

# Appendix L:

## **Strengthening Iowa's Mental Health and Developmental Disability Workforce: Building and Sustaining Competencies**

A White Paper Developed by

Allen Parks, EdD, MPH – Director  
Division of Mental Health and Disability Services  
Iowa Department of Human Services  
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# Strengthening Iowa's Mental Health and Developmental Disability Workforce: Building and Sustaining Competencies

Allen Parks, EdD, MPH – Director  
Division of Mental Health and Disability Services  
Iowa Department of Human Services  
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## Background on Mental Health and Developmental Disability Workforce Development

There is a crisis nationally and in Iowa regarding the workforce that delivers mental health and developmental disability services. It is characterized by serious workforce shortages, difficulty recruiting employees into careers and into positions in these fields, high turnover rates, lack of access to relevant and effective training, and the slow pace with which the evidence on effective care informs the practice of the workforce.

Demand for healthcare that is both clinically –effective and cost-effective has led to the proliferation of practice guidelines (such as those promulgated by the American Psychiatric Association) and to increasing demand for evidence-based approaches to behavioral health care (such as the Substance Abuse and Mental Health Services “Toolkits”). However, the fact that there is still wide variation in clinical practice patterns and failure to deliver care in accordance with established guidelines has generated concerns about the competence of the workforce.

*The President's New Freedom Commission on Mental Health in 2003 described the need for “significant changes in practice models and in the organization of services to improve access, quality and outcomes in mental health.” The Commission recognized that substantial changes are needed in both who does the work in mental health and how that work is done.*

Three major reports have underscored concerns in this area. In their landmark *Quality Chasm* Series, the National Academy of Sciences/Institute of Medicine (2001, 2002, and 2003) focused on errors in healthcare delivery. While individual practitioners make errors, the IOM assigned responsibility for quality of care issues to the systems of care in which individuals practice and the educational institutions responsible for preparing those individuals. Quite simply the slow pace of educational reform has left the curriculum in training institutions lagging behind the changes in general healthcare and in mental health and developmental disabilities regarding evidence-based practices, multidisciplinary practice, and managed care approaches.

With an increase in consumerism, demand for more information and meaningful participation in treatment, there has been a major shift away from “traditional” clinical roles. However, the newer, non-traditional competencies, such as shared-decision making with consumers of care, are rarely addressed in training programs. Numerous professional organizations and accreditation entities have studied this issue over the last ten years.

During the period 2001-2004, with support by the federal government, the **Annapolis Coalition on the Behavioral Health Workforce** convened a series of national meetings and expert panels

to build consensus on the current problems and issues in workforce training and to identify potential strategies for strengthening effectiveness and relevance of education offered to all segments of the workforce. The proceedings of these meetings are available at: [www.annapoliscoalition.org](http://www.annapoliscoalition.org). A considered focus of these meetings was on the description of competencies related to the treatment of mental health problems, mental illnesses, substance use disorders, and co-occurring illnesses.

In 2003, the Coalition reported on “Best Practices in Behavioral Workforce Training and Education. The “Best Practices” were:

1. Education and training is competency-based.
2. Students are taught to engage in life-long learning.
3. Practice guidelines are used as teaching tools.
4. Students develop competency with manualized therapies.
5. Teaching methods are evidence-based.
6. Curricula are routinely updated to address the values, knowledge and skills that are essential for practice in contemporary health systems.
7. Skill development focuses on clinical, clinical management, and administrative capabilities.
8. Professional training instills in students an understanding of the competing paradigms of service delivery and the diverse scientific, professional, economic, and social forces that shape healthcare.
9. Students train in treatment programs that are competitive in the healthcare marketplace and are similar to the sites in which they are likely to practice after the completion of training.
10. Training sites are diverse, interdisciplinary, and enable students to follow consumers throughout the continuum of care and the course of recovery.
11. The “workforce” is broadly defined and all segments of the workforce receive training. Training is offered to culturally diverse groups of individuals.
12. Consumers and families are engaged as teachers of the workforce.
13. Teachers and supervisors are experienced in providing treatment and currently involved in the delivery of healthcare.
14. The faculty of training programs is interdisciplinary in composition and represents a diversity of approaches to the delivery of behavioral healthcare.
15. Training programs reward faculty for teaching excellence.

