A National Action Plan for Workforce Development in Behavioral Health

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Across all sectors of the behavioral health field there has been growing concern about a workforce crisis. Difficulties encompass the recruitment and retention of staff and the delivery of accessible and effective training in both initial, preservice training and continuing education settings. Concern about the crisis led to a multiphased, cross-sector collaboration known as the Annapolis Coalition on the Behavioral Health Workforce. With support from the Substance Abuse and Mental Health Services Administration, this public-private partnership crafted *An Action Plan for Behavioral Health Workforce Development*. Created with input from a dozen expert panels, the action plan outlines seven core strategic goals that are relevant to all sectors of the behavioral health field: expand the role of consumers and their families in the workforce, expand the role of communities in promoting behavioral health and wellness, use systematic recruitment and retention strategies, improve training and education, foster leadership development, enhance infrastructure to support workforce development, and implement a national research and evaluation agenda. Detailed implementation tables identify the action steps for diverse groups and organizations to take in order to achieve these goals. The action plan serves as a call to action and is being used to guide workforce initiatives across the nation. (*Psychiatric Services* 60:883–887, 2009)

On September 10–11, 2001, a diverse group of individuals concerned about the future of the behavioral health workforce gathered in Annapolis, Maryland. Persons in recovery, family members, behavioral health advocates, educators, providers, federal administrators, and representatives from accrediting organizations came together to identify major workforce challenges and potential strategies for improving recruitment, retention, training, and education. The focus encompassed the workforce that serves adults and children with mental health problems, substance use conditions, or co-occurring mental and addictive disorders.

There was broad consensus at the summit that the behavioral health field had been facing a workforce crisis of growing proportions (1). As of 2001 the content of graduate curricula tended to lag significantly behind findings in evidence-based research and changes in practice. Continuing education programs primarily used didactic teaching methods that had proved ineffective in changing staff practice patterns. The training provided to direct care staff without graduate degrees tended to be minimal. Also, the roles of consumers and families in the workforce in caring for themselves and each other were too often unrecognized and unsupported. Recruitment and retention and a dearth of emerging leaders to succeed the aging leadership of the field were equally troubling concerns.

That initial summit led to the establishment of the Annapolis Coalition on the Behavioral Health Workforce and spawned a multiyear, phased effort to address workforce issues in all sectors of the behavioral health field. The recommendations from the first summit were widely disseminated at professional conferences and through publication of the proceedings (1). The leadership of the coalition subsequently assisted the President's New Freedom Com-

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Seven strategic workforce goals for the behavioral health system

Broadening the concept of workforce

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

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

Strengthening the workforce

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

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

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

Structures to support the workforce

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

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

mission in drafting language on the workforce crisis for the commission's report (2); commissioned independent reviews of workforce problems and strategies for selected populations, sectors of the field, and treatment approaches (3); conducted a national search for innovative workforce practices in this field (4); convened a second national summit with a focus on workforce competencies (5); advised the Institute of Medicine on workforce issues for its report on the quality of care for mental and substance use conditions (6); and provided technical assistance to numerous states and organizations.

These phases of work set the stage for the development of a national action plan on the workforce crisis. This article reviews the rationale for developing such a plan, highlights the process of development, and describes the seven core strategic goals that serve as the recommended framework for workforce planning and quality improvement in all sectors of this field.

The concept of a national action plan

In this most recent phase of work, the Annapolis Coalition was commissioned by the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop a strategic plan for workforce development that was national in scope. The work was funded by all three centers within SAMHSA: the Center for Mental Health Services, the Center for Substance Abuse Treatment, and the Center for Substance Abuse Prevention. The charge was to develop a core or common set of workforce strategic goals that would be relevant to prevention, treatment, resilience, and recovery across the mental health and addiction sectors of the field and to identify the specific actions necessary to achieve these strategic goals. The national action plan was envisioned to be a resource for bringing increased attention to the workforce crisis and informing the efforts of government agencies, private organizations, and individuals in their efforts to develop and implement a plan of action tailored to local workforce needs.

The planning process

The Annapolis Coalition assembled a team of workforce experts from diverse sectors of the field to guide the planning process. These senior advisors convened a dozen expert panels and work groups that were charged with examining the workforce challenges relevant to child, adolescent, and family care; school-based mental health; consumer and family roles in adult mental health care; cultural competency and disparities; substance abuse prevention; substance use disorders treatment; the care of older adults; rural health care; provider accreditation; training and education; information technology and distance learning; and workforce financing.

These advisors and their planning teams reviewed the published literature and reports on the workforce problems in their sector of the field. They gathered feedback from stakeholders across the nation through a Web-based call for recommendations and through planning sessions held during professional meetings and specially convened planning retreats. It is conservatively estimated that over 5,000 individuals were involved in the planning process over an 18-month period.

