BEHAVIORAL HEALTH WORKFORCE EDUCATION: AN ESSENTIAL ELEMENT OF SUSTAINABLE REFORM

Recommendations from

The Annapolis Coalition on Behavioral Health Workforce Education

Presented as Public Comment to the

New Freedom Commission on Mental Health

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1 The Annapolis Coalition was formed as a partnership between the American College of Mental Health Administration and the Academic Behavioral Health Consortium. The work of the Coalition has been supported by those two organizations, the Agency for Healthcare Research and Quality, and the Substance Abuse and Mental Health Services Administration.
BACKGROUND

The Annapolis Coalition on Behavioral Health Workforce Education resulted from growing national concern about the relevance and effectiveness of efforts to train providers of mental health and addiction services. The Coalition was founded by the American College of Mental Health Administration and the Academic Behavioral Health Consortium in order to address four fundamental problems: (1) students completing graduate programs and residency training programs are not adequately trained to practice in the current healthcare environment; (2) practicing professionals receive neither effective continuing education nor the skills to employ emerging evidence-based models of practice; (3) bachelor-degreed and paraprofessional direct care providers are given minimal training in clinical interventions, even though they may have the most contact with people suffering serious disabilities; and (4) consumers and family members are seldom offered training despite the enormous role that they play as primary caregivers. And sadly, the public health perspective on the value of prevention, early identification and early intervention are honored in training programs more in word than deed.

The Coalition has sponsored a national meeting and a continuing national dialogue on this issue. It has released a detailed analysis of these problems and a comprehensive set of recommendations for reform. These were published in 2002 as a special double issue of the journal Administration and Policy in Mental Health, Behavioral Health Workforce Education and Training (Volume 29, Number 4/5, May, 2002).

RELEVANCE TO THE WORK OF THE COMMISSION

In creating the Commission, the President spoke of “cracks” in the system of care. We believe that one root cause of these problems is the chasm that
currently exists between the content of typical training programs and the skills that providers actually need in order to practice safely and effectively. It is a gulf as large as the “quality chasm” in American healthcare that was identified by the Institute of Medicine.

Many examples of the training chasm can be cited. While multidisciplinary approaches are considered essential in the treatment of persons with severe mental disorders, the field continues to train professionals in single discipline silos. Despite the emphasis on evidence-based practice, few members of the workforce receive systematic training in these treatment models. Behavioral health researchers have identified evidence-based approaches to building skills in clinical populations, but these principles and practices are largely ignored in efforts to build skills among our own workforce.

While three-quarters of insured Americans are covered by managed behavioral health plans, students do not develop the skills to work in managed health systems as they are excluded from providing ambulatory services under these arrangements. Even though there is growing recognition of the importance of chronic illness self-management and natural supports, consumers and their family members are too seldom educated about their essential role as partners and decision-makers in their healthcare, and even less often are the experiences of consumers and families tapped to assist in training providers.

Lastly, despite the growing recognition of the importance of culturally competent services to meet the needs of an increasingly diverse population, racial and ethnic minorities are under-represented in the current workforce and curricula lack adequate training in cultural literacy and the multi-cultural complexities of mental health diagnosis and treatment. Training also tends to focus
inadequately on other elements of diversity, including gender, age, and developmental stage.

Members of the Commission have heard, through public comment, from hundreds of people about problems related to access, coordination, cultural relevance, lack of family involvement, and the slow dissemination of model programs. While resource constraints clearly contribute to the ills in our systems of care, many of these ills are compounded by ineffective training. It is generally estimated that over three-fourths of expenditures on behavioral health are expenditures on the workforce. Comparatively few resources, however, are devoted to systematically training this workforce. And when we do train, too often the focus is on outmoded treatments and on preparing students for practice in a traditional health care environment that no longer exists.

Without conscious, concerted, and urgent attention to improving workforce education, the recommendations that the Commission generates may not be achievable or sustainable over time. We urge that the Commission and each of its committees address this crucial issue in your final report to the President.

This issue is an “elephant in the room” for all discussions and efforts to reform the delivery of mental health and addiction services.