The Annapolis Coalition has argued persuasively that states must broaden their workforce development focus and place much greater emphasis on direct care, paraprofessionals, who comprise more than half of the workforce in most treatment settings. The Coalition wrote:

*“Within the field of behavioral health, formal and substantive training is most often provided to professionals in graduate programs. Unfortunately, the training offered to direct care staff members, many of whom have high school diplomas or bachelors degrees, is generally quite limited. To the extent that training is offered to these latter groups of individuals, it tends to be driven by accreditation and regulatory requirements and focuses on basic topics such as infection control and fire safety. Efforts to offer even minimal training are hampered by the high turnover rates among these segments of the workforce.*

*Within mental health and substance abuse treatment systems, these direct care personnel should receive substantive and ongoing training designed to address the functions that they fulfill during the enormous number of hours that they spend in contact with consumers. Since roughly 80% of resources in behavioral healthcare are human resources, there is no justification for deploying direct care personnel, but leaving them untrained.*

In a similar vein, The Annapolis Coalition has placed emphasis on the need to support and development the capacities of consumers and family members to care for themselves and each other:

*Similarly, much of the care given to individuals with mental and addictive disorders is provided directly by families and by consumers. In some sense, these may constitute the largest, yet most unrecognized, segments of the “workforce”. In addition to their role in providing family and peer support, the recovery movement has emphasized the central and active role that consumers should play in setting personal priorities, establishing the goals of treatment, and selecting services. While there have been notable efforts to develop and offer training about mental illnesses and addictions to families and consumers (i.e., NAMI), the vast majority still receives no substantive education. Concerted efforts are required to provide education that is tailored to the needs of families and consumers, and they should play a central role in developing and refining those educational programs.” (Hoge, Huey & O’Connell, 2003).*

## A Focus on Competencies

Training has historically focused on students or employees participating in a curriculum, without thorough assessment of their skills at the completion of training. There is a major trend underway to change to a new workforce development paradigm that emphasizes building specific competencies, comprises of knowledge, skills and attitudes, with assessment of these competencies at the completion of training.

A national panel of experts convened by the Annapolis Coalition in 2004 issued a set of **general recommendations** on this topic:

1. Behavioral health competencies should be identified and assessed for a broadly defined “workforce” that encompasses: (a) the various providers who deliver care within the formal behavioral health system, (b) members of the general and specialty healthcare system and human service system who routinely encounter individuals with mental health problems or illnesses and substance use disorders, and (c) persons with these disorders and their families.
2. Initiatives to identify and assess competencies in behavioral health must strive to achieve reliability and validity through the use of established methods in the field of competency development.
3. All members of the behavioral health workforce should develop competencies in the identification, assessment, treatment and prevention of mental health problems or illnesses and substance use disorders, including care of individuals with co-occurring mental and addictive disorders.
4. The content of competency-based training and education must be broadened beyond the traditional clinical paradigm, to include prevention, early intervention, rehabilitation, and recovery- and resilience-oriented approaches to care.
5. The traditional focus on the competency of *individuals* in the workforce must be complemented by concerted attention to defining and assessing the competencies of treatment *teams*, *organizations*, and *systems* in which these individuals function.
6. Persons with mental health problems or illnesses, substance use disorders, and the families of these individuals should play a central role in building a competent workforce by having *formal* input into both the identification of essential competencies and into competency assessments of individual providers, treatment teams, service organizations, and systems of care.
7. All segments of the workforce must develop competencies in delivering culturally, linguistically and developmentally appropriate services.

8. Given the prevalence of stigma, disparities in access to care, and inequities in coverage for care for those individuals with mental illness and substance use disorders, a core competency that should be developed by all members of the behavioral health workforce is the ability to advocate effectively for individuals and for groups on individuals who are diagnosed with these disorders.
9. A “competency collaborative” should be established to link the multiple groups and organizations that are developing behavioral health competencies. This collaborative should identify the optimal common or core competencies to be demonstrated by most providers.
10. Federal, state, foundation, and professional association funding priorities should support a health services research agenda that evaluates the link between competent performance and healthcare outcomes.

