidence Based Practices for Children and Families*: a technical assistance center that provides innovative, multi-modal training, coaching, and technical assistance for individuals and groups whose communities are building systems of care for children and their families.
- *The Michigan Association for Infant Mental Health (MI-AIMH)* is an interdisciplinary, professional organization established to promote the optimal development of infants, toddlers, and families through relationship-based training and advocacy efforts. The Endorsement for Culturally Sensitive, Relationship-Based Practice Promoting Infant Mental Health exemplifies the organization's efforts to provide a professional development pathway that reflects infant mental health competencies that are integral to best practice in the infant and family field.

In the Core Area of **Consumer and Family**, three programs are highlighted:

- *Children and Adults with Attention-Deficit Hyperactivity Disorder (CHADD) Parent-to-Parent Training:* A program developed by parents with lived experience with ADHD that provides educational information and support for individuals and families dealing with AD/HD to help navigate the challenges across the lifespan.
- *The Georgia Certified Peer Specialist Project (Peer Specialist Training and Certification Program):* Based on principles of recovery and self-determination, a program that provides intensive training, testing, certification, and continuing education and ongoing technical support to peer specialists.
- *META Services Recovery Education Center:* From training Peer Support Specialists to recovery transformation training for organizations and systems, the META REC provides

education and training on a variety of topics related to recovery, recovery practices, developing a peer workforce, WRAP, and more.

In the Core Area of **Cultural Competencies and Disparities Issues**, three programs are highlighted:

- *Communicative and Cultural Competency for Mental Health Providers (CCC-MHP):* a training program to improve the language and cultural proficiencies of bilingual mental health providers who serve Spanish-speaking Latino clients and their families.
- *Growing Our Own*: 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 (AANHOPI).
- *Rural Human Services:* A program to enhance service delivery by training and employing village residents to work as providers in their own communities in rural Alaska.

In the Core Area of **Rural Issues**, three programs are highlighted:

- *Alaska Behavioral Health Workforce Initiative Partnership:* A joint effort of the University of Alaska, the Alaska Mental Health Trust Authority, and the State of Alaska, Department of Health and Social Services, Division of Behavioral Health to develop a strategic plan to address behavioral health workforce recruitment and retention problems in rural Alaska.
- *Rural Psychiatric Residency Program at the University of New Mexico Health Science Center:* Psychiatric residency program designed to enhance training and competencies in special rural practice issues, exposes residents to the significant and unique cultural and class demographics found in rural America, and prepare residents for future positions as psychiatrists in rural communities.

In the Core Area of **School Based Mental Health**, one program is highlighted:

- *Center for Advancement of Mental Health Practices in Schools*: Online graduate degree programs in the area of school-based mental health designed to train community and school-based personnel about the numerous mental health issues that commonly affect school-aged children as well as how they can better serve such children in the classroom. The focus of all instruction is on preventative, evidence-based practices designed to promote mental health.

In the Core Area of **Substance Use Disorders Treatment**, three programs are highlighted:

- *Leadership Institute*: Six-month leadership preparation program 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.
- *Project MAINSTREAM: An Interdisciplinary Project to Improve Professional Education in Substance Abuse:* A multi-disciplinary project designed to overcome the lack of substance abuse prevention services in generalist healthcare through strategic planning, interdisciplinary faculty development program, and national and regional electronic and training infrastructure to support expanded faculty development in substance abuse.

- *Taking Action to Build a Stronger Workforce:* Initiative to develop and implement strategic plans in New York, New Jersey, and Pennsylvania to address state needs in the area of workforce development.

In the Core Area of **Substance Abuse Prevention**, three programs are highlighted:

- *Core Competencies that Facilitate the Implementation of SAMHSA Strategic Prevention Framework:* Based on SAMHSA's SPF process, a core competencies training system for community planning aimed to help community coalition members develop their collective ability to engage in successful community problem solving.
- *Nebraska's Community Academy:* A series of 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.
- *The North Carolina Governor's Academy for Prevention Professionals:* A rigorous, highly structured, two-week immersion curriculum in prevention that uses didactic, experiential, interactive, and participatory learning modalities to provide the building blocks of prevention education to a broad range of students.

In the Core Area of **Older Adults**, three programs are highlighted:

- *Emergency Preparedness for the Elderly*: A flexible, comprehensive, multi-modal curriculum that shows providers in multiple health care professions how to assist elderly persons to plan for and survive disasters and their aftermaths.
- *The Outcomes-Based Treatment Planning System (OBTP):* 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.
- *SAMHSA Older Americans Substance Abuse and Mental Health Technical Assistance Center:* A technical assistance center that serves to identify evidence-based programs for older adults and provide education, direct training, and technical assistance to State agencies and providers across the country.

Core Area:
Children and Adolescents

Choices, Inc., Technical Assistance Center for Systems of Care and Evidence Based Practices for Children & Families

Target Audience: Practicing professionals, students, family members
Focus of Innovation: Children and families, community leadership development

Innovation Description:

The Choices, Inc. TA Center provides training, coaching and technical assistance for individuals and groups whose communities are building systems of care for children and their families. The TA Center conducts 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. All trainings are based on the unique needs of the individuals, organizations and communities that participate, resulting in highly relevant and dynamic learning experiences. Additionally, monthly one-on-one, site coaching is provided to those charged with coordinating local systems of care. The training the TA Center provides is relevant to all aspects of SAMHSA's service mandate, including prevention, intervention and treatment, for both mental health and addictions services audiences. The TA Center moves training and education opportunities out of traditional, formal educational settings (i.e. universities and training sites in government buildings) into the communities where the current needs, realities and resources can best be integrated into the training experience.

Significance:

Beginning with the Surgeon General's report on Mental Health in 1999, it has been well documented that there is a need for training providers qualified in new service delivery approaches. Because research in evidence-based practices has outpaced the capacity of human service education and training to prepare a cross disciplinary workforce that is skilled and able to deliver services using methods that are now known to succeed, the Choices, Inc. TA Center provides training that constantly strives to incorporate new thinking, research, and creativity, thereby helping to close the science to practice gap. Additionally, several goals of the President's New Freedom Commission are addressed: Mental Health Care is Consumer and Family Driven (a cornerstone of training and coaching); Disparities in Mental Health Services Are Eliminated (a majority of the communities are rural with few formal services); Excellent Mental Health Care is Delivered and Research Accelerated (identification and dissemination of effective models of care in Indiana).

Novelty:

The varied strategies used to distribute information and educate the workforce in Indiana (and occasionally elsewhere) provide an opportunity to reach a broad cross-section of those who touch the lives of children with mental health needs and their families. The use of individualized coaching for communities based on their needs had not been done before in Indiana.

In training sessions, adult learning principles are honored by creating interactive learning experiences that help participants learn and retain information. Technology is utilized through the use of an active listserv that is used for answering questions and sharing information. A

statewide system of care conference is hosted that enables families and professionals from the far reaches of the state to network and learn together. The TA Center collaborates with Indiana universities to educate undergraduate and graduate students and worked closely with Indiana State University (ISU) to craft a Facilitator Development Training. Families Reaching for Rainbows, Inc., the Indianapolis chapter of the Federation of Families for Children's Mental Health and the provider of statewide technical assistance specifically aimed at developing family support organizations throughout Indiana, is a valued TA Center partner in training workshops.

Transferability:

Several trainings and workshops have been conducted on the topic of coaching communities in system of care development. In an effort to increase facilitator (care coordinator) skills, satisfaction and retention, the TA Center worked with ISU to create a full day Facilitator Development Training. The TA Center has also facilitated regional NEWS (Network for Encouraging Wraparound Support) groups so that coordinators have an opportunity to meet in person and share successes and challenges. A "TA Center Menu of Services" highlights the capacity of the TA Center and several products are being marketed to national audiences. Examples of such products include: an Indiana System of Care Resource Manual; a quarterly newsletter that is mailed to nearly 1700 individuals; The Facilikit, a file box filled with tips and tools for wraparound facilitators; and a guide entitled, "Hiring Strategies for Your System of Care."

Effectiveness:

The TA Center has conducted an annual Strengths Based Site Assessment, which provides ratings of a community's stage of readiness for change. This instrument is completed by TA Center Site Coaches in conjunction with community representatives, and coded by the TA Center Directors and Choices Quality Manager. Communities have increased their level of readiness for change in each year the TA Center has worked with them (see Effland, Walton & McIntyre, 2005). The TA Center is also currently engaged in a pilot project where TA Center Site Coaches are administering the Wraparound Fidelity Index 3.0 (Suter, Burchard, Bruns, Force and Mehrtens, 2002) to a non-random sample of caregivers, care coordinators and youth in Indiana. Comments also have been solicited about the site coaches from each of their communities at the time of their annual reviews.

Furthermore, training evaluations are completed at the end of each training workshop. Overall, the evaluations have been very complimentary. Additionally, participants are surveyed at the annual conference with regard to their opinions about the keynote sessions and concurrent sessions, as well as the food and facility. In the first year, members of the Choices research staff called the lead contact person at each site and administered a short questionnaire asking whether they were happy with the service they received from their Site Coach and the TA Center. The results of this survey indicated a high degree of satisfaction with services.

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The Michigan Association for Infant Mental Health Endorsement for Culturally Sensitive, Relationship-Based Practice Promoting Infant Mental Health

Target Audience: practicing professionals from multiple disciplines, who have specialized training in the direct care of infants, young children and families or who have a bachelor's, master's or post-master's degree in an infant and family related field

Focus of Innovation: quality services for infants, young children and families, with an emphasis on nurturing relationships promoting social and emotional health, as well as oversight processes through professional endorsement

Innovation Description:

The Michigan Association for Infant Mental Health (MI-AIMH) is an interdisciplinary, professional organization established to promote the optimal development of infants, toddlers, and families through relationship-based training and advocacy efforts. Incorporated in 1977, MI-AIMH has offered training opportunities to interdisciplinary groups of professionals for over 25 years. With an annual membership of over 400 professionals and 13 affiliate chapters, MI-AIMH is proud of its role as an educational and training association.

