

Chapter Twelve

Workforce Development

Symposium

Building a National Strategic Plan for Workforce Development

Symposium Introduction

Carol MacKinnon Lewis

There is a growing consensus that improvements in quality of care will not be achieved without systematically addressing a range of problems related to the behavioral health workforce. These problems include severe shortages of qualified providers, driven in part by difficulties in both recruitment and retention. There are also substantial concerns regarding the education and training provided to members of the workforce: major segments of the workforce receive no substantive training; graduate and residency education programs have not kept pace with dramatic changes in the field's approach to service delivery; continuing education is based almost exclusively on ineffective lecture models; and consumers and families receive little educational support despite their major role in caring for themselves and others. The Substance Abuse and Mental Health Services Administration (SAMHSA) is supporting the development of a National Strategic Plan on Workforce Development in Behavioral Health.

This symposium provided the historical development of and necessity for this initiative. Sybil Goldman, Senior Advisor on Children at SAMHSA described the objectives of this initiative and placed them in the context of SAMHSA's efforts to foster the transformation of care as envisioned in the report of the President's New Freedom Commission. Development of the National Strategic Plan is being coordinated by The Annapolis Coalition, which is an organization dedicated to improving behavioral health workforce education and development. The Coalition's Co-chair, Michael Hoge, provided an overview of workforce planning efforts, to date, and described the process that will lead to the development of the National Strategic Plan. Larke N. Huang, a member of the President's New Freedom Commission and Senior Consultant to The Annapolis Coalition, discussed the workforce crisis in children's behavioral health and presented preliminary ideas on the essential elements of the National Strategic Plan as it pertains to caring for children and their families. Randolph Muck, Team Leader for Adolescent Treatment in SAMHSA's Center for Substance Abuse Treatment presented information on the workforce issues specific to treatment for adolescents with substance use disorders and discussed possibilities for improvement within behavioral health in the screening, identification, and treatment of these youth.

Behavioral Health Workforce Education and Development: Initiatives Supported by The Substance and Mental Health Services Administration

Sybil K. Goldman

Introduction

The best intended plans for systems of care for youth and families cannot succeed unless the pressing issues of workforce development and personnel shortages in behavioral health are addressed. These are not new issues; indeed, they have been discussed and recommendations made for more than a decade. In the late 1980s, key leaders in children's mental health met at Boston University to discuss what they saw as an emerging problem around workforce recruitment, retention of workers, and the quality and training of a workforce that could deliver state-of-the-art services to children and their families. Even then, the complexities of the problem were recognized, along with the number of players and systemic levels: universities; accrediting bodies; federal, state and local agencies; insurers; provider agencies and many more.

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The concerns of that group were later echoed in national reports such as the Surgeon General's Report on Mental Health (U.S. Department of Health and Human Services, 1999); *Crossing the Quality Chasm: A New Health System for the 21st Century* (Institute of Medicine, 2001); *Achieving the Promise: Transforming Mental Health Care in America*, President's New Freedom Commission on Mental Health Report (2003), and by other prominent organizations across the field. There was a consensus among all of the reports that America needs a better health care workforce: one that includes consumers and families in decision-making, is responsive to and reflects the myriad of cultures and languages found in our society, is knowledgeable about best practices, and has the skills, attitudes, and knowledge based on the progress made and the lessons learned in the field of child behavioral health. Moreover, over the next 10 years, these issues are projected to reach critical proportions and represent a serious threat to children, adolescents and families who have or are at risk for mental, emotional, and substance use disorders. In this presentation, the complexity and enormity of the workforce problem facing us was addressed as well as the Substance Abuse and Mental Health Services Administration's (SAMHSA's) efforts to respond.

A new and improved workforce cannot be produced through old, out-dated training programs. Too many university programs throughout the country are still using the traditional models. They are not relevant to current needs and thus are not producing a workforce with the necessary core competencies to adequately serve children who have or are at risk for mental and/or substance use disorders, and their families.

Currently, training programs do not include key components of an effective service delivery system that reflect the dramatic shifts that have occurred in the last 20 years, such as:

- Family driven and youth guided care where families and youth are part of the decision making process and are partners in all aspects of the service system;
- An individualized care planning approach, based on family strengths and culture;
- A comprehensive array of services and supports that include evidence-based interventions;
- An understanding of the multiple systems and funding streams that comprise the child service delivery system;
- Strategies for working collaboratively across systems and working in teams;
- Outcome-based accountability; and
- New ways to put technology to use for behavioral health for children and their families. Most graduate training programs in social work, psychiatry, psychology, counseling, and nursing are not teaching these core competencies.

A vast array of in-service and continuing education training opportunities exist to address some of these training needs for the human service workforce, including professionals, those with undergraduate degrees, consumers, families, youth, and the front-line providers who make up much of the service delivery system for children and families. But overall, continuing education and in-service training—while important components of ensuring a quality workforce—are idiosyncratic: some are very effective, but most are not. Until we work in partnership with our universities, professional associations, and state and community service providers around meaningful, integrated, consumer- and family-driven, culturally competent and evidence-based training programs—and until all university programs start doing a better job of recruiting students—our work force crisis will prevail.

Shortage of Providers

The need for a better-prepared workforce is only half of the workforce problem. We currently have a shortage of providers, making matters even worse. Some children and families do not have access to any mental health or substance abuse professionals adequately trained in the arena of children's mental health. This is especially the case in rural areas. Since rural populations tend to be poorer, few child psychiatrists choose to live in rural areas, causing a severe "mal-distribution" of child psychiatrists. For example,

Massachusetts has 17.5 child and adolescent psychiatrists per 100,000 youths while West Virginia has only 1.3. Recruitment, retention, and retirement issues contribute to the shortage problem, a problem that must be addressed given that the prevalence of children's mental health problems is likely to increase as stressors in society continue to increase, according to the previously cited reports.