The following are specific recommendations from Annapolis group on **competencies**:

1. Dedicate a greater proportion of the investment in human resources to developing those resources. Since some 75% of expenditures of MH/BH organizations are for human resources there should be payoff in investing in the individual human resources that comprise any organization.
2. Adopt and integrate the sophisticated methods for competency development and application that are readily available from business and industry.
3. Observe “exemplary” employees in order to identify and describe essential competencies.
4. Provide detailed information about required competencies to direct care staff, supervisors and trainers.
5. Increase the emphasis on developing skills and abilities in training.
6. Performance in “real world” settings should constitute the ultimate criterion of competency.
7. Link competencies to outcomes.
8. Teach students and practitioners to be self-directed learners and problem solvers.
9. Distinguish between Difficult to- and Easier-to-Develop Competencies (what kinds of competencies need a “program” vs. shorter “training”).
10. Shape treatment program to promote competent behavior.

**The Annapolis Coalition stated:**

*“In this era of increased accountability for the use of scarce resources, we can no longer reward students for simply “doing time” in our educational systems. We can no longer afford to teach outdated modes of practice or fail to provide the workforce with the skills that are essential in modern healthcare systems. We no longer have the luxury to assume that students will get their “real” education as on-the-job training after the completion of their “formal” education. No longer should we tolerate the deployment of direct care personnel who have been given no substantive training in the treatment of individuals with mental illnesses and addictions. No longer should we ignore and fail to educate the vast reservoir of human resources that is comprised of consumers, families, and those working in the general medical, school and human service systems, where individuals so often seek help for their psychological and substance abuse needs.*

*There is growing concern about the quality of healthcare in American, accompanied by calls for reform. Improvements in the quality of care will be driven, in large part, by efforts to enhance the education of the workforce. If the field is to make progress in implementing best practices in treatment, it will be essential to implement best practices in workforce education... Human resources are the principal resource in behavioral health. We must nurture these resources and use them wisely.” (Hoge, Huey & O’Connell, 2003).*

## Workforce Development Strategic Goals

From 2005-2007, with underwriting from the Substance Abuse and Mental Health Services Administration, the Annapolis Coalition developed a comprehensive, national strategic plan on workforce development, *An Action Plan for Behavioral Health Workforce Development*. The report has become a template for action to strengthen workforce in a number of states. The plan identifies seven goals, which are consistent with the goals of Iowa's reform of mental health and developmental disabilities services:

- 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.
- GOAL 3: Implement *systematic* recruitment and retention strategies at the federal, state and local level.
- GOAL 4: Increase the relevance, effectiveness, and accessibility of training and education.
- GOAL 5: Actively foster leadership development among all segments of the workforce.
- GOAL 6: Enhance the infrastructure available to support and coordinate workforce development efforts.
- GOAL 7: Implement a national research and evaluation agenda on behavioral health workforce development.

While the work of the Annapolis Coalition cited above has focused largely on mental and substance use conditions, parallels to the field of intellectual and development disabilities are numerous. Recent work in the state of North Carolina has laid out the commonalities across these disorder populations and the potential benefits of a joined effort. (*North Carolina Commission for Mental Health, Developmental Disabilities, and Substance Abuse. Direct Support Professional Work Group Report*, November 2007, Hewitt, Edelstein, Seavey, Morris, and Hoge.)

Iowa's Center for Disabilities and Development reviewed trends in Iowa, noting that issues arise from the confluence of historical trends and from interests, which compete and occasionally overlap. Reviewing the movement to rebalance long-term care, for example, yielded the following observations:

- Community provider capacity to provide HCBS is circumscribed by their ability to recruit and retain competent staff. Workforce issues are reportedly more acute in rural areas.
- Iowa community providers cite both State Medicaid regulations (such as the 20% administrative cap, which limits the resources available for training) and county reimbursement restrictions as barriers to having sufficient funds for paying competitive wages, offering benefits, and training/retaining staff.
- Community providers do not receive rate increases with the same frequency as institutional providers limiting the providers' ability to offer merit or cost of living increases to their employees. Even when they do receive those increases, their effect may be negated by the caps on reimbursement rates or on service units available to individuals.
- There is no centralized resource for specialized disability trainings in Iowa or funding assistance to assure trainings are accessible to all direct care workers. Many providers train staff in-house, and some collaborate in bringing in outside resources for such specialized topics as working with people with dementia or behavioral issues. Iowa

Caregivers Association and others offer a few sessions on the needs of specific populations at their annual members' conferences.

