

The Continuing Challenges of Strengthening the Behavioral Health Workforce

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The 2000 Santa Fe Summit of the American College of Mental Health Administration (ACMHA), under the co-leadership of Leighton Huey, MD and Pam Hyde, JD, focused on the issue of training and education of the workforce. The title of the meeting was ***Changing the Actions, Strategies & Behaviors of Clinicians, Consumers, Families & Organizations: The critical role of education and training.*** The meeting confirmed the belief of ACMHA leadership and the planning committee that workforce issues had been under-attended for years, resulting in deficits of crisis proportions.

Subsequent to that meeting, six members of the College (Neal Adams, MD; Allen Daniels, EdD; Michael Hoge, PhD; Leighton Huey, MD; John Morris, MSW, and Gail Stuart, RN, PhD) made the commitment to pursue the issue and to focus national attention on workforce issues.

That work had its first formal fruition in September, 2001, when the initial Annapolis Conference on the Behavioral Health Workforce was held; the work of this meeting was memorialized in a special double edition of *Administration and Mental Health*¹ (Hoge & Morris, 2002). CMHA and HRSA both contributed support to the meeting; ACMHA Fellow Ron Manderscheid was instrumental in arranging assistance. This was followed in quick succession by testimony before the President's New Freedom Commission on Mental Health and completion of a special white paper on workforce commissioned by CMHS for the Institute of Medicine's Quality Chasm Series (Morris, Goplerud and Hoge, 2004). Another special double issue of *Administration and Policy in Mental Health* followed (Hoge, Morris & Paris, 2004) and took on the issue of best practices for

¹ Saul Feldman, a founder of ACMHA, was editor of the journal at this time, and his support for this work was steadfast.

workforce development, highlighting the importance of such issues as evidence-based teaching, innovation in education and training practices, and the importance of educating the mental health workforce on issues related to substance use.

A second Annapolis meeting, held in May, 2004, focused on competencies in the behavioral health workforce, and again resulted in a special double issue of *Administration and Policy in Mental Health* (Hoge, Morris and Paris, 2005).

Initially functioning as a collaborative under the joint sponsorship of the American College of Mental Health Administration and the Academic Behavioral Health Consortium, The Annapolis Coalition on the Behavioral Health Workforce, Inc. was chartered as a not-for-profit 501(c) (3) corporation in May, 2005. Since that time, the Coalition has continued to work to highlight the importance of workforce issues at the county, state, regional and national level.

One of the recommendations of the President's New Freedom Commission on Mental Health (2003) was that a national action plan be developed for behavioral health workforce issues. The Substance Abuse and Mental Health Services Administration (using funding from all three SAMHSA Centers—the Center for Substance Abuse Prevention, the Center for Substance Abuse Treatment, and the Center for Mental Health Services—and the Office of the Administrator) engaged the Coalition to lead the national planning process.²

² Kathryn Power, Director of CMHS, in her role as leading transformation called for in the New Freedom Report, and Gail Hutchings, ACMHA member and then Special Assistant to the Administrator at SAMHSA, were instrumental in supporting this work.

The planning process was stimulated by the high degree of concern among a broad range of stakeholders (consumers, family members, practitioners, providers and academics) about the status of the behavioral health workforce. Among all stakeholder groups, there was an almost palpable sense of pessimism about its future with high rates of turnover, and low rates of recruitment—especially in rural and minority communities, difficulties with retention of staff, and the aging of the workforce.

This work culminated in the release, in 2007, of *An action plan on behavioral health workforce development* (Hoge, Morris, *et al.*, 2007), which was released electronically on both the SAMHSA website (www.samhsa.gov) and the Coalition website (www.annapoliscoalition.org). A link to the Action Plan is also located on the ACMHA website (www.acmha.org).

The report reflects the fact that workforce problems impact virtually every aspect of prevention and treatment across all sectors of this diverse field, with far-reaching implications for pre-service and continuing education, recruitment and retention.

One of the most distinctive elements of the design of the report was a commitment on the part of both SAMHSA and the Coalition to have the report cut across the content areas of the SAMHSA Centers (substance abuse prevention, substance abuse treatment, and mental health services and supports). There was also a commitment to look across the life-span, and to make the plan as concrete and practical as possible.

The process was designed to build on previous workforce planning efforts, including the CSAT sponsored report on *Strengthening Professional Identity: Challenges of the Addiction Treatment Workforce*, the *New Freedom Commission Report*, and the 2006 Institute of Medicine Crossing the Quality Chasm Report, *Improving the Quality of Health Care for Mental and Substance-use Conditions*.

The Coalition-designed process for completing the plan sought to identify current weaknesses in workforce development efforts in behavioral health; to develop a vision for a future workforce that is engaged, competent and diverse; and to identify practical, actionable strategies that can be implemented at multiple levels of intervention to achieve that vision. The ultimate aim of this effort was to dramatically improve the quality of care received by individuals (persons in recovery) and their families who are served by behavioral health care providers, as well as to support the health promotion and illness prevention capacities of communities. No previous planning effort had been so broad or comprehensive in scope, and the challenges of crossing traditional silos were significant.

Multiple Moving Parts...