Recruitment Issues. There are many factors contributing to the recruitment problem. Low salaries, poor benefits, and the hassles of third-party reimbursement have been cited as obstacles to attracting more graduate students to child and family behavioral health programs. Extensive and costly training is another deterrent. We must overcome these obstacles and improve our recruitment efforts, otherwise the workforce shortfall will only worsen.

Retention Issues. Retaining professionals in the field is as problematic as recruiting them. The difficulty in persuading people to stay in behavioral health is fueled by the same reasons that make it difficult to recruit them in the first place. While work in this field can be rewarding, it can also be stressful and challenging without adequate support and training. Turnover is a major concern in both the substance abuse treatment and prevention system and in the mental health delivery system. One study by McLellan found that more than half of the substance abuse treatment program directors and a similar proportion of counselors surveyed were in their current jobs for less than a year.

Retirement Issues. The forecast over the next 10 years is even more daunting. An estimated one-third of the workforce will be reaching retirement age. Many of the current generation of leaders will be retiring and their replacements are not being recruited or retained. Further exacerbating the problem is a trend that shows—unlike their baby boomer predecessors—that the next generation of workers, typically, do not stay in one career but pursue multiple careers throughout their lifetime. (This trend, by the way, may be very positive for our field!)

Although a rather bleak picture has been painted, there is hope that we can make changes; where there is crisis there is opportunity. Through leadership and partnerships, concerted steps are being taken to repaint this picture. SAMHSA is taking strategic action to increase the number of behavioral health care providers and improve their training. SAMHSA's Administrator, Charles Curie, has made improving the workforce a cross-cutting principle on the SAMHSA Matrix which means these activities and resources are receiving priority status.

Goals and Strategic Plan

The President's New Freedom Commission on Mental Health report (New Freedom Commission, 2002) identified six goals as the foundation for the transformation of mental health. SAMHSA, specifically the Center for Mental Health Services (CMHS), is working with 19 Federal agencies on an action agenda to implement these goals, as well as the other goals and recommendations of the Commission Report. As part of the mental health transformation agenda and the Administrator's other priorities for Reducing the Substance Abuse Treatment Gap and Implementing a Strategic Prevention Framework, SAMHSA is investing in the development of a strategic plan on workforce that will include children/youth and adults and will address both mental health and substance use, a plan presented below in the summary by Michael Hoge.

The Strategic Plan grows out of the work of the SAMHSA-funded Annapolis Coalition. The Annapolis Coalition examined training offered in many graduate programs and continuing education programs and has identified core competencies for training and education in behavioral health. This Plan will be important because it will provide a blueprint for SAMHSA activities, identify priorities and gaps, and determine critical partnerships. To address these workforce challenges, we recognize we must work in concert with others. The plan will help us be smart in how we can best utilize our resources and impact change. For example, SAMHSA spends millions of dollars annually in training and technical assistance. It is important that those dollars are used effectively to enhance our workforce. This Plan will help to inform future initiatives as well as those in which we are currently engaged, some of which are described below.

Minority Fellowship Program

One important SAMHSA initiative to address the disparities in care and provide culturally competent care is the Minority Fellowship Program. Ethnic groups continue to increase across the country and represent about 25% of the population. Meanwhile, the number of professionally trained minority mental health providers is only 8%. The Minority Fellowship program invests \$3.3 million per year to the American Nurses Association, the American Psychiatric Association, the American Psychological Association and the Council on Social Work Education to support graduate education fellowships for minority students in these fields.

Federal National Partners

As Senior Advisor on Children, I convened a workgroup across the three centers at SAMHSA—The Center for Mental Health Services, The Center for Substance Abuse Prevention and The Center for Substance Abuse Treatment—to develop a blueprint for action to guide our children’s activities through SAMHSA. Because workforce emerged as a priority issue of concern across the three Centers of SAMHSA, a subcommittee was formed to address workforce issues. Given that the issues are complex and resources limited, our approach has to be strategic. So through Georgetown University, federal agencies were convened to inventory and share information on workforce training. We discovered that our federal partners are also allocating significant resources for training and competency development.

An outgrowth of the workgroup was a meeting of Federal National Partners for Mental Health Transformation, which was held in November of 2004. More than 20 key federal agencies and more than 40 public/private organizations were represented and discussions included a focus on leadership and human services workforce issues. A task force of federal agencies and national partners will continue to work together on action steps.

SAMHSA Human Services Workforce for Children and Families Project

Another product of the SAMHSA Children and Families Workgroup is a directory of web based training resources for mental health and substance abuse professionals working with children and adolescents developed by the University of South Florida, Louis de la Parte Florida Mental Health Institute.

Center for Substance Abuse Treatment Programs

The Center for Substance Abuse Treatment (CSAT) has been active in providing leadership on workforce issues in the substance abuse field. A CSAT publication, *Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice*, is currently being used by several professional organizations as the basis for developing certification requirements for addiction counselors. Randy Muck’s summary to follow provides more detail on CSAT workforce activities.

Strategic Plan for Interdisciplinary Faculty Development

SAMHSA’s Center for Substance Abuse Treatment, the Health Resources and Services Administration’s Bureau of Health Professions and the Association for Medical Education and Research in Substance Abuse jointly developed the *Strategic Plan for Interdisciplinary Faculty Development: Arming the Nation’s Health Professional Workforce for a New Approach to Substance Use Disorders*. The report includes a summary of the core knowledge, attitudes, and skills needed by health professions in all disciplines to effectively identify, intervene with, and refer persons with substance use disorders.

Conclusion

The initiatives highlighted may appear to be small steps toward the transformation of our behavioral health care workforce, but they can make a big difference. As we continue to engage each of the players involved and as each of us does our part, we will reach the goals outlined by the President’s

New Freedom Commission. I adhere to the Confucius proverb, “A journey of a thousand miles begins with a single step.” Our journey has begun; now it is up to all of us to do what is necessary to reach our destination. Together, we will succeed...we must succeed...because future generations are depending on us. We must never forget that children living with or at risk for mental illnesses and their families across this great nation deserve to receive treatment from a competent and well trained workforce. They deserve an opportunity for resilience and recovery, and they deserve to live a full life in their community.