- Anecdotes about inadequately trained HCBS provider staff, high turnover rates and inconsistency in the daily provider team have discouraged some families from pursuing community living options for loved ones.
- Some community providers point to need for funding to decrease the discrepancy in wages and benefits between State Resource Centers and community-based employment.

If Iowa is to build and sustain a workforce capable of offering the highest quality, evidence-based services to its citizens with behavioral health, developmental and other disabilities, the foundation must be its workforce. Continuing to educate and train the workforce in an outmoded fashion cannot continue, and an infrastructure to meet the emerging demands must be created.

## **The Current Mental Health and Developmental Disability Workforce in Iowa**

Iowa's current workforce includes a mixture of categories, disciplines and levels of education. There are significant shortages in highly trained specialties (child psychiatry, individuals cross-trained in treating co-occurring mental illnesses and substance use disorders, individuals cross-trained in treating co-occurring mental illnesses and intellectual/developmental disabilities, etc.) and significant challenges are presented in the recruitment and retention of skilled workers in many of the state's rural communities. Although Iowa has made strides in involving persons with disabilities and their families in the workforce, much work remains to be done. We have much work to be done in assuring the linguistic and cultural competence of our workforce.

For all of these reasons, it is time for Iowa to make a significant investment in the preparation, continuing education, and support for its behavioral and other disabilities workforce.

## **The Proposal**

Training designed for the mental health and disability services workforce in Iowa is sporadic, decentralized, and lacks uniformity. The Mental Health and Disability Services Division of the Iowa Department of Human Services, the Iowa Consortium for Mental Health and the Iowa Disabilities and Development Center propose the creation of a specialized center to take the lead in meeting the state's need for standardized, centralized and customized development of the mental health and disability services workforce to be housed in the Des Moines area. The ultimate organizational structure of this center will require additional exploration, but a white paper prepared for MHDS (see Appendix B) provides some examples from other states. The first steps are to create infrastructure and a workforce collaborative to lead the further development of this workforce center.

In addition, this proposal includes a series of strategies proposed to address Iowa's workforce needs in mental health and developmental disability services. In order to ensure buy-in and demonstrate the utility of the core center concepts, the implementation of a series of training initiatives for high priority workforce development areas will yield tangible results.

### **Vision and Goals of the MHDSTI**

The vision of the proposed Mental Health and Disability Services Training Institute is

*to build a skilled mental health and disability services workforce, including consumers and their families, that will work in local communities, community mental health centers, key state agencies, and service organizations to implement efficient, appropriately applied, and evidence-based services that 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.*

## Programs

The goals will be accomplished through:

1. Train for Competencies
  - Develop training programs designed around worker needs and mental health and disability practitioner competencies and priorities.
  - Develop a standard training program for consumers and families to prepare them to serve as trainers.
2. Offer Comprehensive Evidence-based Training Programs
  - Promote and/or provide high-quality learning opportunities in accessible settings and formats in an “evidence-based” way.
  - Provide systematic, competency-based training programs for key mental health and disability transformation topics.
  - Develop and provide targeted educational initiatives related to the implementation of specific evidence-based practices such as Assertive Community Treatment, Integrated Dual Diagnosis Treatment, Supportive Housing, Illness Management and Recovery, Family Psychoeducation, etc.
3. Build Systems that Support Practitioner Development and Career Ladders
  - Promote credentials and competency-based training requirements for mental health practitioners.
  - Implement training and development of competency-based Supervisory skills.
  - Seek partnerships with colleges/universities and other education providers to meet mutual practice and training needs of both mental health practitioners and students.
4. Build Systems/ Organizations that Support the Use of Evidence-based Practices
  - Support and model the values of mental health transformation towards the achievement of a recovery-oriented service delivery system that is consumer and family driven.
  - Serve as a technical resource to state agencies, community-based organizations, consumers and recovery organizations.
  - Coordinate existing resources to focus on and leverage training for implementation efforts.
5. Disseminate Current Mental Health Practice Research.
  - Provide current and state-of-the art treatment practice information and resources through specialized publications, web-based information, and the use of Telebehavioralhealth and Teletraining.
  - Provide coordinated and targeted technical assistance to Iowa’s provider community to ensure that policy infrastructure modifications are made to ensure that improved practices can be financed and delivered statewide.