A Brief Overview: In 2002, MI-AIMH expanded its professional activities to include the *MI-AIMH Endorsement for Culturally Sensitive, Relationship-Based Practice Promoting Infant Mental Health.* MI-AIMH professionals in the infant and family field developed a set of competencies integral to quality services provided to infants, very young children and families in many settings, e.g. hospitals, mental health agencies, public health clinics, child care centers, early childhood programs.

Designed to recognize professional competency at four levels, endorsement verifies that an applicant has earned an educational degree (as specified), participated in specialized in-service trainings, worked with guidance from mentors or supervisors, and acquired knowledge promoting culturally sensitive, relationship-based service to infants, toddlers, parents, caregivers and families. Professionals from multiple disciplines may apply for endorsement at one of four professional levels: level 1, infant family associate; level 2, infant family specialist; level 3, infant mental health specialist; and level 4, infant mental health mentor. Endorsement offers a pathway for workforce development, as candidates are encouraged to engage in specialized course work or trainings and reflective supervision or consultation while pursuing careers in the infant and family field. Colleges and universities, as well as organizations and agencies, may plan educational programs and trainings for infant and family professionals that relate to specific knowledge, skills and behaviors indicated in the competencies at all 4 levels.

The MI-AIMH Endorsement competencies include the following core areas of expertise: theoretical foundations; law, regulation & agency policy; systems expertise; direct service skills; working with others; communicating; thinking; and, reflection. Each area of expertise is detailed and includes knowledge or skills, as well as examples of behaviors that illustrate competency.

Skills reflect strategies to prevent and treat social and emotional disorders in infants, young children and parents who are adolescent or adults.

Significance:

A successful infant and early childhood mental health system of care requires attention to the educational and training needs of the workforce (Huang, MacBeth, Dodge & Jacobstein, 2004). This includes a knowledge base specific to infants, young children and families; skills specific to this age group; understanding of systems in which very young children and families are served; and a focus on personal values or beliefs. The MI-AIMH Endorsement successfully addresses these important workforce issues in the identification of core competencies and criteria that professionals across disciplines must meet to promote social and emotional well-being or to treat mental health concerns in infancy and early parenthood.

Novelty:

The MI-AIMH Endorsement is among the most comprehensive, competency-based systems for workforce development promoting social and emotional well-being in the infant and family field. It offers a developmental pathway for professionals from multiple disciplines that provide services to infants, young children and families in a variety of settings, recognizing those professionals for specialized education or training and supervised work experiences. Criteria for endorsement encourage professionals to integrate new knowledge about infancy and early childhood mental health with strategies that are culturally sensitive and skillful. The emphasis on reflective supervision while providing educational, behavioral and mental health services to infants, toddlers, caregivers and parents encourages a framework for best infant and early childhood practice that is "cutting edge."

Transferability:

The MI-AIMH Endorsement, including the competencies, the process, the test materials and the 4-level system for professional development, may be purchased for use by other entities/states. MI-AIMH issues a 3-year license, renewable, to use all of the competencies and/or the endorsement system to build a workforce prepared to address the mental health needs of children in their earliest years with respect for relationships, culture, strengths and needs of each family served. Of additional importance, educational institutions are using the core competencies to shape curricula for the preparation of undergraduate, graduate and post-graduate students; states are using the competencies to build new services. Service agencies and groups use the competencies to guide staff development training, workshops, and interdisciplinary community training programs that address the social and emotional needs of infants, very young children and their families.

Effectiveness:

Individual professionals report that the MI-AIMH Endorsement provides a professional development ladder, encouraging and supporting specialization in infancy and early childhood, family relationship development and reflective practice. Although a relatively new system, endorsed professionals have returned to school to complete degrees and continue graduate study in infant mental health. Over 40 professionals joined interdisciplinary, infant and early childhood reflective practice groups co-sponsored by MI-AIMH, a direct result of the criteria for earning endorsement. Professionals from other states have applied for and earned the MI-AIMH

Endorsement. Affiliate groups in Texas, New Mexico, Oklahoma and Arizona have purchased a license to use the MI-AIMH competencies and/or the full endorsement to build a competent workforce in their states; other groups pending.

Additional Descriptive Materials:

The full competency booklet (30 pages) is available through the MI-AIMH Central Office website: www.mi-aimh.msu.edu

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Core Area:
Mental Health Consumers and Families

Children and Adults with Attention-Deficit Hyperactivity Disorder Parent-to-Parent Training

Target Audience: adults and children with AD/HD, families, health care and social service providers, school personnel,

Focus of Innovation: Parents of children and adolescents with AD/HD, providers: state, regional, and local

Innovation Description:

Parent to Parent: Family Training in AD/HD is an innovative program that provides family members, care providers and adults with AD/HD state-of-the-art information about the disorder. The curriculum was developed by three dedicated volunteers, mothers of children with AD/HD, using the resources of CHADD's National Resource Center on AD/HD. While the scientific and health care information was developed with the input from leading experts in the field, the curriculum is infused with the "lived experience" of families that deal with AD/HD every day. The 14 hour curriculum includes a comprehensive review of what is known about AD/HD, assessment and diagnosis, behavioral interventions, medication, co-occurring disorders, family impact, parenting strategies, special education laws and rights, Section 504 regulations, developing an educational team and lastly, the impact of AD/HD on teens and adults. More than 350 overhead slides are included in the structured presentation materials and each participant receives a manual of readings, worksheets, assessment forms and reference materials.

Parent to Parent is especially effective because CHADD trains parents nationwide to teach the classes. Working within a highly structured curriculum, teachers do not have to be health professionals or educators to be effective because the most important expertise they bring to the class is their experiences parenting children with AD/HD. Using this 'train the trainers' approach allows the rapid increase in the number of classes taught and parents reached by the program.

The structured curriculum covers:

- Overview of AD/HD
- Assessment to Multimodal Treatment
- The Impact of AD/HD on the Family and Creating Developmentally Appropriate and Positive Behavioral Interventions
- Developing Parenting Strategies and Interventions to Strengthen Family Relationships
- What Do I Do When My Child is Having Difficulty at School: Understanding the Federal Education Laws
- Working with Schools: Building an Education Team that Works
- AD/HD Across the Life Span: Teens and Adults with AD/HD

Significance

Parent to Parent is designed to help family members effectively manage the challenges of living with a child or adult with AD/HD and to become more effective members of the health care and educational teams working with their children. Of the 73.2 million children in the United States

in 2004, 7.8% or 5.7 million children could be diagnosed with AD/HD, according to a recent national survey conducted by the Centers for Disease Control and Prevention. The mental health challenge represented by those numbers is present in every community, every school and every classroom. Parents are the ultimate extension of the mental health workforce and as they become more effective partners in the treatment process, the entire mental health system benefits.

While Parent to Parent is designed for families, both teachers and health care providers have participated in the training and praised the program for its information and effectiveness.

Novelty

Parents and adults with AD/HD often must rely on the "expertise" of others in managing the disorder, without becoming a fully informed partner in the process. It is not for lack of trying, but parent friendly material and information is hard to come by. All too frequently this means that families are uninformed consumers of health care and educational services for their children. By educating parents with state of the art information on health care for and education of children with AD/HD, we are preparing these families to be far more effective at home, at school and in accessing effective health care. One of the most valuable aspects of the training is the strong focus on the "lived experience." Course leaders aren't just experts: They are mothers and fathers who live every day with children with AD/HD. Their expertise and empathy help class participants to open up and participate more fully in the training. These teachers really do understand what life is like at home.

Transferability

Parent to Parent is modeled on the highly successful Family to Family program from NAMI. Program curriculum and materials are well developed and extremely structured. Three times a year CHADD trains teachers in a series of 2 ½ day intensive orientations to the program and materials. These teachers live throughout the country and-return home to offer the classes in their local communities. Each teacher is asked to offer the class at least once a year. To date 125 teachers from Washington to Florida and California to New York have been trained. Several teachers offer classes for the Hispanic population and translated course materials for use with Latino families. The number of classes offered and the number of families who participate are anticipated to grow exponentially as additional teachers are trained. Eventually we hope to have classes accessible to most families in the US.

Effectiveness

Parent to Parent is still in the early stages of implementation. In its first year 404 students have taken the classes and additional classes are being added all the time. An evaluation tool is given to every student to be completed at the end of the course; this source of evaluation and feedback will grow as more students complete the course. Some of the initial comments include:

> "… fabulous program, we were so appreciative."
>
> "… great articles."
>
> "Excellent class."
>
> "Thorough, well thought-out."

"I found this very informative. The manual is something I have wished for since my child was diagnosed in Kindergarten. He is now an 8th grader."

The average ratings on a Likert scale for a class just completed were:

Content—4.7 out of 5

Relevance—4.6 out of 5

Materials and Handouts—4.8 out of 5

Presenters—5 out of 5

Additional Descriptive Material:

A teacher manual and participant manuals are available for those participating in the classes. In addition a CD and DVD with the PowerPoint presentation for each class is available for teachers.

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Georgia's Peer Specialist Training and Certification Program

Target Audience: consumers
Focus of Innovation: adult mental health

Innovation Description:

Based on principles of recovery and self-determination, the Georgia Certified Peer Specialist Project provides intensive training, testing, certification, continuing education and ongoing support to consumers who wish to support other persons in recovery from mental illness. Certified Peer Specialists (CPSs) are trained in a specific skill set to role model recovery and teach the use of self-directed recovery tools. CPSs partner with clinically trained mental health providers in an array of services provided by Georgia's community based mental health agencies including Assertive Community Treatment (ACT), Community Support Individual (CSI) and Team (CST), Psychosocial Rehabilitation (PSR) and Peer Support services. The program specifically trains and supports participants in using skills to inspire hope, engage the adult mental health consumer in creating and achieving recovery/life goals, and orient the mental health system toward recovery.

This program is targeted to individuals who self-identify as former or current consumers of mental health or dual diagnosis services; are well grounded in their own recovery experience; hold a high school diploma or GED; demonstrate basic reading comprehension and written communication skills; and have demonstrated experience with leadership, including advocacy, or creation or implementation of peer-to-peer services.