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A National Initiative to Improve Behavioral Health Workforce Development

Michael A. Hoge

Introduction

There is a national crisis regarding the behavioral health workforce. This crisis is marked by a number of paradoxes that characterize the education of providers in mental health and addiction services. First, graduate programs have not kept pace with the dramatic changes wrought by managed care and subsequent health care reforms, leaving students unprepared for contemporary practice environments. Second, continuing education models persist in using passive, didactic models of instruction that have been proven ineffective in controlled research (Mazmanian & Davis, 2002; Freemantle, Wolf, Mazmanian & Taylor-Vaisey, 1999). Third, non-degreeed and bachelor-degreeed direct care providers, who may have the most contact with consumers, receive very little training. Fourth, consumers and families, who play an enormous care-giving role, typically receive no educational support, nor is their unique knowledge and their experience used in the training of other members of the workforce. These problems of relevance and effectiveness of training are compounded by major difficulties recruiting and retaining qualified individuals as members of the workforce.

Origins of The Annapolis Coalition

Two organizations have joined forces to address this crisis by creating The Annapolis Coalition on the Behavioral Health Workforce. The two founding organizations of The Coalition are the American College of Mental Health Administration (ACMHA) and the Academic Behavioral Health Consortium (ABHC). ACMHA is a national, interdisciplinary body with a 25-year history of efforts to preserve and improve the quality of behavioral health care, with a special emphasis on administration and leadership. Since 1997, ACMHA has convened the Santa Fe Summits on Behavioral Health, which have brought national leaders in the field together to address topics such as quality improvement, practice guidelines, education and training, financing of services, and cultural competence. ABHC is a non-profit membership organization comprised of universities and their departments of psychiatry. Its mission is to foster the adaptation of academic behavioral health departments to the changing health care environment and to promote reform in the arenas of clinical care, education, and managed care.

Mission of The Annapolis Coalition

The members of the Annapolis Coalition on the Behavioral Health Workforce are engaged in efforts to build a national consensus on the nature of the workforce crisis, promote enhancements in the quality and relevance of education and training, and improve recruitment and retention to the field. Draft objective, mission, and vision statements (described below) and a draft set of strategic workforce goals (Table 1) have been circulated by the Coalition for public review and comment.

Objective. To forge a national plan of action to strengthen the behavioral health workforce.

Mission. To ensure the availability of a workforce, sufficient in size and skill, to meet the needs of individuals with mental illnesses and substance use disorders by providing care that is safe, person-centered, effective, efficient, equitable and timely.¹

Vision. With respect to the workforce, we envision a future in which:

- persons with mental illnesses, substance use disorders, and their families are empowered through knowledge and skills, valued as full partners in the treatment process, recognized for the care they provide to themselves and others, and called upon to educate members of the workforce about these illnesses;
- a culturally diverse group of individuals who value and respect persons with these illnesses are recruited to work in this field and are retained through career paths that offer continued professional growth, mentoring, and compensation commensurate with the requirements and responsibilities of this work;
- those who provide treatment and prevention activities engage in a process of lifelong learning, informing their work with the most current scientific evidence and offering interventions that are most likely to be effective;
- educators use teaching strategies of proven effectiveness to assist students and trainees in achieving and demonstrating the competencies that are essential for practice in a rapidly changing healthcare environment; and
- systems, organizations, and interdisciplinary teams that provide services actively support the recruitment, retention, continued development, and competent performance of individuals in the workforce.

Table 1
Strategic Workforce Goals

1. Empower consumers and families as caregivers and educators;
2. Recruit and retain a qualified workforce in adequate numbers;
3. Use effective training strategies;
4. Employ competency-based approaches for workforce training and development;
5. Engage members of the workforce in a process of life-long learning;
6. Develop managers and leaders for all segments of the workforce;
7. Ensure that workforce education, development, and oversight processes (certification, licensure, accreditation) have relevance to current practice;
8. Use interdisciplinary training to teach interdisciplinary practice;
9. Ensure that systems of care and the organizations within them actively foster and support competent performance of individuals in the workforce; and
10. Secure financing that is adequate to maintain a qualified workforce and create incentives for excellence.

¹The "six aims" of care are adopted from the Institute of Medicine's *Crossing the Quality Chasm: A New Health System for the 21st Century* (2001).

Activities of the Annapolis Coalition to Date

The Annapolis Coalition's principal activities have focused on knowledge development, network creation, and consultation and technical assistance. Members have synthesized published recommendations on strategies for improving the quality and relevance of workforce education and training—the goal being to identify innovation in workforce education, as well as change strategies and tactics for overcoming the obstacles to educational reform. Another primary function of The Coalition is creation and maintenance of a network of stakeholders concerned about the future of the workforce; this entails linking those who have similar interests, and those who can be of assistance to each other regarding innovation, curriculum content, teaching strategies, etc. To support this network and identify best practices in workforce education, educational events for stakeholders and national working meetings have been convened. Finally, drawing on this knowledge base, Coalition members now provide expert testimony to national initiatives on workforce issues, provide consultation to states and others regarding curriculum development and performance-based purchasing of training, and support the Substance Abuse and Mental Health Services Administration (SAMHSA) in the development of a national action plan for improving the workforce.

Project Phases

The work has evolved in five phases:

Phase I: Building Consensus. At the recommendation of SAMHSA leadership and with the support of AHRQ, this initial phase focused on developing a national consensus on the nature of the workforce crisis and key strategies of reform. To accomplish these objectives, a meeting of 65 stakeholders was held in Annapolis, Maryland on September 10-11, 2001. The name of The Annapolis Coalition is derived from this initial gathering of providers, academics, consumers, and family advocates. In advance of the meeting, a series of position papers were prepared and circulated, each outlining the problems and potential solutions for improving the training of various segments of the workforce. During the Annapolis meeting, participants critiqued these papers, which were then revised based on the feedback received and published as a special double issue of the journal *Administration and Policy in Mental Health* (2002).