## **Strategies and Structures to Achieve the Goals**

Creation of an Iowa Mental Health and Disability Services Institute will require a methodical, multi-phased approach. Each of the elements detailed below is a building block designed to ensure success and sustainability. While these activities are discretely identified and budgeted for accountability purposes, they can and should be activated concurrently as part of a comprehensive planning and implementation design. In addition to the brief narratives provided in each section, a break out of expenditures appears in attached spreadsheets.

The development design proposed has two distinct elements, best described as (a) infrastructure development, and (b) special initiatives. The first provides the underpinnings necessary to keep the ultimate goal of sustainability, while the latter are focused on bringing immediate assistance to high priority concerns of the Iowa system. Creating an Institute in a vacuum will not engage stakeholder participation and buy-in unless the emerging Institute can demonstrate immediate return on investment.

## **Development of the Mental Health and Disability Services Training Institute**

In the winter of 2006 and spring of 2007, the Iowa Department of Human Services (IDHS), Division of Mental Health and Disability Services (MHDS), in collaboration with the state legislature, embarked upon a Mental Health Systems Improvement (MHSI) initiative that included a number of workgroups focusing on systems change. One workgroup focused on evidence-based practices. In 2007, the Iowa legislature (HF909) directed the IDHS to:

**“develop a comprehensive training program concerning such practices for community mental health centers, state resource centers and mental health institutes, and other providers, in collaboration with the Iowa Consortium for Mental Health.”**

In the summer of 2007, the MHDS began a planning process that included the Iowa Consortium for Mental Health, the Center for Disabilities Development, the Iowa College of Public Health, the University of South Florida Mental Health Institute, ZiaPartners, Inc., and the Annapolis Coalition to form the Mental Health and Disability Services Training Institute (MHDSTI). That planning process sought to respond to the legislative mandate to develop a comprehensive training program as stated above.

Also during the summer of 2007 other workgroups were meeting with MHDS that included various stakeholders such as providers, county representative, family members, consumers and advocacy groups. Guided by expert technical advisors such as the Annapolis Coalition and the Iowa Consortium for Mental Health a plan evolved for the creation of the MHDSTI. The MHDSTI was envisioned as a center for evidence-based training on mental health and disability issues for professional and direct care staff providers, family, consumers, including DHS mental health institutes, resource centers, community mental health centers and other community substance abuse and mental health providers. Specific provider populations initially targeted by the MHDSTI were those offering co-occurring mental health and substance abuse disorder services, as well as those providing emergency mental health, children’s mental health, and school mental health services.

Iowa is in the process of transforming its publicly funded mental health system to a consumer and family-driven system that embraces prevention, resiliency, and recovery as guiding principles. Implementing that goal requires shedding old stereotypes of mental illness and replacing them with new attitudes and services that support people with mental illnesses. In the midst of this transition, the mental health system faces a crisis in providing appropriate mental

health services to forensic clients. Without systematic and quality training as well as attention to effective strategies needed for implementation of new practices, the realization of Iowa's transformation goals could be compromised.

This initiative will require dedicated in-state staff and resources to ensure that all relevant partners are included, and that the efforts to develop Iowa's capacities are a constant focus of attention. For the initial year of this effort, we are proposing to hire a Project Director and an administrative assistant to manage all of the elements of the development process; the Project Director should be someone of demonstrated planning and organizing skills, with a good understanding of behavioral and other disabilities services, with additional expertise in the working with both academic and practice communities. In addition, funds are proposed for logistics support to convene meetings, publish reports, and to engage the services of needed consultants.