A core CPS Project Faculty partners with a variety of guest CPS trainers to deliver the experiential training over a two-week period. Participants receive the Participant's Manual with handouts that can be used on the job, the Facilitator's Guide, a WRAP book and additional workbook and audio training tapes. Certification testing occurs approximately one month later; consists of written and oral components; and is scored by a panel of three CPSs. Training participants and CPSs are invited to attend regular Continuing Education meetings. In addition to Continuing Education, this unique workforce is also supported by technology-based and face-to-face technical assistance, consultation and peer support.

Significance:

This program increases the number of credentialed staff available to serve mental health consumers by utilizing a previously untapped group of individuals—those with lived experience of mental illness and the accompanying stigma associated with being diagnosed. Because of their lived experience, CPSs have a unique ability to gain the confidence and trust of individuals in treatment settings to assist them to move beyond the disabling consequences of both the illness and the negative beliefs that often accompany the diagnosis of a mental illness. CPSs provide services targeted at helping consumers to be fully empowered partners in service/recovery/life planning and to fulfill their own needs and wants, including attainment of the skills, resources, and supports that will enable them to live and work in the community of their choice. Their

presence in the traditional behavioral health workforce serves to reduce stigma and promote and develop consumer-directed, recovery-oriented services that fulfill the recommendations of the President's New Freedom Commission.

Novelty:

This program utilizes individuals with lived experience of mental illness and recovery and places as much importance on that experience as on academic preparation for serving individuals with mental illness. It recruits participants from within the service system and teaches a skill set that draws on the expertise of their lived experience to provide services that promote and facilitate consumer involvement and direction in their own recovery. Retention of CPSs is supported through the fostering of CPS peer relationships through a CPS web-based bulletin board, email list-serve as well as personal consultation and technical assistance by CPS Project staff.

Transferability:

CMHS and Centers for Medicare and Medicaid Services (CMS) are supporting the replication of the program nationwide. The Georgia training was modified for national standards by the Appalachian Consulting Group who wrote the Resource Kit for CMHS. Job descriptions, curriculum materials, core competencies and the CPS Code of Ethics developed by the GA CPS Project have been adapted for use in other states to replicate this program. Additional information for program replication can be found in the CMHS funded toolkit entitled, *Building a Foundation for Recovery: How States Can Establish Medicaid-Funded Peer Support Services and a Trained Peer Workforce* DHHS Pub. No. (SMA) 05-8088. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2005. This resource will soon be available electronically at www.samhsa.gov or by calling SAMHSA's National Mental Health Information Center at 1-800-789-2647 or 1-866-889-2647 (TDD).

Future plans include an external review of the training and certification program to identify the strengths and opportunities for improvement of the program as well as to recommend fidelity measures for implementation.

Effectiveness:

In 2004 the Georgia Department of Human Resources (DHR), Division of Mental Health, Developmental Disabilities and Addictive Disease (MHDDAD) conducted a study to document improvement over time for consumers enrolled in peer supports and to evaluate the effectiveness of peer support services by comparing individual-level service outcomes with outcomes produced by other services (specifically, generic/traditional day services). The study utilized 2003 treatment data for Medicaid eligible consumers with severe and persistent mental illness (SPMI) from the State's external review organization's data system. Outcomes for both studies focused on improvements in (1) current symptoms/behaviors, (2) skill deficits, and (3) available resources/needs.

Overall, data for peer support consumers showed improvement in each of the three outcomes over an average of 260 days. For each outcome, impact of peer supports is positive and small, but statistically different from zero (using effect size = Cohen's d with adjustment for paired observations).

When looking at the comparative analysis of peer supports to day supports, between group effects were estimated through OLS regression. For each of the three outcome measures the level of improvement for consumers enrolled in peer supports was greater than day supports, and the difference between the groups was statistically significant at the $p < .05$ level of confidence.

Additionally, consumers in Georgia have identified a relationship with a CPS as a significant factor in their recovery. In 2004 and 2005 the Georgia Mental Health Consumer Network (a 3,000 member body) voted as its number one priority, to increase the employment and salaries of peer specialists, which reflects the popularity of this service with consumers. An independent, formal evaluation will be completed in the near future.

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META Services Recovery Education Center

Target Audience: consumers
Focus of Innovation: adult mental health, consumers & families, leadership development

Innovation Description:

The META Peer Employment Training (PET) is a 70-hour specialized class to teach individuals diagnosed with serious mental illness the skills needed to obtain competitive employment in the field of Peer Support. The PET recognizes that there is no better person to inspire the hope for recovery than someone who has “walked the same path”. The Peer Support Specialist credential is I.T.E., “I’m the Evidence.”

The PET program was conceptualized by two individuals who wanted to make a difference in the way traditional mental health services were provided: Eugene Johnson, President and CEO of META Services and Dr. Lori Ashcraft, Executive Director of the META Recovery Education Center. In 2000, Johnson and Ashcraft concluded that META needed to re-vision and transform its entire service delivery model. Believing the key to this transformation would be employing trained peers to work in the discipline of Peer Support as full members on all META's service delivery teams, META obtained funding from the Arizona Rehabilitation Services Administration to provide the training and supports needed for mental health peers to become successful team members and join the mental health workforce.

Today, these peer employees work in all META's programs and teams as Recovery Educators, Recovery Coaches in the Community Building supported housing program, Peer Advocacy Specialists on hospital inpatient units, Recovery Coaches on case management teams, and Peer Support Specialists providing one-to-one peer support in the community. Over $5,000,000 of Medicaid reimbursed services are provided annually by the META peer staff. Annual compensation for the peer staff is over $3,000,000. These funds, previously spend on treatment services, are now going into paychecks that improve their quality of life.

Significance:

Between October 2000 and December 2005, 606 students have graduated from the PET in Phoenix. Although the class content is advanced and the learning expectations are rigorous, 95% of the individuals who enroll in the training are successful in meeting the requirements of the training program by passing the attendance and competency testing. Four-hundred and forty-nine of the graduates have obtained employment as Certified Peer Support Specialists (69% employment outcome). By the end of December 2005, 212 Peer Support Specialists were employed at META, 66% of META's total workforce, resulting in a complete recovery transformation of the organization from 1999 when META hired its first peer provider.

Novelty:

The PET program has demonstrated that anyone labled with a serious mental illness with the desire to obtain meaningful employment can be successful working as a Peer Support Specialist.

The demands and stress of these challenging positions, rather than causing relapse and an increase in difficulties have, in fact, strengthened recovery as the peers find new meaning and purpose in life by giving back to others. Furthermore, the PET has demonstrated that peer support employees can be depended on to participate as full members of the service delivery team, that the team can learn to welcome the contribution of the peer support discipline, and that an organization can change and adapt its culture to fully support the integration of peer providers into its workforce.

Transferability:

During the past two years, over 500 peers have been certified as Peer Support Specialists in twelve states and New Zealand using META instructors and META's copyrighted 229 page publication, Peer Employment Training Workbook as the class textbook. Recently META has developed the Peer Employment Training Facilitator's Guide and the Peer Employment Training Supplemental Guide which META is now using in a trainer certification program to train local facilitators. Over 15 trainers have been certified and there are ongoing projects in Alaska, Arizona, California, Tennessee, Michigan, New Jersey, North Carolina, Virginia, Washington, and New Zealand that will soon result in many more certified local trainers. Certified facilitators sign an agreement with META to assure quality and fidelity to the training values, training model, and curriculum.

Effectiveness:

An independent study was completed by Boston University Center of Psychiatric Rehabilitation of the participants in PET during the first year of the program. These findings were recently reported, Hutchinson, Anthony, Ashcraft, Johnson, et al., “The Personal and Vocational Impact of Training and Employing People with Psychiatric Disabilities as Providers”, Psychiatric Rehabilitation Journal, Winter 2006, Volume 29 Number 3.

> “This study examined the feasibility of a structured peer provider training program and its effect on peer providers with respect to their own personal and vocational recovery.
>
> Methods: Sixty-six individuals…. were assessed prior to and after the training on scales to measure recovery, empowerment, and self-concept. Analyses of variance were used to examine subjective changes in these measures. Job acquisition and retention data were also examined at posttest.
>
> Results: Participants experienced gains in perceived empowerment, attitudes toward recovery and self-concept. Trainees went on to obtain peer provider positions within the mental health agency in which they received the training and 89% of those trained retained employment at 12 months…."

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Core Area:
Cultural Competencies and Disparities Issues

Communicative and Cultural Competency for Mental Health Providers (CCC-MHP)

Target Audience: Practicing Professionals

Focus of Innovation: Cultural Competency

Innovation Description:

The *Communicative and Cultural Competency for Mental Health Providers (CCC-MHP)* research project 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 focuses upon mental health providers who work in community-based agencies and public schools. Training is offered in three formats: a sixteen-session continuing education course, a four week intensive summer institute, and through online instruction. The effectiveness of each of the training programs is being evaluated and the comparative effectiveness of the three formats is being assessed. Language skill acquisition and cultural competence in service delivery are central outcomes being evaluated. Standards for culturally sensitive service delivery and professional language proficiency are being established as the foundation for developing new measurement instruments to assess competency in the delivery of Spanish-language mental health services.

Significance:

The need to provide mental health services in the language of the client is well established. However, there is a severe shortage of mental health professionals who have been trained to provide services in languages other than English. The goal of CCC-MHP program is to reduce the disparity in the delivery of mental health services to language minority clients by producing providers who are as competent in delivering services in Spanish as they are in English. The program was developed for providers who serve Spanish-speaking clients and their families; but the training model could be replicated with other languages.

Novelty:

While there is extensive literature to guide practitioners in culturally relevant services for Hispanic clients, there is little available to assist bilingual practitioners in providing services in Spanish. The CCC-MHP program, which is conducted entirely in Spanish, is the first training curriculum that explicitly addresses the need for language proficiency as well as cultural competency. Participants in the CCC-MHP training programs enter with basic conversational skills in Spanish but lack the training and experience needed to utilize their education and professional skills, which were obtained in English, to their work with Spanish-dominant clients.

Transferability:

CCC-MHP is in the final stages of producing curriculum and training manuals, which will allow others to replicate the training. These manuals should be available in October 2006. Until then, the syllabi for the training and glossary of mental health terms developed as part of the program are available upon request.

Effectiveness:

Preliminary results for the program evaluation indicate that the training has been effective in increasing confidence and competence in delivering services in Spanish and language proficiency. The impact of the training on consumers has not been evaluated.