Phase II: Dissemination of Recommendations. The second phase of this work, funded by SAMHSA, with in-kind support from the founding organizations, involved several elements. Dissemination of the recommendations from the first Annapolis Conference occurred through a dozen presentations at national professional meetings, distribution of over 500 copies of the proceedings to key leaders in the field, and creation of a website, listserv, and database of interested stakeholders. As an outgrowth of these dissemination efforts, The Annapolis Coalition has built informal working partnerships with numerous professional and advocacy groups that are invested in addressing the workforce crisis.

As part of this dissemination effort, Co-chairs of the Coalition formulated and presented a series of recommendations to the President's New Freedom Commission. They then consulted the Commissioners and Commission staff, preparing language on the workforce crisis that was subsequently included in the final report.

The final element of Phase II involved the preparation of five additional position papers, which expanded the intellectual and scientific foundation on which further workforce reform efforts can be built. The papers outline best practices in workforce education, teaching strategies that have an evidence base, a compendium of innovative practices in behavioral health workforce education, children's workforce issues, and the need for substance use disorders training among the mental health professionals. These papers were subsequently published as a special issue of *Administration and Policy in Mental Health* (2004).

Phase III: Focus on Competencies. SAMHSA awarded The Annapolis Coalition funding for a third wave of activity focused on furthering the use of competency-based approaches to building a stronger workforce. Four position papers were developed in this phase, drawing heavily on advanced work

on competencies in business and general medicine. The topics included: fundamental concepts and definitions; strategies for building competency models; tools for assessing competency; and progress in competency development for key segments of the behavioral health workforce. This phase of work included convening a second national meeting, focused on competencies, in Annapolis, Maryland on May 10-11, 2004. The papers developed as part of the focus on competencies were published as a third special issue of *Administration and Policy in Mental Health* in May 2005.

Phase IV: Consultation to the Institute of Medicine. As part of the work of the Institute of Medicine's (IOM's) Committee on Crossing the Quality Chasm, Adaptation to Mental Health and Addictive Disorders, the Annapolis Coalition was commissioned by the IOM and SAMHSA's Center for Mental Health Services to prepare a white paper for the Committee on Behavioral Health Workforce Issues. The Coalition Co-chairs collaborated with Eric Goplerud of George Washington University as a co-author of the white paper. Dr. Goplerud is an expert in substance use disorders treatment and workforce issues.

The Annapolis Coalition also convened an expert panel comprised of consumers, family members and professionals from the mental health and addiction fields to generate a report of recommendations for the IOM Committee to consider including in its final report.

Phase V: National Strategic Plan. Again with support of SAMHSA (in this instance, a joint funding effort of the Office of the Administrator and the Directors of the Center for Mental Health Services, the Center for Substance Abuse Treatment, and the Center for Substance Abuse Prevention), The Annapolis Coalition has entered the most ambitious phase of its work.

Over the course of calendar year 2005, The Coalition will undertake two major tasks: (1) creation of a national strategic plan on behavioral health workforce improvement, and (2) providing technical assistance to the field on workforce issues. The national technical assistance effort will focus on consultations, clearing house functions, an improved and expanded Annapolis Coalition website, creation of a database of stakeholders, list-serves, and other activities. The national strategic planning process is designed to seek broad input from the field in order to identify a core set of practical, viable strategies for strengthening the workforce. A variety of strategies are in place to seek input and expert opinion on the highest priority elements of an action plan, and the net is being cast as broadly as possible to ensure the relevance of the findings. The action plan expands the work of The Coalition from its initial focus on education and training to now include issues of recruitment and retention.

Vehicles for development of the national plan include: engagement of senior advisors in selected content areas; creation of expert panels; review of existing workforce documents, reports, and literature; presentation of the planning process and requests for recommendations in national meetings; specially convened planning meetings; and open calls for input. The draft plan is due to SAMHSA at the end of 2005, and will be distributed to the field for review and comment in the spring of 2006.

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Challenges and Solutions in Developing the Children's Behavioral Health Workforce

Larke Nahme Huang

Introduction

The need for “significant changes in practice models and in the organization of services to improve access, quality and outcomes in mental health” was described in a report from the President's New Freedom Commission on Mental Health (2003). The Commission recognized that changes are needed, both in terms of who does the work in mental health and how that work is done. There are a number of challenges that must be addressed in order to accomplish those changes.

Challenges for the Children's Workforce

Workforce issues are particularly critical in the child and adolescent area. The mental health needs of children and adolescents are complex, as they are constantly changing and those changes are linked to developmental stages. Children and adolescents with mental health needs interact with multiple child-serving systems that are “fluid and unboundaried” (e.g., child welfare, education, juvenile justice, substance abuse, childcare, early intervention, etc.). Traditional mental health service delivery has involved child psychiatrists, psychologists, clinical social workers, psychiatric nurses, case managers, and others. However, there are other nontraditional resources such as parents and paraprofessionals who are positioned to partner in providing mental health services to children and their families. Indeed, family members have described themselves as an untapped “silent army” ready to partner with professionals although many professionals do not understand or make effective use of partnerships with families in treatment.

Demographic challenges. There are demographic trends that have significantly influenced the challenges facing the workforce area in children's mental health. It is projected that by 2030, there will be more than 83 million children in the United States under the age of 18, an increase of 16% over 2000 Census figures. Moreover, the growth rates among ethnic and racial youth are expected to dramatically shift between 1995 and 2015: 74% among Asian American children and youth; 59% among Latino children and youth; 19% among African American children and youth; 17% among American Indian children and youth; and minus 3% among white, non-Hispanic children and youth.