Based on our work to-date, the Annapolis Coalition offers a series of specific recommendations for potential inclusion in your final report. We thank you for the opportunity to make this public comment to the Commission, and applaud your willingness to tackle the enormously complex task of improving services to people with mental and addictive disorders.
RECOMMENDATIONS FOR ACTION:

1. That the Secretary of the Department of Health and Human Services issue a national call for all behavioral health education and training programs to conduct a voluntary self-assessment and to make that assessment available to the public. These “New Freedom Educational Self-Assessments,” as they might be known, would address a standard list of domains in an effort to identify for each program the extent to which

- Evidenced-based practices are taught
- Teaching methods are of demonstrated effectiveness in building skills
- Competencies to be acquired are identified and the competency of individual trainees is assessed
- The curriculum covers skill development related to
  - Clinical, rehabilitative, and recovery approaches to treatment
  - Communication and shared decision-making with consumers and families
  - Maximizing patient safety and reducing errors in care
  - Practicing in managed health systems
  - Treating persons with co-occurring mental illness and addictions
  - Collaborating with primary (medical) care providers
  - Providing culturally competent care
- Training experiences are interdisciplinary
- Training sites and experiences parallel those that trainees will encounter after training completion
- The diversity of the community is reflected by those preparing to enter the clinical workforce
- Consumers and families have a role as educators in the training program
And further, that the Secretary create, through the Substance Abuse and Mental Health Services Administration (SAMHSA), a website to which participating training programs could post the results of their self-assessment and briefly highlight specific training innovations. This website could serve as a resource for all stakeholders in workforce education and a tool for disseminating information to educators about innovative practices.

This national call for self-assessment could be conducted in a manner that avoids explicitly “prescribing” specific approaches or standards regarding training. An open-ended response format would allow programs great latitude in formulating their responses. However, this process could be effective in bringing attention to various areas of education and training that many believe are in need of reform.

The self-assessment approach would be further strengthened by including a procedure for the training program to solicit and publish consumer, family and payer perceptions of the training program and the preparedness of its graduates.

2. That the Secretary of the Department of Health and Human Services utilize the existing partnership between SAMHSA and the National Association of State Mental Health Program Directors to develop model, portable curricula for the training of direct care staff in the nation’s public sector system. These curricula should be targeted primarily to those members of the workforce who have not had graduate training in the treatment of persons with mental illness or addictive disorders.

3. That the Administrator of SAMSHA establish geographically dispersed technology transfer centers that develop and offer state-of-the-science
education and training to members of the workforce and provide consultation to existing training programs regarding evidence-based educational techniques. This initiative would serve as one strategy within a multi-year plan to move “science to services” for people with mental illness. Economic efficiencies might be achieved by linking these new centers to the existing Addiction Technology Transfer Centers (currently funded by SAMHSA through the Center for Substance Abuse Treatment).

4. That the Secretary of the Department of Health and Human Services promote evidence-based practice and evidence-based education by requiring that: (a) all federally supported educational meetings, conferences, and training programs demonstrate the use of evidence-based teaching strategies, and (b) all federally funded initiatives to develop or improve treatments include a plan to foster sustainable change in practice by simultaneously creating instruments such as fidelity measures, competency models, and educational toolkits.

5. That the Secretary of the Department of Health and Human Services direct that policies and procedures be developed in all federally supported health plans (including managed care plans) to foster the participation and reimbursement of appropriately prepared and supervised trainees. The objective of this initiative will be to foster the acquisition of students’ skills for practice in the nation’s current health system of hospital-based and ambulatory care by allowing their participation in that system.

6. That the Secretary of the Department of Health and Human Services direct that NIMH, NIDA, NIAAA, and SAMHSA include specific set-asides to support (1) the education of primary consumers and family members in their role as providers and essential partners in recovery oriented services for serious mental illnesses, and (b) research conducted by consumers or about consumerism in behavioral healthcare. This would build on the
admirable work of SAMHSA in supporting peer-operated services and acknowledging the central role of consumers and families in the treatment and recovery process.

7. That the Secretary of the Department of Health and Human Services direct that no training using funds provided by the Department will be expended unless 1) there is evidence of the substantive involvement of consumers and family members in the design and/or delivery of the training, and 2) there is evidence that the curriculum adequately addresses issues of cultural competence and diversity.

8. That the Secretary of the Department of Health and Human Services direct that additional strategies be developed to promote increased opportunities for inclusion of ethnic and racial minorities in the behavioral health workforce to reflect the changing demographics and needs of communities for culturally and linguistically competent providers.

**SUMMARY**

These recommendations have been made with conscious attention to the charge given to the Commission to identify strategies for improving services that are not dependent on identification of new resources. While we understand that charge, we also believe that an investment of additional resources in education and training will be necessary to achieve the desired result of a coordinated, recovery oriented system of care for adults with serious mental illnesses, and for children and families with serious emotional disorders.
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