Additional Descriptive Material:

A description of training programs and a Spanish/English Glossary of Mental Health terms available through the OLLU Psychology Department web page at: http://www.ollusa.edu

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Growing Our Own

Target Audience: graduate students/ psychiatric residents, consumers
Focus of Innovation: adult mental health, consumers and families, cultural competency,

Innovation Description:

The *Growing Our Own* 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 (AANHOPI). In addition to the curriculum, NAAPIMHA developed the Standardized Patient evaluation protocols that can be used to assess both the effectiveness of the training curriculum as well as the clinical skills of the interns. Borrowed from the medical school training, this method has been shown to be an effective tool to help medical students gain competencies in working with patients but had not been developed for mental health training. Preliminary data from the sites in San Francisco, Seattle, Denver, Wai'anae, and New York has been very positive.

The *Growing Our Own* curriculum is based on the DSM IV Outline for a Cultural Formulation that provides a rich theoretical framework in making culturally appropriate assessments, diagnosis and treatment plans. Consumers were involved at every level of development for the curriculum and evaluation and provided input based on what they found to be helpful in their recovery. The five modules build on each other and are intended to help the intern/resident develop an approach that avoids simplistic clinical formulations based on stereotypes.

- Module 1~ Self Assessment
- Module 2~ Connecting With Your Client
- Module 3~Culturally Responsive Assessment and Diagnosis
- Module 4~Culturally Responsive Intervention
- Module 5~Culturally Responsive Systems

Significance:

There continues to be a serious lack of clinicians who are trained to provide culturally and linguistically appropriate services to the Asian American, Native Hawaiian and other Pacific Islander populations. NAAPIMHA brought together leading experts on the topic to develop the first national multi-site training effort to address this critical need. The training was significant in two other areas as well. It developed effective Standardized Patient protocols that had not been developed for use in mental health training. The project also established a national consumer group that is helping to develop a much needed consumer voice.

Novelty:

The training program identified core competencies that cut across the disciplines of psychiatry, psychology, counseling and social work. The content and core competencies were built upon

feedback from consumers who were also used to teach Module II at some of the sites. The training developed Standardized Patient protocols that have been successful in training physicians but had not been used in the mental health arena. The curriculum avoided focusing solely on the consumer and helped the clinician understand their role in the process as well as the impact of the broader system both the consumer and the service delivery system.

Transferability:

The curriculum is fully manualized with videotapes, training exercises and reading materials identified for each module. The *Growing Our Own* curriculum was designed to address the specific needs of AANHOPI populations but can be modified for use with other diverse populations. Based on the Outline for a Cultural Formulation found in the DSM-IV manual, it teaches clinicians how to assess the role of culture versus memorizing details about a specific population that only leads to overly simplistic answers. This approach leads to a more accurate, sensitive and dynamic process of assessment, diagnosis and developing a course of action.

Effectiveness:

The preliminary data has been very positive using both qualitative and quantitative data. Interns across all sites showed an improvement in their ability to engage effectively with the clients and do a culturally appropriate assessment and diagnosis. Their sensitivity to and awareness of the cultural/social/political/environmental factors that influence the emotional health and well-being of an individual increased. Student satisfaction across all sites was very high. Supervisors at site that had previous formal training indicated an increase in level of sophistication around assessing cultural impact for all clients, not just AANHOPI.

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Rural Human Services Program

Target Audience: Non-degreed or Bachelor-degreed direct care staff

Focus of Innovation: Child & Adolescents, Cultural Competency, Prevention & Health Promotion- Mental Health; Prevention- Substance Abuse; Providers; Recruitment & Retention; Rural

Innovation Description:

The Rural Human Services (RHS) Program provides culturally competent entry-level training (including basic skill development) and employment to village residents for delivering behavioral health services in their own communities. While enrolled in training, RHS students are employed as behavioral health providers in their home communities and receive supervision from licensed clinicians.

The RHS training program operates collaboratively with a larger systems project that includes tribal employers, the State of Alaska Division of Behavioral Health, and Alaska Native Tribal Health Consortium. The RHS Program empowers local providers, offers an academic path to a historically underserved population, and promotes the availability of culturally competent services to small, remote, indigenous communities. Furthermore, RHS establishes a unique university learning environment that respects, values, and supports Alaska Native world views, while also teaching mainstream behavioral health knowledge and skills.

Over the past eleven years, 220 RHS students, 98% of whom are Alaska Natives, graduated from RHS by completing the 32-credit UAF Certificate. 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 can articulate seamlessly into the Associates Degree (Human Services), Bachelor Degree (Social Work, Psychology, Human Services, or Rural Development), Master’s and Ph.D.

Significance:

The RHS Program addresses a critical workforce need in rural Alaska. Small remote communities in Alaska and elsewhere face critical issues in recruitment and retention of trained and culturally competent behavioral health providers. By forming collaborations with Alaska Department of Health and Social Services and a variety of tribal and rural employers, the University of Alaska developed a program to enhance service delivery by training and employing village residents to work as providers in their own communities. UAF has articulated its academic programs so RHS Certificate graduates can move seamlessly to Associates, Bachelor, and Master’s and Ph. D. degrees in behavioral health fields.

Novelty:

The RHS program reaches a population that was traditionally underserved by the university system. The typical student is an employed Alaska Native between the ages of 35-50 with no prior university experience. Students travel to a hub community for 12 intensive weeklong

sessions over 4 semesters but continue to live and provide services in their communities. Some unique features of the instructional process are: cohort model, attention to personal and professional development, indigenous elders on the teaching team, and use of materials relevant to rural Alaska. The State of Alaska provides grants to employers to cover training costs.

Transferability:

The process by which this program developed is transferable to other indigenous and minority communities. The delivery methods may vary by context. A local advisory body is essential. Any community or institution may replicate this process provided it has leadership from the community, willingness to share the indigenous knowledge base, cooperation with behavioral health agencies and the support of an institution of higher education.

Effectiveness:

Student satisfaction is high -- 98% of the alumnae rated the program overall as *superior* or *above average* (independent qualitative evaluation and UAF program assessment survey). RHS is the primary training vehicle for village providers in rural Alaska. Data made available by 12 rural agencies employing 89 RHS students and graduates as village-based providers documented the following services in FY04:

- direct client services to an average of 3,251 clients each quarter
- 1,926 emergency responses during the year
- 34, 247 contacts made through prevention projects, educational workshops, and healthy activities during the year
- RHS village workers spent 47% of their time on direct client services and 41% on prevention and education activities

This data represents minimum numbers as it includes only those employers who receive funding through the State of Alaska Rural Human Services Systems Project. “By all measures the Rural Human Services System Program is successful. Agencies employing RHSSP trained village workers report that the village staff are effectively intervening in behavioral health emergencies and reducing the number of crisis transports outside the community…in addition, increasing numbers (of graduates) are choosing to continue their education…partly due to this heightened interest, several University programs are coordinating to make it easier for rural Alaskans to pursue advanced degrees in social work, psychology and human services, without leaving their communities for extended periods.” (The State of Alaska Mental Health Board in its Strategic Plan: A Shared Vision II 1999-2003)

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Core Area:
Rural Issues

Alaska Behavioral Health Workforce Initiative Partnership

Target Audience: graduate students/psychiatric residents, practicing professional, non-degreed or bachelor degreed direct care staff, consumers, families, community members

Focus of Innovation: rural mental health

Innovation Description:

The Alaska Behavioral Health Workforce Initiative Partnership has evolved over many years through partnership between the University of Alaska System, the State of 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 of the Western Interstate Commission for Higher Education (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 education 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 curriculums which support a career ladder to enable Alaska to "grow its own" workforce.

Hallmark programs include:

- Rural Human Services Certificate program
- Distance Cohort Model for theBSW
- Distance Cohort Model for the MSW
- Ph.D. in Clinical Psychology with rural and indigenous focus
- Children's Mental Health Certificate Program
- Training Academy for Rural Behavioral Health, targeting practicing professionals
- Formation of a Behavioral Health Alliance, a university -wide multidisciplinary academic planning council
- Alaska Mental Health Trust Authority adoption of a focus on workforce development

Policy directions include:

- Increase the supply of workers from certificate to doctoral level
- Improve course and program articulation across universities campuses and programs
- Increase cultural competence skills of the existing and new workforce, and
- Ensure curriculum reflects new practice trends, especially integration of substance abuse and mental health practices

In the fall of 2004, the partners committed $4.178 million in new funds over four years to address these strategic goals. Since then, investment has continued to grow.

Significance:

In largely rural states, such as Alaska, there have been historic difficulties in recruiting and retaining an effective behavioral health workforce. The President's New Freedom Commission

on Mental Health described in detail the significant problems facing mental or behavioral health systems throughout the country. Alaska will face a 47.3% increase in the need for behavioral health professionals by 2010. Current increased enrollment and graduate trends in UA behavioral health programs will not fill the projected demand.

Novelty:

The first ever University of Alaska/Behavioral Health stakeholder discussion on workforce development was convened in the spring of 2004. Over 100 providers, policy makers, and educators attended this two-day summit. Recommendations were made in the areas of collaboration, education, financing, and evaluation and research. This was followed by a Behavioral Health Workforce Summit in 2006 which produced more strategic direction for the institutional partners.

Transferability:

Collaborations are created to develop more rural-specific training and continuing education opportunities at all levels of competency. Distance education is used to expand access to continuing education that enables rural persons to obtain professional training. This will allow for improved access to higher education for under-represented students.

Effectiveness:

Data on the effectiveness of the Alaska Behavioral Health Workforce Initiative Partnership is currently unavailable,however data is being collected to a) articulate coursework and training among UA behavioral health programs, as well as workforce needs and b) analyze factors that increase enrollments and declared majors, as well as factors that promote retention and degree completion.