Population challenges. There are also epidemiological trends that will contribute to concern about issues related to workforce development. There are increasing numbers of youth with emotional behavioral problems (Friedman, Kutash & Duchnowski, 1996; Pottick, 2002), including very young children referred for treatment with social-emotional disturbances (Meyers, 2005; Pottick & Warner, 2002). One child in five in the United States has a diagnosable mental disorder and one in 10 has a serious emotional disturbance that causes substantial impairment in their functioning. There are increasing numbers of children and youth with co-occurring mental health and substance abuse disorders (Pottick, 2002; Holden & Santiago, 2002), as well as mental health disorders and developmental disabilities (Emerson, 2003). Children are being cared for by family members who themselves have mental health and/or substance abuse problems.

System challenges. There are a number of key principles that have been identified as critical by the President's New Freedom Commission on Mental Health (2003) if the proposed transformation is to be accomplished. Some of these are system-level issues and are specific to training. There is an overall critical shortage of behavioral health providers, particularly for children from targeted populations (e.g., young, diverse populations, co-occurring disorders, in rural areas). Further, there is a mismatch between the training that universities are providing and the realities of practice. Education must be aligned with the necessary core competencies to adequately serve children with behavioral health needs. Human service providers need to be trained to have the attitudes, behaviors, and skills that are congruent with the changing field of children's mental health. This calls for:

Adopting New Values and Principles:

- Providing services for children in context of family, a “whole family approach”
- Working with the cultures of the child and family
- Best serving children and families in their homes and communities

Adapting to a New Operating Environment:

- Work is collaborative, e.g., cross-agency service planning teams
- Work is interdisciplinary, e.g., broader view of who are the providers
- Outcomes are based on goal of maximizing potential and resiliency
- Using technology and information technology to improve services

The President’s New Freedom Commission provided an opportunity to highlight workforce development issues, reflected in goals 3, 4, and 5 (see Hoge’s summary, above). The development of a comprehensive strategic plan to improve the recruitment, retention, diversity and skills of the workforce is called for. The Center for Mental Health Services (CMHS) has authorized the development of a National Strategic Plan for Workforce Development that includes a Child and Adolescent Workforce Panel with the explicit task of providing recommendations for expanding and improving the children’s behavioral workforce; these recommendations will be included in the National Strategic Plan.

A variety of approaches are being utilized in the following order: (1) gather and review reports, plans, written documents, (2) hold discussion groups at child-focused meetings, (3) make general and targeted requests for recommendations from key stakeholder groups, (4) convene meetings of the Panel to synthesize key recommendations, within the framework of 10 strategic workforce goals, (5) submit recommendations to the National Panel, and (6) sustain a collective voice in the field to move this agenda for children and families forward.

Discussions with State Mental Health Directors

Early discussions with State Children’s Mental Health Directors have revealed a number of trends. They are experiencing: a high turnover rate; a shortage of child psychologists and psychiatrists, particularly in early childhood; a lack of high quality supervision; a lack of bilingual staff, and; a lack of staff to serve rural communities, or who understand rural cultures. A high proportion of the early entry staff is inexperienced and they have to “unlearn” what they were taught in graduate school. Pay is grossly inadequate, with too few benefits. A number of strategies that been implemented by several states are:

- Connecticut: forged collaboration between State Mental Health Authority and State University (UConn)
- Kansas: Kids Training Team at Wichita State uses case managers from the field as trainers/faculty
- Vermont: collaboration with the Federation of Families to put a 7.5% salary increase in the Governor’s three-year plan
- Iowa: working with neighboring states to share clinicians
- South Carolina: telemedicine and telepsychiatry; differential pay for underserved areas; system of care training in medical schools
- Idaho: “new worker academy,” based on system-of-care principles, for child welfare and mental health workers; mandatory during six-month probation period
- Arizona: pre- and post-service workforce trainings by family members and consumers
- Indiana: Technical Assistance center for systems of care that conducts state-wide regional trainings

Selected Recommendations from State Children’s Directors

Recommendations were solicited from the State Children’s Directors pertaining to doable action steps/interventions that are feasible in response to the 10 Strategic Workforce Goals. Their recommendations included: (a) in university pre-training and in-service training, incorporate families as developers of training, and as co-trainers and evaluators across the disciplines; (b) develop a fidelity scale for training in system-of-care values and principles to ensure that the workforce has the competencies required to work in systems of care; and (c) develop benefits, salary and loan repayment incentives to help retain a quality workforce

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Adolescent Substance Abuse Treatment Workforce Training and Development of Effective Interventions for Adolescents

Randolph Muck

Introduction

Since the early 1990s through 1997, the rates of adolescent substance use almost doubled and the number of adolescents presenting for substance abuse treatment increased by 57%. However, as of 1997, there were few published studies of adolescent treatment and many were of relatively weak methodological quality (e.g., low participation rates, high attrition rates, few to no standardized measures, non-experimental designs with just two observations and no comparisons, low sample sizes, low statistical power and weak analysis). Even where there were some promising approaches, there was a lack of manualized approaches that could be readily replicated or disseminated. The state of adolescent treatment and workforce development lagged similarly behind, since there was a paucity of training in interventions related to adolescent substance abuse treatment. Many treatment programs serving adolescents used adult models of treatment that have now been proven to be ineffective.

CSAT Funding Program

Given the dearth of knowledge about treatment for youth and the concomitant lack of proven effective protocols specific to adolescent treatment, The Center for Substance Abuse Treatment (CSAT) began in 1997 to fund studies/programs to develop effective interventions for adolescents that could be transported to the field, using standardized measures, multiple sources of information (e.g., self-report, collaterals, urine screens, records reviews) and with multiple follow-ups at least at 3, 6, and 12 months post intake (the majority of CSAT's adolescent treatment grant recipients have maintained at least 85% participation and follow-up rates of 85-95%).

The Global Appraisal of Individual Needs (GAIN; Dennis, Dawud-Noursi, Muck, & McDermeit, 2002) is the assessment instrument used by the majority of the CSAT funded adolescent treatment grantees since 1997, of which there are currently over 140. The use of a standardized assessment with uniform datapoints for follow-up has allowed for the pooling of data across sites and has led to numerous publications and many ongoing investigations. Currently, with data on over 6,000 youth nationwide, this data set is being used by investigators to answer pertinent questions related to the treatment and outcomes of youth with substance use disorders. Additionally, training and certification is provided to clinicians to use this tool for clinical decision-making, and as a crosswalk to DSM-IV-TR (American Psychiatric Association, 2000) and ASAM Patient Placement Criteria (Mee-Lee, Shulman, Fishman, Gastfriend, and Griffith, 2001).