Each planning group generated a report of findings and recommendations. Members of the Annapolis Coalition compared the content of these work products and identified a core set of strategic goals that were generally relevant to all sectors of the field. These were reviewed, edited, and approved by the senior advisors, after which the reports from the planning teams were further analyzed to identify a set of objectives necessary to achieve each goal and the specific actions necessary to accomplish each objective. Detailed implementation tables were created that mapped actions to recommended stakeholders, resulting in a blueprint of how the nation, through collective action, could make major progress on the seven strategic goals. The emerging action plan was revised through feedback from the senior advisors and from 200 stakeholders convened by SAMHSA to review the document. The result, *An Action Plan for Behavioral Health Workforce Development* (7), is publicly available at www.annapoliscoalition.org and www.samhsa.gov.

Seven strategic goals

The strategic goals serve as the cornerstone of the plan (see box on this page). The first two center on broadening the concept of the workforce in behavioral health. Goal 1 calls for a significant expansion in the role of in-

dividuals in recovery and of their families in guiding their own care, providing care and support to others, and influencing the knowledge and skills of the traditional workforce. Specific objectives focus on providing more information and education to persons in recovery and their family members (8,9), developing skills in shared decision making (10–13), significantly expanding peer and family support services (14–16), increasing the employment of persons in recovery and family members in the behavioral health care system (17,18), and formally engaging these individuals as educators of the traditional workforce through teaching about the "lived experience" of illness, treatment, and recovery (17,18).

Just as individual consumers identify and address their own needs, so too do communities identify and address their problems associated with behavioral health care. For example, the role of community coalitions in responding to local drug abuse problems is well documented (19). Goal 2 calls for expanding the role and capacity of communities as part of the workforce to identify their local needs and promote behavioral health and wellness. Underlying objectives involve building the competency of communities in needs assessment, capacity building, planning behavioral health and wellness programs, intervention strategies, and evaluation (19,20). Increasing the competency of the existing behavioral health workforce to support and collaborate with community organizations and coalitions is a secondary yet essential objective.

The second cluster of strategic goals is more traditional in nature and focuses on strengthening the behavioral health workforce. Goal 3 calls for systematic efforts at the federal, state, and local levels in recruitment and retention. Reports of recruitment indicate widespread problems in all sectors of the field, and data suggest that high rates of turnover undermine the functioning of service organizations. The primary objective for accomplishing this goal involves the implementation and evaluation of specific interventions designed to address the factors that appear to affect recruitment and retention, which include wages and benefits, nonfinancial rewards, job characteristics, and the characteristics of the work environment. Other objectives entail the expansion of stipends, tuition assistance, and loan forgiveness; a public relations campaign on careers in behavioral health; enhanced efforts to recruit and support a more culturally and linguistically diverse workforce; and increased use of "grow your own" strategies that involve hiring entry-level workers indigenous to the local area and ensuring a viable career ladder for their sustained professional growth. This latter approach is highly relevant to staffing rural areas, recruiting persons in recovery, and attracting culturally diverse individuals into the workforce.

There are widespread concerns that education and training programs have not kept pace with the dramatic changes in health care delivery, not only in behavioral health but in all health professions (21). Goal 4 of the action plan envisions increased relevance, effectiveness, and accessibility of training and education. Specific objectives designed to achieve this goal involve the identification of core competencies for mental health practice, such as those that exist for addiction counseling (22); the refinement of competencies and competency-based curricula for other sectors of behavioral health (23); the adoption of evidence-based education methods (24–26); and a national initiative to ensure that every member of the workforce acquires basic competencies related to both mental and addictive disorders. The absence of such cross-training is one of the most pressing workforce problems.

The current contingent of leaders in the field is approaching retirement, and there are growing concerns about an inadequate pipeline of new leaders to fill the expected void. Goal 5 calls for active leadership development among all segments of the workforce, including professionals, persons in recovery, and family advocates. Accomplishing this goal will entail clarifying leadership competencies unique to behavioral health, providing continuous leadership development opportunities to emerging leaders, and evaluating the impact of these efforts. Focusing on the development of supervisory skills was recommended as the first step in leadership development. It is an issue of high priority given the erosion of clinical supervision and clinical supervisory skills in many service organizations and systems of care (27,28).

The last cluster of goals is centered on the need for improved structures to support the workforce. Goal 6 identifies the need for enhanced workforce infrastructure at several levels. At the federal level, the objectives involve establishing a technical assistance structure for workforce development, a federal interagency partnership to coordinate federal workforce initiatives in behavioral health, and a workforce demonstration fund. Objectives at the provider organization and system level involve increased use of data to track, evaluate, and manage key workforce issues; the strengthening of training and human resource departments; and increased use of information technology to train and support the workforce. At the payer level, changes in the economic market for behavioral health services are necessary; financing methods and funding levels in most systems do not support adequate human resource development (29).