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Rural Psychiatry Residency Program at the University of New Mexico Health Science Center

Target Audience: Graduate Students/Psychiatric Residents

Focus of Innovation: Adult Mental Health; Child & Adolescent; Leadership Development; Recruitment and Retention; Rural

Innovation Description:

The rural psychiatry residency track at the University of New Mexico School of Medicine is part of the psychiatry department's larger outreach program that is designed to enhance the training and competencies of the behavioral health work force throughout the state. This track, which has been in existence for over 10 years, recruits residents as they begin their residency and helps them develop their own "training plan" in rural sites—including community mental health centers and primary care clinics. The residents spend one day a month their third year, and up to two days a week for six months to a year their fourth year at these sites throughout the state—from Zuni and Gallup to Clovis and Tucumcari, from Taos and Farmington to Silver City and Las Vegas (NM). The residents are only required to spend 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 CMHC's, ways to integrate more effectively with community resources like schools, the broader medical community, the local police department, tribal councils and local health care boards. Some have chosen to incorporate research and learning the tools of program evaluation as part of their experience. The residents have local supervisors who are on the University's clinical faculty as well as Psychiatry department faculty who help mentor this rotation.

The program has grown to include approximately 3-4 residents each year. Several years ago, all child fellows began rotating through a rural site with appropriate supervision their second/last year of training. This year, one resident, keen on having a rural experience to prepare him for practice after graduation, is doing his required substance abuse/ dual diagnosis rotation in a unique site bordering the Navajo Nation.

This program is funded through a Joint Powers Agreement with the state of New Mexico's Behavioral Health Services Division. It allows residents to prepare for their future as community psychiatrists in rural communities while becoming important role models as teachers, supervisors and collaborators with other medical and behavioral health providers.

Significance:

This program addresses the recognized need to train psychiatrists in the special practice issues as well as the significant and unique cultural and class demographics found in rural America. This exposure as residents encourages them to work in dramatically psychiatrically underserved areas of the country with confidence and competence. They learn how to devise their own "training plan" which will give them experience shaping their work environment so that it will meet their needs successfully as practitioners. The residents also learn how to network with other providers, community leaders and other rural psychiatrists throughout the state. They learn from role

models (rural clinical faculty) how to address obstacles to care and how to creatively problem solve.

Novelty:

As far as we know, this program is the only program of its kind in the western United States, and perhaps the entire country that offers residents a special track to learn about and experience rural psychiatric practice in CMHC's, primary care sites, as well as the opportunity to research and conduct assessments of treatment outcomes, patient demographics, and program evaluation in rural communities. The program also encourages the development of relationships with state administrators and innovators in new systems of care

Transferability:

Most psychiatric residency programs should be able to adapt this program to fit the needs of the training program as well as to enhance the training of residents in the needs of underserved consumers. States with large rural components and public medical schools who have as their mission the provision of care statewide should be able to adopt aspects of this program within the residency's training requirements.

Effectiveness:

Data on the effectiveness of this program largely focuses on two areas: a) the pool of psychiatric residency applicants each year and b) participation in a rural practice environment upon graduate. Both of these indicators provide some evidence for success. Residents who apply to the University of New Mexico psychiatry program often mention this unique training opportunity as a reason for applying, thus enhancing the pool of psychiatric residency applicants. In addition, almost half of the residents who have participated in the program practice in a rural environment upon graduation. The program is currently in the process of evaluating the effectiveness of the program more systematically.

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Core Area:
School-Based Mental Health

Center for Advancement of Mental Health Practices in Schools – Online graduate degree programs with a focus on mental health training for educators and practitioners

Target Audience: Graduate students; Practicing professionals (graduate-degreed); Bachelor-degreed direct care staff; Other healthcare agencies or human service community providers

Focus of Innovation: Child, adolescent, and adult mental health; Co-occurring disorders; Oversight and systems change processes; Prevention and health promotion-mental health; Recruitment and retention

Innovation Description:

Due to the increasing mental health issues in the schools today, there is an increased need to train school-based personnel in the area of mental health. In response to this need for better training and preparation, the Center for the Advancement of Mental Health Practices in Schools (CAMHPS) at the University of Missouri – Columbia developed online graduate degree programs in the area of school-based mental health. These programs are designed to educate school-based personnel and other community providers about the numerous mental health disorders that commonly affect school-aged children and how they can better serve such children in the classroom.

Through these programs, school-based personnel are now able to obtain a graduate degree (masters and/or education specialist) accessible through the delivery of online learning. Through this online learning community, school based personnel gain invaluable experiences communicating with teachers, administrators, etc. from around the world and have access to professors from across the United States with expertise in specific academic content related to their respective fields of practice (e.g., law, psychology, medicine, etc.). Coursework is designed to provide students with proactive, prevention focused, evidence-based practices proven effective in the fields of education and mental health. Furthermore, content areas are designed in response to the needs identified by educators currently working in the field. These programs also recognize and address the importance of personal mental health (e.g., teacher stress, attrition) for educators as this is critical to their ability to successfully educate today’s youth who constitute tomorrow’s workforce.

Significance:

These online programs target a severely neglected area of formal mental health training for school-based personnel at the pre-service and in-service levels. They are unique as they focus on providing current, evidence-based mental health training directly to those who implement and apply preventative measures for *all* children in the school systems where they work. In addition, these programs provide a way to disseminate evidence-based mental health information broadly and rapidly to meet the needs of school-based personnel as well as provide a sense of efficacy in combating the complicated mental health issues in the school environment.

Novelty:

The first of its kind nationally, the online program is housed at a major accredited university and was developed out of the expressed needs of school personnel to rectify deficits in their training and experience working with children and families concerning mental health issues. Rather than focusing solely on academic pedagogy typical of most graduate degree programs in education, this program addresses the *non-academic* barriers to learning that school based personnel must address *before* optimal learning may occur. Through its online medium, these programs provide opportunities to further their education while continuing to work. This also places students in a unique position to immediately apply current learning to practice under university supervision.

Transferability:

Ongoing consultation and collaboration are fundamental values adopted by CAMHPS. CAMHPS has created a model for professionals from various disciplines capable of replication and/or adaptation in a variety of settings. For example, the unique and varied content areas in this program provide educators and health professionals with the opportunity for professional development, thereby facilitating communication and a systems of care approach between the home, school and community. Furthermore, the resources and information available through the online programs can be modified as instructional modules and utilized for presentations and training sessions for school-based personnel as well as other education and health care professionals.

Effectiveness:

Evidence of effectiveness has been seen primarily through required, anonymous, university-conducted student evaluations and anecdotal evidence. However, a University-based research stipend has been granted to evaluate the knowledge base, attitudes, and efficacy of the students in the program. Preliminary evidence suggests positive program outcomes. As well, students have consistently given high ratings for course content, instructor effectiveness, and courses as a whole (mean=4.75 on 5 point Likert scale). Numerous anecdotal comments illustrate exemplary transmission of mental health content through online technology; students have expressed how the program has instilled in them a level of confidence and knowledge in order to create a more positive learning environment while managing everyday problems in the classroom.

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Core Area:
Substance Use Disorders Treatment

ATTC Leadership Institute

Target Audience: Mid-level managers in addiction treatment agencies

Focus of Innovation: Leadership Development

Innovation Description:

The Leadership Institute is a six-month leadership preparation program 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. It was developed by the Southern Coast Addiction Technology Transfer Network (ATTC) in collaboration with United States Department of Agriculture Graduate School, and SAMHSA/CSAT Partners for Recovery. The National ATTC office coordinates the program's implementation, and the Institute is offered by all ATTCs nationally. Participants are chosen from nominations by agency directors and supervisors and are recognized as individuals who have the realistic potential to become leaders, demonstrate a commitment to their agencies, and demonstrate a career commitment to the addictions field, in general. The Institute utilizes a four-phase design:

- **Phase 1: Assessment** - Trainees undergo a formal 360˚ assessment of their leadership and management interests, values, and skills through a standardized assessment instrument and feedback process.
- **Phase 2: Training Experiences** – Trainees participate in a five-day Immersion Training session which establishes the conceptual framework and a body of knowledge for understanding the theory and practice of leadership. Trainees are then paired with a mentor, a recognized leader in the addiction field, who guides their protégé in the development of an Individual Leadership Development Plan (ILDP) to address competencies identified from the assessments and individual leadership development objectives. Each trainee is required to take additional continuing education based on his or her ILDP. Training events beyond the initial immersion training continue to emphasize leadership competency areas with special educational sessions, distance learning, and readings.
- **Phase 3: Experiential Learning** - This phase moves the trainees from the classroom into their own organizations to practice and polish their leadership competencies. Trainees must complete an individualized leadership project (ILP) under the guidance of their mentor and agency supervisor.
- **Phase 4: Recognition** - The Leadership Institute culminates with trainees/protégés presentation of their individual projects. A formal certificate of proficiency is awarded.

Significance:

Many national and regional workforce surveys indicate that the addiction field is undergoing a leadership crisis as many agency directors/managers are approaching retirement age within the next decade, and considerable turnover is occurring at high levels of treatment organizations. Research related to retention of employees finds that retention involves more than satisfaction with salary and enjoyable work. Other critical retention variables are: the degree to which employees believe they fit into their workplace, how adept they are at work, how well they get along with co-

workers, and how they align with organizational values. The ATTC Leadership Institute provides training and growth opportunities that not only increase leadership knowledge and skills, but also reinforce these critical retention variables.

Novelty:

Formal leadership preparation is not often utilized in non-profit addiction treatment agencies as commercial leadership programs or college courses are typically cost prohibitive. The field's leaders have historically come from the promotion of clinical staff that were willing to accept the responsibility for program administration and leadership. Many did not have the opportunity to receive formal business or leadership training, having to hone their skills through trial and error. The ATTC Leadership Institute is available at a very low cost to the trainee and their agency, and provides a comprehensive leadership development program that contains all of the elements determined through research to be most effective in cultivating leadership skills.

Transferability:

Replication of the model is consistent throughout the 14 Addiction Technology Transfer Centers. At the present time, the leadership skill assessments and curriculum for the initial Immersion Training are the property of the Graduate School, US Department of Agriculture. Products created by the National ATTC Network are available to the public but do not represent the entire leadership training package.