In 1997 CSAT funded the first grant program geared specifically to adolescents—the Cannabis Youth Treatment (CYT) Study. As a result of this study, five effective outpatient treatment interventions were identified and manualized, allowing for training of clinicians in these interventions. Following CYT other grant programs have evaluated and manualized effective approaches for intensive outpatient and short-term and long-term residential treatment for adolescents that are in the public domain and readily available to program managers and clinicians for use within a variety of settings.

Intervention Program Replication and Workforce Development

In 2003, as a direct outcome of CYT, CSAT funded 22 programs across the nation to replicate one of the treatment protocols developed in CYT (Motivational Enhancement Therapy/Cognitive Behavioral Therapy 5; MET/CBT5) within their treatment programs. Over the next three years this naturalistic experiment of the adaptation/adoption of this protocol into standard clinical practice will be tested. A major goal of this grant program is improvement of the workforce. A national certification program for supervisors and clinicians providing this intervention has been instituted. A train-the-trainers approach has been

developed to allow for ongoing training at local program sites and viability of continued workforce training once the federal funding ends. Individual sites are adding what they believe are clinically necessary adjuncts to the approach, including family sessions and case management. The intervention is being replicated in primary care, juvenile justice, student assistance, and community outpatient treatment programs.

On September 30, 2004, CSAT funded an additional 16 sites to replicate this protocol. In addition to the workforce training in the intervention and the GAIN, a cohort of those funded in 2004 are involved in a process evaluation to better understand the barriers and facilitators in adopting/adapting a manualized approach within a community treatment setting. This is a response to the needs of program administrators and program managers to understand how to implement effective treatment protocols for adolescents within their community settings.

Across CSAT-funded adolescent programs, upwards of 70% of all youth presenting for treatment have concomitant mental health issues. Additionally, trauma has been identified as an important and frequently occurring experience in the lives of youth who have presented for treatment within CSAT funded programs. Work is ongoing to identify effective treatment approaches and treatment settings wherein these youth can experience the best outcomes. The Addiction Treatment Technology Transfer Centers, funded by CSAT and located in seven regions serving the U.S. treatment system, are providing on-line and face-to-face training for clinicians in these and other areas of need for adolescent treatment providers.

Continuum of Care

Assessment, clinical placement, treatment interventions, and continuing care are all components of a continuum of care. The ability to intervene with youth and step them up, or down, within a continuum of care is recognized as important for a treatment system. To explore how this might be realized within communities, CSAT funded cooperative agreements for the development of systems of care for adolescents with substance use disorders. This program, Strengthening Communities—Youth (SCY), is developing systems of care in a number of communities around the country. This program is also collaborating with SAMHSA's Center for Mental Health Services Comprehensive Community Mental Health Services for Children and their Families program. Training in the provision of effective interventions is one of the major goals of this grant program.

Understanding the importance of continuing care following treatment, CSAT funded 17 residential treatment sites to provide continuing care services after the active phase of residential treatment. This program, known as Adolescent Residential Treatment (ART), and its Continuing Care Component, is in its third year of operation. Clinicians in these programs have been provided training in various models of continuing care (e.g., intensive case management, assertive community reinforcement) and will have much to add to the field in the next several years, both in terms of workforce development and continuing care approaches that provide the best clinical outcomes.

Next Steps

As the number of adolescent programs funded by CSAT has increased, there has been concern about the lack of infrastructure at the state level to support these programs once federal funding has ended. CSAT will award grants to states to develop infrastructure and hire a full-time coordinator for adolescent treatment services throughout the state. Training and supports for program managers and clinicians in community-based settings is one of the requirements for each of the funded sites. These awards are expected to be made during the summer of 2005 and will include a multi-site evaluation component to identify promising practices, policies and procedures that can be effectively transported to other states.

CSAT and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) have initiated planning for a meta-analysis of the experiments to date and to begin a "synthesis" to calibrate the non-experimental evaluation studies. With over 6,000 youth observed at least at intake, 3, 6, and 12 months later, the current CSAT adolescent treatment data set already includes over half the available data in the field. This

project is a direct response to the needs of the workforce to understand practice parameters or the active ingredients in treatment for adolescents to which they must attend to achieve positive clinical outcomes.

Through its discretionary grant portfolio CSAT is dually focusing on developing and identifying effective treatment approaches, and training the workforce in implementation and sustainability of these approaches. These efforts are interwoven across a variety of grant programs and contracts that serve adolescents and their families throughout CSAT.

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Topical Discussion

Building the Workforce Plan for Children

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Introduction

The purpose of this session was to foster discussion around the creation of a National Strategic Plan on Workforce Development in Behavioral Health, which is being sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). This plan is to address issues related to workforce recruitment and retention and to the quality and relevance of workforce education and training. The Annapolis Coalition, which has been engaged by SAMHSA to coordinate the development of this plan, has been seeking broad input from the field to inform the plan's development and recommendations. Participants in this discussion had been invited to attend a preceding symposium, *Building a National Strategic Plan for Workforce Development*, in which an overview of the workforce planning efforts was provided and the process that would lead to the development of the National Strategic Plan was described. In that session there was discussion regarding the workforce crisis in children's behavioral health and preliminary ideas were presented on the essential elements that should constitute the plan as it pertains to caring for children and their families.