An array of planning vehicles was used because of the wide scope and reach of the action plan and the need for multiple methods of data collection. Nationally recognized experts in workforce development from diverse sectors of the field were engaged as senior and technical advisors to manage planning in their area of expertise, to function as emissaries in this process to their peers. Many of those leaders were recruited to serve on the National Steering Committee of the Annapolis Coalition, which reviewed and vetted all

recommendations and the content of the final report. The advisors convened and chaired 12 expert panels and workgroups that were responsible for: reviewing prior workforce reports and recommendations; obtaining input from colleagues via professional meetings and planning sessions conducted across the country; identifying workforce development innovations; and formulating a set of proposed goals, objectives, and actions. Expert panels were generally larger in membership and/or had a longer life span than the workgroups. Panels and workgroups were convened around the following topical areas: Child, Adolescent, & Family Panel, School Based Mental Health Panel, Consumer and Family Panel/Adult Mental Health, Cultural Competency and Disparity Panel, Substance Use Disorders Treatment Panel, Substance Abuse Prevention Panel, Older Adults Panel, Rural Panel, Provider Accreditation Panel, Educators Workgroup, Information Technology/Distance Learning Workgroup, and a Financing Workgroup.

Other strategies, such as an open call for submission of information and recommendations via the Internet also was issued by the Annapolis Coalition, which also reached out to a wide range of groups and organizations through e-mail, postal service, phone, conference presentations and in-person interviews. Recommendations submitted through all sources were organized into seven goal areas, which were expanded into detailed implementation tables, clustered around the specific objectives necessary to achieve each goal. These implementation plans, along with the text developed to explain the recommendations, were reviewed and revised by the National Steering Committee. Senior and technical advisors then drafted additional sections of the report that focused on their sector, population, or other area of expertise. The draft report was vetted through

a national conference held by SAMHSA in July of 2006 with over 200 participants drawn from all sectors of the field. Modifications to the report were made based on feedback from participants prior to its eventual release.

The final report gives an overview of the behavioral health workforce as it is currently constituted, and the environment in which it functions; general findings about the characteristics of the workforce crisis; and a set of seven strategic goals, accompanied by specific objectives and recommended actions necessary to achieve these goals. An Executive Summary was published along with the full report.

The goals

The actual language of the goal statements is presented below:

GOAL 1: Significantly expand the role of individuals in recovery, and families when appropriate, in participating in and ultimately directing or accepting responsibility for their own care, providing care and supports to others, and in educating the workforce.

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

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

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

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

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

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

Compressing the work into seven goal areas involved significant discussion, debate and compromise, but there was also a commitment to having a manageable number of goals and to achieving maximum consensus among the many competing interests and points of view. One concept was clear from the earliest days of this work: its impact on primary consumers (people in recovery and their families, and those at risk for developing mental and substance use conditions) was always understood as the “True North” of the project. Goal one has primacy of place for that reason.

Facing the challenges of change

The Action Plan grapples with the reality that translating recommendations into action requires significant attention to the levers of change - those seemingly small forces that can exert enormous influence on a much larger mass – borrowing the metaphor from the concept of a lever in physics: properly placed, balanced and utilized, a lever creates a mechanical advantage that produces significant movement beyond that which could be expected if the same amount of force were applied in less strategic ways.

A number of levers of change were identified by the Institute of Medicine in its report on *Health Professions Education: A Bridge to Quality* (2003) and the more recent report on mental and substance use conditions (2006). These include financing, licensing, credentialing, accreditation, and faculty development. Organized advocacy is another lever that warrants focused attention, and the Coalition has always considered leadership

a vital lever of change. ACMHA, with its focus on leadership, is one of those levers, and has a widely recognized place as a thought-leader on this and many other behavioral health issues.

What has happened since the release of the report

The Coalition has now shifted its focus from simply raising awareness and planning to offering technical assistance to states, regional and local governments and academia to assist them in making the changes that are required to fundamentally change behavioral health workforce development. To further this goal, the Coalition has entered into strategic partnerships with The Western Interstate Commission on Higher Education (with a special focus on rural and frontier communities), and with Mental Health America of Los Angeles. In addition, the Coalition has been working with the Lewin Group and the College of Direct Supports on a groundbreaking set of initiatives that engage the aging, intellectual and development disabilities and behavioral health fields in addressing challenges related to the direct care workforce. This last effort has resulted in the release of a major report funded by the Centers for Medicare and Medicaid Services³ (Hewitt *et al.*, 2008) that synthesizes information about the direct support workforce across intellectual/developmental disabilities, aging, physical disabilities and behavioral health. Over the past 24 months, the Coalition is working or has worked with state governments or non-profits in California, Iowa, Louisiana, New Jersey, New Mexico, North Carolina, and Vermont on a range of activities from strategic planning to creation of workforce

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collaborative that bring together stakeholders to reshape their behavioral health workforce efforts. A major project, undertaken in collaboration with WICHE and the University of Alaska, is focusing on worker competencies.

Conclusion and Acknowledgements

A national action plan will be meaningless if it does not serve as a catalyst for concrete, concerted action at the local, state and regional levels, and the Coalition is encouraged by the enthusiasm and commitment of groups around the country, not least of which is the American College of Mental Health Administration. As we have often noted, and as say prominently on the Coalition's home page, workforce development is a critical component of sustainable reform. If we fail to train and support the people who deliver the prevention, treatment, services and supports we seek, they will never achieve the promise of which we are capable, and which our fellow citizens deserve.

We salute the American College of Mental Health Administration for its vision in holding Santa Fe Summit 2000 (and its co-chairs Leighton Huey and Pam Hyde), for its support during the early phases of the Coalition's work, and for continuing to highlight the importance of workforce issues through mechanisms such as this Webinar. As always, we thank Kris Erickson, Executive Director of ACMHA for her tireless work. And finally we thank the thousands (yes, thousands) of individuals who contributed their thoughts, ideas and experiences in the development of the report that was the topic of the Webinar—and the thousands who continue to work to make real, substantive change happen.

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