Effectiveness:

While plans for a thorough evaluation of the Leadership Institute are under consideration, no such assessment was completed during the pilot stage. There are, however, indicators that strongly suggest the effectiveness of the program. A sampling of satisfaction measures gathered from immersion trainings demonstrates that participants are very satisfied with this component. For example, 100% of participants of Northwest Frontier's training indicated that they were satisfied with the overall quality of the event, the quality of the instruction, and the materials. Similarly, Pacific Southwest's data shows that, on a five-point scale where one indicates very satisfied and five indicates very dissatisfied, immersion training participants' mean score in rating the overall quality of the event was 1.19 (SD 0.4). An evaluation of the Southern Coast ATTC, the originator of the program, revealed that six months after the graduation ceremony, 73% of protégés continued to benefit professionally from their experience and 80% of protégés continued to use their new skills in carrying out their jobs. In October 2005, an informal questionnaire regarding the mentorship component of the Leadership Institutes revealed that program graduates, as well as mentors and ATTC directors, were very satisfied with the mentorship component of the Leadership Institutes and strongly supported continuing the program.

Additional Descriptive Material

The Leadership Institute section of the National ATTC Office:
http://www.nattc.org/leaderInst/index.htm

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Project MAINSTREAM: An Interdisciplinary Project to Improve Professional Education in Substance Abuse

Target Audience: Multidisciplinary health professional faculty

Focus of Innovation: Prevention- Substance abuse; curriculum change- health professions

Innovation Description:

Project MAINSTREAM: An Interdisciplinary Project to Improve Professional Education in Substance Abuse is a multidisciplinary project designed to overcome the lack of substance abuse prevention services in generalist healthcare. In 1999, The Association of Medical Education and Research in Substance Abuse (AMERSA) entered into a five-year cooperative agreement with the Health Resources Services Administration (HRSA) and the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse Mental Health Services Administration (SAMHSA). The Project had three main objectives: 1) to produce a strategic planning document to advise the federal government and others on improving substance abuse education for generalist health professions; 2) to administer an interdisciplinary faculty development program to improve substance abuse curricula in the training programs of 15 health disciplines and 3) to develop national and regional electronic and training infrastructure to support expanded faculty development in substance abuse. The disciplines targeted by the Project were 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. The main vehicle for curricular change was a required collaborative education project to develop trainees' core competencies in basic substance abuse prevention services. The Project focused on training of *future* rather than *current* professionals, emphasizing the need for sustainable curriculum change in health professional schools and the need for the availability of state-of-the- science resources.

Significance:

Effective public health strategies for addressing risky and disordered substance use include screening, brief intervention, and appropriate referral; providing prevention services for children of parents with substance use disorders; and implementing selected community-based prevention programs of established effectiveness. Most Americans do not receive these services but could if the millions of health care professionals in generalist practice were prepared to deliver them. The Project addressed this need by defining these competencies as integral to generalist practice and enhancing health professional curricula to assure that the services are delivered by all generalist practitioners.

Novelty:

The Project was novel in that it was comprehensive, combining a definitive blueprint of health professional competencies related to substance abuse services, the *Strategic Plan*; an effective interdisciplinary approach to developing those competencies, Project MAINSTREAM; and a Web resource (www.projectmainstream.net) to house evidenced-based training materials and the *Strategic Plan*. The emphasis on *future* rather than *current* workforce development through sustained curriculum change is also novel.

Transferability:

The overall concept of the Project serves as a model that others might replicate in instances where effective public health strategies exist but the workforce is not universally prepared to deliver those evidenced-based services. One example is the current need to assure that health professionals are prepared to meet the threat of bioterrorism. In addition, the syllabus, composed of 11 modules, addressing core competencies related to substance use, is readily transferable to a variety of educational institutions and service delivery systems. Each module includes PowerPoint slides, lecture notes, suggested learning activities, and references.

Effectiveness:

Thirty-nine MAINSTREAM fellows reported reaching a total of 10,170 trainees with substance use educational offerings. A total of 66,995 hours was delivered with each trainee receiving an average of 6.58 hours of instruction that would not have occurred without the Project. Ninety percent of these training hours were designed as part of required courses in the institutions. An extensive evaluation was conducted as part of the Project. Interdisciplinary collaboration and mentoring, two features of the program, were positively evaluated. An independent evaluation was conducted but those results are not yet available.

Additional Materials: The *Strategic Plan* and a comprehensive syllabus with eleven modules targeting significant issues related to substance use disorders are available at www.projectmainstream.net.

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Taking Action to Build a Stronger Workforce – Facilitating and Implementing Workforce Development

Target Audience: Practicing professionals; Non-degreed or Bachelor-degreed direct care staff; consumers

Focus of Innovation: Adult mental health; Child & Adolescent; Consumers & Families; Co-occurring disorders; Cultural competency; Elderly; Leadership development; Oversight processes; Prevention-substance abuse; Professional associations; Providers; Recruitment & Retention; Rural; Substance use disorders treatment

Innovation Description:

In the late 1990s, reacting to more than a 25 percent loss of credentialed professionals in its Statewide addictions workforce in five years, the New York State Office of Alcoholism and Substance Abuse Services (OASAS) collaborated with the Alcoholism and Substance Abuse Providers of NYS, Inc. (ASAP) and the Institute for Professional Development in the Addictions (IPDA) to conduct a comprehensive assessment of this emerging problem. After conducting a series of Statewide Focus Groups to solicit input on workforce concerns, OASAS formed a Steering Committee on Workforce Development to recommend and implement strategies to address five major areas of focus: compensation; administrative relief; marketing; credentialing/licensure; and organizational culture/best practices.

Based on the many innovative initiatives that had been already implemented successfully in New York State, in 2003, the Northeast Addiction Technology Transfer Center (NeATTC) gathered leaders to address workforce issues in its geographical region (NJ, NY and PA). The purpose was to encourage states to learn from national experts and the experiences of New York State, while working to build a plan, implement that plan, and study and evaluate its implementation over time. As part of the process, each state established Workforce Committees to recommend and implement strategies relative to the five major areas of focus noted above.

Significance:

The motto selected to emphasize the importance of this effort was: “Without a Competent Workforce We Cannot Deliver Competent Care.” Based on this ideal, states developed unique plans with the aim of achieving the following goals: retain current workforce members; develop well-defined career paths with fair compensation; expand SU workforce efforts to all related disciplines; improve recruitment; enhance credentialing and professional competence (e.g., all disciplines, use of mentors and incentives, remove state recognition barriers, etc.); and identify new sources from which workers may be recruited with a focus on members of the recovery community and second career individuals.

Novelty:

1. The relationship between workforce development and improved treatment outcomes had not been sufficiently examined or supported prior to the initiation of this project.
2. The willingness of NY to share its successes with the rest of the NeATTC region so other states did not have to “reinvent the wheel.”
3. The willingness of Single State Directors to collaborate with the NeATTC and honestly evaluate and share solutions to existing problems.
4. The openness of leadership to: seek expert advice from outside the SUD field; clearly and honestly identify all factors – monetary and non-monetary – contributing to the crisis; and build upon strengths while removing or at least recognizing barriers to success.
5. Participants’ commitment to implement solutions despite events beyond their control (e.g., funding cuts and state leadership changes, to name a couple).
6. The ability of each state and the NeATTC to work together to obtain additional technical assistance funds to support the initiative.

Transferability:

If each state can come together to make a prioritized commitment to workforce development and build a comprehensive strategic plan to address it, regional ATTCs would be able to facilitate a similar process. Key components for success would include the financially supported facilitation by the ATTC, the leadership commitment and effort of each state, unique state workforce development plans and a willingness to recognize the problems and build solutions that are logical, actionable and progressive to measure success. Regional plans must be in line with other national reports (e.g., Institute of Medicine’s *Crossing the Quality Chasm* [2001, 2006], SAMHSA/CSAT *National Treatment Plan* [2000], SAMHSA/CSAT *Strengthening Professional Identity* [in press], and the upcoming SAMHSA National Strategic Workforce Plan).

Effectiveness:

Each state has made significant strides in developing their workforce.

New York:

- Invested $8.5 million in 2005-2006 to enhance worker salaries, improve benefits, offset liability insurance costs, and support services for the working poor
- Realized a 177% increase in the number of CASAC applications since 2001
- Pursued a unified client reporting system to reduce counselors’ paperwork burden
- Created a new Trainee certification to stimulate interest in the field
- Implemented plans for a new credential (for compulsive gambling counselors) and specialty designations (for gambling and cultural diversity/competence)
- Created a list of 10 principles and practices that will assist agencies in developing a strategic and integrated approach to create an atmosphere of excellence

New Jersey:

- Offered over 1,000 scholarships for training programs
- Created a residential college program to help professionals finish their CADC certification

- Created a book for college and university field instructors to assist students in finding a field placement

Pennsylvania:

- Recommending Cost of Living Adjustments tied to inflation
- Plan to work with Single County Authorities to design incentive packages for preferred providers as a way to earn more based on standardized benchmarks
- Developing partnerships with recovery organizations to identify how to effectively engage volunteer and paid recovery community individuals

The NeATTC simultaneously launched a number of other initiatives to support these efforts including: state focus groups; Workforce Development Summits with Progress Reports; a needs assessment; routine progress reporting; development of specialized training in clinical supervision; a recruitment video (now used nationally) targeting potential new workers; a regional Leadership Institute to train future leaders; and cross state and interdisciplinary recognition of substance use disorder CE credits.

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Core Area:

Substance Abuse Prevention

Core Competencies that Facilitate the Implementation of SAMHSA Strategic Prevention Framework

Target Audience: Other: members of community coalitions

Focus of Innovation: Leadership Development

Innovation Description:

CADCA in partnership with the World Health Organization Collaborating Centre for Community Health and Development at the University of Kansas, developed core competencies training for community planning based on SAMHSA's SPF process (assessment, capacity building, planning, implementation, and evaluation). The aim of this training system is to help community coalition members develop their collective ability to engage in successful community problem solving. The core competency process teaches coalition members what they need to learn, what they need to do and the products they need to create to develop and carry out a community level collaborative strategic plan that over time results in measurable, population level reductions in whatever "problem" is deemed important by the community (i.e. substance abuse, teen pregnancy, violence, etc.). CADCA's training delivery methods include face-to-face, video teleconferencing, and web based workstation.

Significance:

The core competencies of community problem solving system provide a complete framework for implementing SAMHSA's Strategic Prevention Framework that is based on research and a marketing and delivery study. It has been pilot tested in a number of settings and scalable to communities throughout the United States. Because it is competency based, participants can learn while doing, make corrections along the way and produce products that can be objectively rated by reviewers and participants.