The Ten Strategic Workforce Goals of the National Strategic Plan were presented as follows:

1. Empower consumers and families as caregivers and educators;
2. Recruit and retain a qualified workforce in adequate numbers;
3. Use effective training strategies;
4. Employ competency-base approaches for workforce training and development;
5. Engage members of the workforce in a process of life-long learning;
6. Develop managers and leaders for all segments of the workforce;
7. Ensure that workforce education, development, and oversight processes (certification, licensure, accreditation) have relevance to current practice;
8. Use interdisciplinary training to teach interdisciplinary practice;
9. Ensure that systems of care (SOC) and the organizations within them actively foster and support competent performance of individuals in the workforce; and
10. Secure financing that is adequate to maintain a qualified workforce and creates incentives for excellence.

The topical discussion session was designed as a highly interactive discussion in which participants were encouraged to share their ideas about practical and achievable strategies for improving the behavioral health workforce. This summary reflects ideas presented during this session pertaining to workforce development in the mental health field, feedback related to the ten strategic workforce goals previously identified by the Coalition, and possible interventions that may be effective in implementing the goals. Common themes that were evident throughout the session related to: characteristics of the future workforce, recruitment and retention incentives, and organizational culture; family/consumer involvement and cultural competence; skills development and training; and the role of government, policy makers, guilds, and licensing regulators. Specific issues/strategies related to each of these themes are described below.

Characteristics of Future Workforce, Recruitment and Retention Incentives

A number of recommendations were made pertaining to the characteristics of the future workforce and ways in which the organizational culture can enhance the recruitment and retention of providers. The need to develop a system of education *and* training was emphasized whereby the benefits of each are clearly defined. It was suggested that the concept of "workforce" needs to be broadened beyond

those individuals in traditional mental health to include those who provide a host of services in the care of children (e.g., pediatricians and other health providers, paraprofessionals, families and youth). Much better incentives to recruit and retain providers (including increased salaries) are needed, as well as an organizational culture that supports front line staff. Supervisors must recognize the importance of training for front line staff and coaching.

Family/Consumer Involvement and Cultural Competence

The shift in families' roles from consumers of care to genuine partners must extend to professional training programs. Family members, as well as youth, should be included in both the design and provision of training. Youth participants sensitized the group to the assumption that "family" also includes youth, which may not be the case; youth voice is imperative. Ways in which family members could be supported were discussed, including stipends, "train the trainer" programs, CEU credits, coaching programs, etc. The need to incorporate cultural and linguistic competence into workforce development initiatives was emphasized.

Skills Development, Training, and Internships

Several strategies were discussed and recommendations made for enhancing skills development and training in the behavioral health field. Education and training should not be defined by discipline, as is the case by professional guilds, but rather should be tied to core competencies, skills, *and* practices. A standard curriculum could be designed to enhance those competencies, focusing on the knowledge, skills and attitudes consistent with current values and principles of systems of care. The need for alternative educational and training opportunities, such as the SOC Professional Training Consortium, was stressed. It was acknowledged that there is not a "Child and Family Behavioral Health Care" program currently. It was suggested that we look beyond traditional disciplines, and possibly create such a degree so that people enter the field by design, rather than through other disciplines such as social work, public health, etc. In addition, a Behavioral Health Institute could be established at a state level that focuses on broad training of the workforce, with an emphasis on life-long learning. Finally, the innovative use of technologies was encouraged, possibly borrowing from telehealth strategies.

Role of Government, Policy Makers, Guilds, and Licensing Regulators

Additional suggestions were offered regarding ways in which government, policy makers and professional organizations could contribute to the education and training of a competent, qualified workforce. A call for strong political leadership for children's mental health was made—leaders who champion the workforce are sorely needed. It was acknowledged that professional guilds could play a significant role; however, a mechanism is needed to transform the way that training and workforce development are conceptualized—and should be tied to skills and competencies rather than disciplines.

Concrete strategies suggested included:

- Distinguishing between educational development and oversight (oversight includes licensure and certification [state regulatory issues]);
- Assessing licensing issues and reciprocity state by state for continuity across states;
- Ensuring federal guidelines are followed at the state level; having available a listing of recommended guidelines that have been published at the federal level;
- Developing individual plans for addressing workforce issues state by state;
- Working with funders and states regarding licensure and reimbursement for more professionals and expand who can be reimbursed, to include paraprofessionals and possibly parents;
- Developing national workforce fellows for each state; and
- Establishing a form of surveillance for data and measurable outcomes; evaluation is needed.

Conclusion

A couple of common themes that emerged were that we need to think of ourselves as “child-serving systems” instead of “mental health providers,” and that there needs to be a combination of demand and reward that entices people to approach workforce development and provision of services differently. We need to identify core competencies, market the competencies, and have accountability. Developing a theory of change for the workforce may aid in this process.

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Topical Discussion

Workforce Development & Emerging Technology in Children's Mental Health

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Introduction

The crisis in mental health care was identified by the former U.S. Surgeon General Satcher's first national report on mental health, with a subsequent conference report focused on children's mental health (US Department of Health and Human Services, 1999, 2001). In 2001, the Institute of Medicine released its report on creating a new health system for the 21st century, increasing quality of care and developing new technologies (2001). More recently, the President's New Freedom Commission report (2003) emphasized the need to utilize emerging technologies, the potential impact on access to care, the application of technology in addressing workforce development issues, and the relevance of the impact of care and workforce development in meeting the needs of underserved populations.

Clearly, advances in new service delivery models and research in treatment effectiveness have outpaced preparation of the human service delivery workforce (Huang, Macbeth, Dodge, & Jacobstein, 2004), resulting in a crisis, both in terms of a shortage of providers and the need for training in new models of care. The academic literature and popular media illustrate shortages in the provision of mental health services to children within private practice, community clinics, public hospitals, and public mental health care systems, including respite care, day treatment, and therapeutic foster care programs. This critical need calls for significant changes in both clinical practice models and service organization to improve access, quality, and outcomes in mental health care, all of which will be challenging—if not impossible to achieve—without a prepared workforce. The purpose of this topical discussion was to introduce three initiatives: (a) the System of Care Professional Training Consortium, (b) the System of Care Curriculum Initiative Listserv, and (c) the Substance Abuse and Mental Health Services Administration (SAMHSA) Human Services Workforce for Children and Families Project, all of which utilize technology in children's mental health to address workforce development issues; participants were encouraged to provide feedback on their potential usefulness.