Total projected cost: \$200,000.00

## **Creating a Workforce Collaborative**

Essential to the success of a statewide effort of this type is an infrastructure to identify and prioritize workforce problems, coordinate or implement interventions, and monitor outcomes. Perhaps most important, an infrastructure is necessary to link and leverage *existing* resources that are available within the state to strengthen its workforce.

The functions of such an infrastructure would include, but not be limited to the following:

**Leveraging** existing resources by:

- Identifying and disseminating information about existing workforce development resources (clearinghouse function).
- Coordinating workforce development efforts among various public and private agencies to achieve efficiencies and reduce duplication of effort.

**Linking** Iowa's mental health and higher education systems in a coordinated effort to develop a pipeline of culturally diverse and appropriately trained mental health providers. This includes:

- Educating educators about current trends in service delivery as a strategy for fostering relevant curricula in the educational system
- Working with the mental health, higher education, licensing systems, and payers to improve career ladders in mental health within Iowa.

**Assessing** routinely the mental health workforce development needs within Iowa, including:

- The magnitude, characteristics, and causes, of recruitment and retention problems, including the impact of compensation and benefits
- The accessibility, relevance, and effectiveness of training and education resources/program.

**Planning** in the form of a biannual strategic plan on mental health workforce development and report on the status of this workforce will be conducted by the Collaborative.

**Implementing** interventions to strengthen the workforce.

**Promoting** employment of consumers, youth, and family members in the mental health workforce.

**Disseminating** best practices in workforce development to employers of the mental health workforce.

**Advising** Iowa's executive, legislative, and judicial branches on workforce issues and policy.

**Applying** for other potential sources of funds to support workforce development.

The structure of the Collaborative would include a General Membership, Executive Committee, Standing Councils, and ad hoc workgroups.

Persons in recovery, youth, and the parents of children and youth with emotional and mental problems would play a major role in all structures.

Technology, in the form of web-enabled conference calls, will be used for selected meetings to maximize efficiency, minimize time and travel-related meeting costs, and foster access for consumers and family members.

The collaborative can serve as the **Advisory Council** to the Institute, ensuring that the voices of key stakeholders are heard, and that all elements of the system are engaged in the selection, design, delivery and evaluation of the work of the Institute. The Collaborative sets the policy direction for the work of the Institute in strengthening Iowa's workforce.

The activities of the Collaborative would be the responsibility of the Project Director identified above in the Basic Infrastructure section; the Institute would staff the work of the Collaborative and provide its administrative home. Resources dedicated to this effort would include logistic support for meetings, development and dissemination of reports, and the services of content and process consultants to advise the process.

Total projected costs: \$150,000.00

## **Special Initiatives**

The Institute should sponsor a series of inter-related initiatives as soon as basic infrastructure is in place. Based on the assessment of the Iowa Department of Mental Health and Disability Services, the following five initiatives should be funded during the first year of the Institute's development. The first initiative (focusing on supervision) is cross cutting and provides the foundation on which the successful dissemination of evidence-based practices can be built and sustained. The remaining five areas focus on areas of urgent need in Iowa's system of care, and addressing them in a manner consistent with the vision of the Institute (using evidence-based methods, incorporating the best science available, etc.) will provide credibility for further elaboration of the work of the Institute.

### Supervision.

A critical element in successful system transformation is intervention at the level of service supervisors. Training clinicians and other direct-care workers in evidence-based practices requires an informed support system; the lynchpin in such a support system is the front-line supervisor. In its national work, The Annapolis Coalition has determined that there has been significant erosion in the role of supervision in service delivery; this has been the case in Iowa as well. The pressure for billable hours has shifted the role of clinical supervision away from the content of service delivery and toward more administrative and financial duties. A concentrated effort to provide training in **effective** supervision is a necessary core step in changing practice. Existing resources are inadequate to address the content of such training, much less to attend to the necessary policy and reimbursement strategies that will need to be developed to shift the system in the direction of evidence-based models.