Goal 7 centers on a research and evaluation agenda to address the paucity of available data about workforce characteristics and workforce development practices. A federal, interagency research collaborative is recommended to identify and support research priorities regarding improved workforce performance as a vehicle for achieving better health care outcomes. A second objective is to provide technical assistance to service organizations and systems of care on evaluation strategies to increase their capacity to evaluate the impact of their workforce interventions.

Dissemination and implementation

The strategic plan that emerged from this process distilled a vast body of information, perspectives, and targeted recommendations about the workforce challenges in behavioral health—at all levels of implementa-

tion. It focused attention on a core set of goals and outlined practical action steps for achieving progress on those goals. It built on the work of related reports, such as the SAMHSA Center for Substance Abuse Treatment's 2006 report *Strengthening Professional Identity: Challenges of the Addictions Treatment Workforce—Framework for Discussion* (30). Like any strategic plan, however, its value now lies in how it is used.

Having engaged the Annapolis Coalition to develop the action plan, SAMHSA used the plan as a source to inform its development of subsequent workforce initiatives (31). Also at the national level, the Annapolis Coalition became the behavioral health arm of the National Direct Support Workforce Resource Center. Funded by the Centers for Medicare and Medicaid Services and managed by the Lewin Group, this center provides technical assistance to states in regard to the primarily non-degreed portion of the health and human services workforce that delivers direct services in the long-term-care, developmental disabilities, and behavioral health sectors. This cross-disability effort, which has engaged a large number of federal agencies as partners, emerged from the growing recognition of the workforce similarities across these sectors, including the substantial challenges in recruiting and retaining such workers. Behavioral health has much to gain from these partnerships, particularly because the developmental disabilities and long-term-care workforces that provide direct support have been the subject of more research and policy development than has occurred in the behavioral health sector.

Within behavioral health, major efforts have been made to disseminate the national action plan in written form and through on-site consultations. Formal consultations on workforce planning and development have occurred in over a dozen states in the past year, largely with state agencies but also involving professional and provider associations. In each of these the action plan and its implementation framework were used to inform workforce planning and development activities. Tailored to local and regional needs, these activities have been highly diverse, including statewide behavioral health workforce planning (California and Iowa), cross-disability workforce planning (North Carolina), design support for the development of a training academy (New Mexico), provider agency planning (New York), and workforce development in juvenile justice (Louisiana).

A formal partnership was developed through the mental health program of the Western Interstate Commission on Higher Education to promote adaptation of the recommended strategic goals, objectives, and actions in rural and frontier America. This has led to two Alaska-based initiatives to strengthen the workforce, the first of which involves the development of core competencies for the direct-support workforce across multiple health and human service sectors. The second initiative, based at the University of Alaska Fairbanks and funded by the Robert Wood Johnson Foundation and the Hitachi Foundation, involves developing and implementing a competency- and workplace-based learning model for Native Alaskan behavioral health counselors serving remote villages in the state (www.jobs2careers.org/SecondRoundGrantees.php). The workforce-based learning model, which is being promoted by the foundations (www.jobs2careers.org/workbased.php), has significant potential as a staff development approach for the direct care workforce within behavioral health.

Conclusions

A decade ago, workforce development was infrequently mentioned as a pressing concern in the field of behavioral health care. Policy makers, agency directors, and program managers now widely recognize workforce problems as a threat to service access and quality but are often overwhelmed by the magnitude and diversity of the challenges. The unique contribution of the action plan is that it provides a framework for focused workforce assessment and quality improvement efforts by varied stakeholders. Its unique strength stems from the fact that it integrates the knowledge and expertise on workforce development from so many sectors of the behavioral health field and was heavily shaped by persons in recovery and their family members.

The national action plan and the subsequent behavioral health workforce development initiatives that have drawn on this resource are the result of productive public-private collaborations on the broad, but increasingly critical, workforce challenges facing the field. As the boundaries among the public, private, and nonprofit sectors have softened, federal powers have shifted largely to state and local governments. Governments at all levels have turned increasingly to private organizations as vehicles for planning, technical assistance, and project implementation (32). Responsibility for workforce issues is strikingly diffuse, which makes the need for ongoing public-private collaboration on strategic planning and action an imperative if the field is to successfully attract new recruits, train and develop its workforce effectively, retain members of the workforce in lifelong careers, and ultimately improve the quality of care provided to consumers, families, and communities.

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