Novelty:

Designed to be delivered outside of traditional academic settings, the system can be delivered in a variety of venues. Participants can be any age, sector or educational background. The emphasis is on systems and environmental change (policies and practices) with the community (not the individual) as the unit of analysis. It involves professionals, policy makers, residents, and service recipients as equal partners. By promoting strategic thinking and a focus on measurable results, it enables coalitions to best address issues in their communities.

Transferability:

The complete package includes: trainer's manual, participant workbooks, power point presentations, video teleconferencing capability (distance learning), a web based workstation, and textbook which can be delivered in two day, four day or year long segments. Trainers are trained and certified. The package is cost effective and "generic" in order to address any type of community problem as opposed to being discipline specific.

Effectiveness:

Because it is based on research and builds on the Community Tool Box developed by the University of Kansas, it reduces barriers associated with evaluation - local communities develop their own evaluation but common metrics are used so that data can be aggregated at higher levels (e.g. state and national). The training system includes measures to evaluate trainees' satisfaction, intent to use and quality of products developed by communities as they go through the SPF process of assessment, capacity building, planning, implementation, evaluation, sustainability and cultural competence.

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Nebraska's Community Academy

Target Audience: Other: Multi-sector community coalitions, including decision makers and individuals representing education, behavioral health, law enforcement, public safety and public health (or for tribal entities, the functional equivalents of above

Focus of Innovation: Leadership development, Prevention and health promotion- mental health; Prevention- substance abuse; Recruitment and retention

Innovation Description:

In response to the realization that there would never be enough State-level staff or technical assistance providers to provide the level of support needed to help communities undertake the arduous process of social change, Nebraska's Community Academy prepares a cadre of "community coaches" to facilitate 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.

Nebraska's Community Academy consists of a series of modules that enable community decision makers and members to: 1) objectively assess and plan for the development of community partnerships or "prevention systems;" 2) objectively assess their local resources, issues and underlying causal factors related to substance abuse; 3) mobilize stakeholders from all sectors of the community and advance community readiness for social change; 4) conduct comprehensive, community-wide planning processes to prevent substance abuse; 5) develop processes for strategy implementation, evaluation and sustainability; 6) build sustainable capacity and infrastructure; and 7) sustain substance abuse prevention outcomes into the future.

The Community Academy consists of the following components, which are provided to community groups in presentation format with an emphasis on small and large group discussion and work:

- Prevention System Development Part I: Assessment;
- Prevention System Development Part II: Planning;
- Prevention System Development Part III: Mobilization;
- Community Planning Part I: Assessment, Goals, Objectives and Outcomes;
- Community Planning Part II: Strategies, Activities and Implementation Planning;
- Community Planning Part III: Evaluation and Sustainability Planning.

Significance:

Nebraska's Community Academy combines comprehensive capacity-building with facilitated networking – a powerful tool for mobilizing communities around substance abuse prevention. The Academy emphasizes "system thinking," and engages communities in collective, objective analyses of the way community members and organizations can work together to coordinate leadership, build capacity and adopt the effective practices needed to solve complex, shared social problems. The Community Academy provides tools to help communities accurately and

objectively assess local problems and conditions and break through assumptions, denial and passivity. Furthermore, community members are taught how to use local data to significantly advance community readiness and generate community support for positive social change.

Novelty:

Nebraska's Community Academy is designed to shift thinking among community stakeholders towards evidence-based problem solving and systems thinking. It maximizes community outcomes and resources by ensuring that locally and culturally-appropriate strategies are selected and implemented based upon objective assessment and diagnosis, thoughtful planning, and careful matching to community goals and objectives, priority risk and protective factors, and community readiness, resources and contextual conditions. In addition, communities are taught how to develop strong local prevention systems in order to collectively harness the social, financial and human capital of all sectors, and strategically leverage that capital to achieve and sustain desired outcomes into the future.

Transferability:

Every module of the Academy includes a PowerPoint presentation with notes. In addition, the following tools are also available:

- Prevention system assessment instrument to identify strengths and areas of development;
- A prevention system planning logic model;
- A community readiness assessment and planning process;
- Mobilization tools for identifying, recruiting and retaining stakeholders, collaborators and allies;
- An "Evidence-Based Planning Toolkit" that provides a comprehensive guide to strategic planning, including worksheets, examples and helpful hints;
- A "Guidance Document for Selecting Science-Based and Promising Substance Abuse Prevention Strategies," containing a comprehensive compendium of effective environmental and individual strategies to assist communities to strategically select strategies that are locally and culturally appropriate, appropriate for target populations, and closely aligned with underlying community causal conditions and desired outcomes.

Effectiveness:

The Community Academy has resulted in significantly enhanced community capacity and reductions in youth substance abuse in Nebraska. Communities that complete the Community Academy consistently produce higher quality substance abuse prevention plans than non-participants. These plans include comprehensive approaches targeting risk and protective factors across multiple domains; clearly identify priority community issues; describe comprehensive partnerships among community stakeholders; identify desired behavior changes to be achieved; and match the use of strategies to local needs. Many participating communities have used their plans to leverage additional local, State and Federal prevention resources sources. In 2005, the number of Drug Free Community grantees in the State of Nebraska doubled, with each grantee being a graduate of the Nebraska Community Academy.

In all, 254 community leaders from more than two dozen disciplines participated in the trainings, which used a "learning community" format to foster peer mentoring, honor adult learning styles, and leverage the wisdom and experience of the community members in attendance.

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The North Carolina Governor's Academy for Prevention Professionals

Target Audience: wide range of practitioners in the field

Focus of Innovation: prevention- substance use

Innovation Description:

The University of North Carolina at Chapel Hill, Division of Student Affairs, through the Center for Healthy Student Behaviors is proud to have created the North Carolina Governor's Academy for Prevention Professionals (GAPP), a two-week immersion curriculum in prevention. In its 17th year and the first of its kind in the nation to prepare individuals as "prevention specialists", GAPP proudly boasts over 780 graduates from the Academy. The Academy provides a core curriculum of 110 hours toward prevention certification through a rigorous, highly structured, educational venture using didactic, experiential, interactive and participatory learning modalities. The mission is to provide solid coursework using a theoretical, science-based measurable context and to present this information in a unique modeling environment.

Students come to the Academy with either past "grass roots" experience in the field and a minimum of a high school diploma to a PHD/MD professional within the health care system. The curriculum seeks to provide the building blocks of prevention education to this broad range of students thus attempting to provide some measures of quality assurance of the professional working in the field of prevention. Curriculum topics include: prevention theory, life skills, developmental life stages, pharmacology, public policy, prevention ethics, prevention domains, cultural competency, evaluation, public speaking and writing skills. The students are also instructed in test taking strategies and prepared to sit for the International Certification and Reciprocity Consortium exam.

The two-week immersion curriculum arms the GAPP graduates with the necessary skills to assist other workers within the state to become stronger prevention advocates. These "preventionologists" provide expertise to others in the areas of community organization/development, program development and evaluation. The faculty is drawn from both within the University as well as from practitioners within the field. Finally, in addition to reaching existing professionals in the field, new for 2005 a Collegiate GAPP Academy was developed to transfer the core prevention principals to the emerging workforce…college students.

Significance:

Existing professionals and emerging professionals come to the field of prevention with varying degrees and educational backgrounds. This diversity, while providing a rich environment for sharing of ideas and concepts, does not necessarily provide the needed science base to our programs. The Academy seeks to provide an initial starting point for this educational base, frame this base in terms of practical experience, and then build a strong network of prevention advocates throughout the state.

Novelty:

The Academy is a significant departure from the workshop model of continuing education to an intense immersion curriculum built around not only the academic information but also a unique modeling structure that provides an environment of practice for the students. The students are offered a mentor/instructor who provides on-going assistance post graduation. By design, and due to the intensity of the academy, a unique camaraderie and a strong network for support are developed among graduates, which strengthens the workforce.

Transferability:

The North Carolina Governor's Academy while unique in its structure can easily be transferred to an appropriate institution or organization via a curriculum transfer. All educational materials are prepared in manual form and organized to be taught independent of each other. In addition, a training manual for mentors has also been published and guides the mentor staff through the academic process. All faculty credentials are carefully reviewed and documented for each course. Finally, all necessary forms, instructions, testing materials and student satisfaction instruments can be made available for duplication.

Effectiveness:

Multiple methods of evaluation have been applied to the GAPP process. Perhaps the strongest measure of success exists in the simple fact that a GAPP graduate exists in every county within the State of North Carolina. The strength of the network and didactic material enables the matriculating student to be successful in the work environment. A measure of this success has been the success rate of GAPP graduates in procuring grant dollars into their counties for primary prevention programs. In addition, the overall graduation rate is well over 90%. Our training satisfaction level is superior and can also be measured by the number of student referrals from past GAPP graduates.

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Core Area:

Older Adults

Emergency Preparedness for the Elderly: A Collaborative on Education and Resource Development for Preparing the Multidisciplinary Workforce

Target Audience: Practicing professionals, non-degreed or bachelor-degreed direct care staff, other healthcare or human service providers

Focus of Innovation: Adult mental health, consumers & families, culturally competency, elderly, professional associations, providers, rural

Innovation Description:

This collection of innovative interdisciplinary training programs was developed by a collaborative of Geriatric Education Centers within the NAGEC (National Association of Geriatric Education Centers) network in response to the dearth of training materials on emergency preparedness in aging. Age-specific emergency preparedness programs can effectively enhance the safety and well-being of older adults, including the most frail and vulnerable and culturally diverse groups, if health care practitioners in institutional and community-based settings are adequately trained.

Interactive training programs include didactic and video-streamed presentations, CD/DVDs, tabletop exercises, web-based resources, games, and experiential healing rituals. Two types emergency preparedness kits—one for elders living in the community and the other for those living in nursing homes, have been designed for distribution. To facilitate learning on multiple levels, several mnemonics and newsletter articles are also available. 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.