The resources allocated here would provide for curriculum development and pilot implementation of supervisory training in the MHDS system of providers, as well as the development of relevant policy and protocol changes needed to ensure continuity in the dissemination of new models.

Projected total costs: \$150,000.00

#### Improved Services for Children, Adolescents and Their Families

This is already an identified high priority for Iowa MHDS, and this funding would ensure that there are resources available to the system to support dissemination of evidence-based strategies. Funds would provide for the engagement of experts in identified best practices and for implementation of training sessions and development of fidelity monitoring technologies to ensure that practices are implemented in a way that is consistent with the scientific findings that drive the practice.

Projected total costs: \$100,000.00

#### Improved Emergency Mental Health Crisis Services

Iowa's hospitals are struggling to meet the demands of persons with mental and developmental disorders in crisis, many of whom could be served both more effectively and in a more cost-effective manner by robust crisis and emergency mental health services, including such strategies as "Mental Health First Aid", peer supports, crisis prevention intervention, use of telephone "hotlines", and the like. Funding would provide for the engagement of key Iowa stakeholders, content experts in model design, and provision of basic training in new approaches to emergency mental health crisis services.

Projected total costs: \$100,000.00

#### Co-occurring Disorders

Iowa MHDS has identified co-occurring disorders (especially mental and substance-use disorders) as a high priority population that is currently un- or under-served. In addition, there are many individuals with co-occurring intellectual/development disorders and mental health/substance use disorders who are not receiving state of the art care. Funding would provide for statewide training on science-based interventions, and for the engagement of content experts for curriculum design and training delivery.

#### Direct Care Workforce.

Although there are efforts underway in Iowa to address the needs of the direct care workforce in the development disabilities area, more effort is needed there. According to the Center for Disabilities and Development, there is no centralized resource for specialized disability trainings in Iowa or funding assistance to assure trainings are accessible to all direct care workers. These efforts need to be expanded to begin to reach the direct care workforce in other areas of the MHDS service system, as well. Funding would provide for development of cross-disciplinary competencies, curriculum development, and training implementation for direct care workers in all MHDS service agencies.

Projected costs: \$100,000.00

#### Consumer and Family Training

Self-directed care is a cornerstone of contemporary practice, which has been recognized in the development disabilities field for some time, and is a hallmark of recovery- and resilience-oriented

systems of care for people with mental and substance use conditions. While often given lip service, consumers and families will not be able to engage in effective management and leadership of their recovery plans without training, education and supports. Funding will provide for the use of existing training models (e.g., NAMI's "Family-to-Family" and "Provider Education" tools, the Certified Peer Specialist training models, etc.) or the development of curricula specific to the needs and desires of Iowa's consumer communities.

Projected costs: \$100,000.00

#### Professional recruitment strategies.

Iowa has experienced chronic shortages at the highest end of the workforce: psychiatrists, psychologists, Master's level licensed social workers, and advanced practice nurses. Under this special initiative, Iowa will establish a pool of dollars to offer financial incentives (stipends, loan forgiveness, supplements) to individuals in the high-need categories who are willing to help meet the skills deficits, especially in our rural and frontier communities. We will select those strategies that have been demonstrated to provide results, and match them to candidates who seem most likely to contribute to our system over time. Consumers seeking services in programs for those with chronic and persistent mental illness will benefit from the recruitment, placement and retention of up to eight psychiatrists, doctoral level psychologists or nurse practitioners with mental health specialization. Once placed in programs service the chronically and persistently mentally ill, these practitioners will provide professional mental health services to Iowans that do not receive the services now.

Projected costs: \$200,000.00

### **Building on Existing Strengths**

Iowa is fortunate to have in place existing structures that can support and enhance the development of the Institute. Chief among these are the Iowa Mental Health Consortium and the Iowa Center for Disabilities and Development. These two entities will play a significant role in the development and functioning of the new Institute, and their current work will be amplified and enhanced by the new structure. In addition to their work, there are several proposed federal efforts (specifically related to telemedicine and to enhanced recruitment and retention strategies for hard-to-find specialists) that would significantly broaden the impact of the proposed Institute.