Workforce Development and Emerging Technologies

Technology has changed the delivery of education and training. Early telehealth and telemedicine initiatives began with the delivery of courses via the media of radio and television. Today, the development of course instruction, delivered through a variety of distance learning methods (e.g., including web-based synchronous and asynchronous communication, e-mail, and audio/video technology), has attracted major university, corporate, and federal participation (Burke, Levin, & Hanson, 2003). These electronic learning environment initiatives increase the number of courses and undergraduate/graduate degree programs being offered without increasing the need for additional facilities.

System of Care Professional Training Consortium

Building on emerging technologies, the Research and Training Center at the University of South Florida, in collaboration with ten other universities, has instituted a System of Care Professional Training Consortium through which coursework in children's mental health, with an emphasis in systems of care, will be offered. In the first year, a Curriculum Committee, consisting of faculty representatives of the participating institutions as well as family members and youth, are working together to plan two web-based/distance learning interdisciplinary training programs—a Master of Science and a Graduate Certificate Program. These programs are being designed to provide a rigorous, values-infused and empirically-based education to individuals in the behavioral health care services field to work with agencies and systems that serve children who have mental health needs and their families, at different developmental stages, within the contexts in which they live.

There are many advantages to forming this System of Care Professional Training Consortium to prepare students to enter the children's mental health workforce. First, the consortium of participating universities can design and offer degree programs and coursework that train professionals in competencies and skills based on system-of-care values and principles, thereby helping to ensure the availability of a qualified workforce. Moreover, this can be accomplished more efficiently through a consortium utilizing state-of-the-art technology than by a single institution, which is noteworthy given the budget cuts that many states and universities are experiencing. Second, the training will be available to a much broader and culturally diverse student body than could reasonably be provided by any one institution, thereby increasing the diversity of mental health providers working with children and families. Third, the Consortium is building upon the strengths of the participating universities in developing its curriculum. Fourth, the accessibility of web-based training will be particularly useful to rural areas, where the recruitment and retention of child welfare workers is especially problematic. Finally, students' experiences will be enriched by the different perspectives of faculty from the participating universities, but also by experts who will contribute through "weekly seminars" via the Listserv.

The System of Care Curriculum Initiative Listserv

A complement to the degree program is an innovative web-based discussion board technology that was recently launched by the Research and Training Center for Children's Mental Health at the University of South Florida. The System of Care Curriculum Initiative Listserv was designed as a resource and communication tool for university educators, students, and mental health professionals who share the system-of-care philosophy and integrate system-of-care values and principles into their provision of services for children and adolescents with serious emotional disturbance and their families.

The purpose of this initiative, which was designed to be used by a broad audience, features document sharing and e-mail subscription services to support the transfer of knowledge within the field and to provide a set of resources and partnerships aimed at incorporating key system-of-care concepts and approaches into curricula. This resource may be used in the development of university-based training programs for new professionals entering the behavioral and mental health field, as well as to retrain and retool existing providers to perform roles and responsibilities for which they have not been explicitly trained.

Unlike traditional listserv or bulletin board applications, this hybrid approach allows registered participants to customize their interactions in several different ways. They may choose to join in a web-based discussion of key topics, utilize the mailbox created by the package for correspondence, or subscribe to topics of interest so that posts in these areas are automatically sent to their preferred e-mail address. This software solution also integrates easy-to-use text editing and formatting, document upload and linking abilities, announcements, and polling features. User access to all features can be customized for each course of study/seminar (e.g., introduction of new topics can be reserved for the moderator/instructor, released upon review by the moderator, or allowed without restriction).

What this means for the delivery of coursework or seminars through the System of Care Training Consortium, is that participants and instructors can post private or public questions and responses, communicate easily among fellow participants, access resources from links, provide documents for review, and receive automatic e-mail alerts to apprise them of new postings. Moreover, this listserv can be used not only by faculty who are explicitly responsible for course offerings, but also to engage national experts as "guest lecturers," exposing students to different perspectives on special topics on a weekly seminar basis.

SAMHSA Human Services Workforce for Children and Families Project

The purpose of the SAMHSA Human Services Workforce Project was to develop a base of common knowledge and understanding about the current status of education and training programs for the human services workforce serving children and adolescents with behavioral health disorders within community-based service delivery systems that are provided under the sponsorship of the public federal child-serving agencies.

As part of its contract with the Workforce Project, the Louis de la Parte Florida Mental Health Institute created a directory that describes web-based training resources that focus primarily on training provided by federal agencies or through funded technical assistance centers, with selected web-based training materials provided by other private and public providers (see <http://www.fmhi.usf.edu/samhsa/>). The project focused on educational and training resources that teach new knowledge, skills, and attitudes to professionals and paraprofessionals serving children with behavioral health needs and their families and address the major components in the system-of-care framework.

All materials in the training directory are catalogued with annotations and describe existing education and training curricula, web-based trainings and web resources for professionals working with children with behavioral health needs, with priorities on those that are consistent with system-of-care values and demonstrate evidence-based and emerging best practices. All items in the database are classed using a controlled vocabulary to ensure precision and relevance for user-based searches.

The database is searchable with both a simple and advanced search engine. The simple search engine features searching (a) by one of the six key domains: Assessment, Cultural Competency, Family Centered, Inter-agency Programs, Strength-based, and Substance Use Disorders; (b) keywords (user-supplied language), (c) for only CEU-based training, and (d) for free (see <http://www.fmhi.usf.edu/samhsa/>) or fee-based training. The advanced search feature allows the user to search across multiple data fields.

In summary, the idea that new technology can cause systemic change is, of course, not a new one. The three initiatives described in this summary demonstrate innovative and viable approaches in workforce development that may fill the gap” between the norm in our educational systems and a vision of what a state-of-the-art, or perhaps state-of-the-science, education could be” (Hoge, 2002, p. 311).

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