Interdisciplinary interactive training emphasizes collaboration with other service systems to enable providers to effectively respond to emergency situations. Programs can be delivered through workshops or distance-learning sessions of varying lengths. To enhance its utility and practicality, training can be completed within a single day. Updates and refreshers can be delivered annually or in response to agency request or newly identified needs. Designed as train-the-trainers models, these programs can be implemented and delivered by other community providers and health professionals who have received the initial training.

Significance:

This collaborative program has provided workforce education and training to individuals in 30 professions, 20 of which are in the health care sector and the remaining professions are in law, law enforcement, security, pastoral care, public health, and social services. Trainees learn specifically how elderly persons respond differently to emergency-induced stress, trauma and confusion than non-elderly persons. Differences in physical health and mental health needs are emphasized. The training is divided into pre-event, event and post-event modules. Maintenance of health is the focus of the post-event module.

Novelty:

Despite millions of dollars in the Federal budget dedicated to curriculum development and continuing medical education programming in emergency preparedness, the only program to provide training on the special needs of the elderly is this NAGEC program. At the urging of NAGEC, the Centers for Disease Control and Prevention (CDC) has created a CDC exemplar group in geriatrics. The GEC faculty who created the NAGEC Collaborative Program currently serve on the CDC exemplar group, on planning committees for state Departments of Public Safety, and education committees for professional organizations, further indicating the rarity of expertise in this topic.

Transferability:

All teaching material for this interdisciplinary collaborative program is available through the NAGEC web site at http://www.nagec.org/ or directly from the contact faculty or web site listed. The program uses multiple modalities, including videos, web-based broadcasts, CD/DVDs, table-top exercises, mnemonics, games (in English and Spanish), and didactic lectures. The GEC faculty who created the educational programs and resources are available for consultation and to advise potential users on how to tailor the material to their needs and to work with them to create novel, culturally appropriate materials. NAGEC is currently developing core competencies in emergency preparedness in aging. All of these components make the NAGEC Collaborative Geriatric Emergency Preparedness Trainings a flexible, accessible curriculum.

Effectiveness:

Primary evaluation has shown that trainees have found this training to be informative and valuable. Over half of those people have been trained in the past 12 months, indicating an increasing perceived need for such training. A research project on the effectiveness of the kits indicates that 80% of trainees have already, or intend to, replicate the kits for their elderly patients.

Additional Descriptive Information:

Products and Resources on Bioterrorism and Emergency Preparedness in Aging available at http://www.nagec.org/

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The Outcomes-Based Treatment Planning System (OBTP)

Target Audience: Practicing professionals

Focus of Innovation: Elderly, Adult Mental Health

Innovation Description:

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 RWJ 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.

Significance:

By the year 2030, the number of persons age 65 and older with major psychiatric disorders will equal or exceed the number in younger age groups with mental illness, such as those ages 30-44 (Jeste et al., 1999). Older persons are more likely to receive inadequate or inappropriate psychiatric care compared to younger adults with mental illness. Poor quality of services and a workforce of providers with inadequate geriatric clinical expertise are core deficits identified by the Older Adult Subcommittee of the recent President's New Freedom Commission on Mental Health. The OBTP is a practical approach to addressing this expertise gap through an integrated decision-support processes for assessing clinical needs and selecting effective services for older adults with mental disorders.

Novelty:

Although there are numerous valid and reliable clinical assessment instruments available for older adults and a variety of effective interventions for major psychiatric disorders in older adults, there remains considerable disconnect between assessment and practice within this population of older adults. OBTP offers an integrated clinical assessment, decision-support, and outcome measurement process.

Transferability:

OBTP consists of two documents—an OBTP Summary Assessment Form and an OBTP Toolkit. Within these two documents, the OBTP system is made up of several parts, all of which are conceptually and structurally linked to form a complete system. A proposal is underway to make the OBTP available to mental health clinicians nationwide, through a Web-based electronic application and database. This would enable an integrated clinical system for 1) assessing the needs of older adults with mental illness; 2) giving guidance about services and guideline –based treatment appropriate to their needs, and 3) measuring the outcomes of such treatment to

improve the quality of care. This system would make easily and widely accessible a needed set of uniform protocols and guidelines, as well as allow for the tracking of client progress over time with standardized measures and progress reports. Finally, it would allow the aggregate analysis of treatment effectiveness by the type and intensity of the treatment, service, or medication used, and by client characteristics.

Effectiveness:

Over the past five years, the New Hampshire-Dartmouth Psychiatric Research Center's Aging Services Division has revised, pilot tested, and refined the OBTP methodology, working with clinicians from the ten community mental health centers in New Hampshire and several mental health and home health agencies in Connecticut and Massachusetts. The OBTP was selected for testing in the Robert Wood Johnson Foundation's National Home and Community-based Care Initiative. The OBTP has been shown through the RWJ 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.

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SAMHSA Older Americans Substance Abuse and Mental Health Technical Assistance Center

Target Audience: Practicing professionals, non-degreed or bachelor-degreed direct care staff, other healthcare or human service providers

Focus of Innovation: Elderly, prevention & health promotion—mental health; Prevention-substance abuse; Providers

Innovation Description:

Estimates suggest that the number of adults, age 50 or older, with substance abuse disorders will double during the next two decades. Additionally, people over age 65 with mental health disorders will increase from 7 million in the year 2000 to 15 million by 2030.

Through partnerships with state and federal agencies and community health care providers, the mission of the SAMHSA Older Americans Substance Abuse and Mental Health Technical Assistance Center (TAC) is to enhance the quality of life and promote the physical and mental well-being of older adults by reducing the risk for and incidence of substance abuse, medication misuse and abuse, and mental health issues late in life. The TAC collaborates with the National Registry of Evidence-Based Programs and Practices to identify evidence-based programs for older adults, and provides education, direct training and technical assistance to State agencies and providers across the country. Through collaboration with the Administration on Aging and the National Council On Aging, TAC staff conducts state planning events and *Get Connected! Toolkit* trainings with service providers and program administrators from the aging, substance abuse, mental health, and public health fields. Responding to requests from the field, the Center has developed the *Increasing Provider Comfort Levels in Working with Older Adults* trainings to enhance and strengthen the skills of providers in the community. Through exhibits, presentations, technical assistance, direct State trainings, and responses to requests from the Center's email and 800-number, the Center has responded to the needs of more than twenty States and the District of Columbia.

Significance:

The State Planning events, along with *Get Connected! Toolkit* and *Increasing Provider Comfort Levels in Working with Older Adults* trainings, present important learning opportunities for organizations and providers of older adult services. These trainings address critical issues such as helping staff recognize, screen for, and address substance abuse and mental health issues in older adults. Trainings are designed to increase staff knowledge, confidence and communication abilities in order for them to work more effectively with older adults. The training includes activities designed to assist providers in overcoming the challenges, such as stigma, faced by many providers working with this population.

Novelty:

Little has been done by state agencies/local providers to prepare for the behavioral health needs of the aging baby boomers. Through training/planning events, the TAC seeks to better prepare

the workforce at all levels to respond to these needs. Adult learning principles are adhered to and a combination of knowledge dissemination modalities is incorporated including lecture, experiential and interactive activities. Participants engage in formal and informal assessment exercises, interactive discussion and program planning activities. Additionally, TAC staff members address issues related to older adult quality of life, the impact of chronic health conditions, and current research regarding health literacy.

Transferability:

Trainings frequently adopt the "train-the-trainer" model and are designed specifically to equip each participant with the tools needed to utilize the knowledge and practice procedures from the trainings within their own programs and to train others. Materials are in a ready-to-use manual that includes staff education curriculum, fact sheets, handouts, replicable forms and a resources list. Alcohol and depression screening assessments are provided for the use of each participant. All hardcopy materials are copyright-free and can be used without restrictions. Included in the kit is a video for unrestricted use and sample publicity materials developed for publicity of organizational and community events.

Effectiveness:

Training effectiveness is evaluated through training satisfaction evaluation forms completed at the end of each training event. In addition, six-month follow-up evaluations are conducted with all participants attending the state planning sessions to learn about ongoing activities related to the training event. In addition, informal surveys are conducted prior to or during the trainings to identify specific needs or topics that participants would like to have addressed, e.g., additional role play scenarios, etc. In this way, the trainings are customized to meet participant needs.

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Appendix A

SELECTION CRITERIA FOR INNOVATIONS In Behavioral Health Workforce Development[1]

The following are criteria to consider in selecting exemplary workforce innovations:

- Its **significance**, the degree to which the program successfully addresses an important element of behavioral health workforce education, training, recruitment or retention. For example:
  - To what degree does the innovation address a workforce issue or problem that is of national import and scope?
  - To what degree does the innovation directly impact the behavioral health workforce, persons in recovery, and/or family members?
  - To what degree has the innovation improved the relevance of training and education to the rapidly changing practice environment?
  - To what extent does the innovation address needs or issues identified in recent reports issued by the U.S. Surgeon General, the Institute of Medicine, the President's New Freedom Commission, or SAMHSA and its Centers?
- Its **novelty**, the degree to which the innovation demonstrates a significant departure from business-as-usual. For example:
  - Does the program represent a fundamental change in the approach to educating providers, students, children or adolescents, or persons in recovery and their families?
  - Does the program incorporate new recruitment and retention strategies?
  - Does the program change the core process by which education or training occurs?
  - Does the program introduce a new resource or technology?
- Its **transferability**, the degree to which the innovation, or aspects of it, shows promise of inspiring successful replication by educational institutions, service delivery systems, or other groups.
  - To what extent is the innovation packaged and readily accessible to others?
  - To what extent can this innovation be replicated by others?
  - To what extent can this innovation serve as a model that others will seek to replicate?
  - To what extent are the components, concepts, principles or insights of this innovation transferable to other disciplines or fields?
- Its **effectiveness**, the degree to which the innovation has demonstrated its utility by achieving tangible results. For example:
  - Has the innovation been formally evaluated or researched and found to be effective using either qualitative or quantitative methods?
  - Has an independent evaluation been conducted (e.g., by persons other than those who developed the innovation)?
  - Is there evidence of "satisfaction" with the innovation among persons in recovery, family members, children or adolescents, students, or providers?

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[1] These criteria were adapted from those used by the John F. Kennedy School at Harvard University in selecting the Innovation in Government Award recipients, www.innovations.harvard.edu.