### **SUMMARY**

The case for transformation of services to people with mental and disability services has been made both nationally and in Iowa. Resources for these services have never been sufficient to meet demands, nor is that likely to change. These two imperatives demand that Iowa ensure that every dollar it spends on services in support of people with disabilities is spent wisely, and that public services for people with disabilities are designed and delivered in ways that ensure that they are effective. This cannot happen in the absence of a workforce that is adequately trained and supported to deliver the highest quality of care that can be delivered. The people who receive those services and supports, and the taxpayers, who pay for them, should expect nothing less. The creation of an Iowa Mental Health and Disabilities Training Institute is a defining step in ensuring that Iowa transforms its system to meet the highest standards possible.

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## APPENDIX A

### PROVISIONAL BUDGET IOWA MENTAL HEALTH AND DISABILITIES TRAINING INSTITUTE

#### ELEMENT 1: Basic Infrastructure

Director	\$ 90,000.00
Administrative Asst	\$ 35,000.00
Office support	\$ 10,000.00
Logistics (travel, meals, printing, etc.)	\$ 40,000.00
Contractual Services (consultants, research, etc.)	\$ 25,000.00
<b>Total Element 1</b>	<b>\$ 200,000.00</b>

#### ELEMENT 2: Collaborative

Meetings (Hotel, meals, travel)	\$ 25,000.00
Other logistics (Printing, website)	\$ 25,000.00
Contractual Services Consultants, surveys, commissioned reports, faculty stipends, etc.)	\$ 100,000.00

<b>Total Element 2</b>	<b>\$ 150,000.00</b>
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### **Element 3: Supervision Initiative**

Curriculum design/Technical Assistance	\$ 100,000.00
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Training sessions/materials	\$ 50,000.00
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<b>Total Element 3</b>	<b>\$ 150,000.00</b>
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### **Element 4: C&A Initiative**

Curriculum design/Technical Assistance	\$ 75,000.00
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Training sessions/materials	\$ 25,000.00
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<b>Total Element 4</b>	<b>\$ 100,000.00</b>
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### **Element 5: Crisis Services**

Curriculum design/Technical Assistance	\$ 75,000.00
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Training sessions/materials	\$ 25,000.00
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<b>Total Element 5</b>	<b>\$ 100,000.00</b>
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### **Element 6: Co-Occurring**

Curriculum design/Technical Assistance	\$ 75,000.00
Training sessions/materials	\$ 25,000.00
<b>Total Element 6</b>	<b>\$ 100,000.00</b>

### **Element 7: Direct Care Staff**

Curriculum design/Technical Assistance	\$ 75,000.00
Training sessions/materials	\$ 25,000.00
<b>Total Element 7</b>	<b>\$ 100,000.00</b>

### **Element 8: Consumer and Family Education**

Curriculum design/Technical Assistance	\$ 75,000.00
Training sessions/materials/stipends	\$ 25,000.00
<b>Total Element 8</b>	<b>\$ 100,000.00</b>

### **Element 9: Recruitment and Retention Strategies**

Design and oversight	\$ 30,000.00
Stipends, loan repayments, supplements	\$ 170,000.00

**Total Element 9** \$ 200,000.00

**TOTAL INSTITUTE DEVELOPMENT BUDGET** \$ 1,150,000.00

## **APPENDIX B**

# **Selected State Training and Research Institutes**

*October 11, 2007*

*A brief review for the  
Iowa Department of Human Services*

Prepared by

John A. Morris, MSW & Michael A. Hoge, PhD

The Annapolis Coalition on the Behavioral Health Workforce

The state of Iowa is wise to look toward sustainability of workforce development, and that suggests creating structures that are designed to span agencies, academia and constituent groups to ensure the structure's survival across changing leadership at the level of the Governor, agencies, or Legislature.

The developmental work to create such a structure must be driven by a clear set of principles, and these must be consistently reflected in any activities that are associated with the reform initiatives in Iowa. Drawn from prior work and recent discussions, we suggest that at least some of those core principles include:

- a. Consumer and family involvement in all aspects of the work must be at the forefront in matters of policy, research, training and education.
- b. Cross-agency, cross institution partnerships have to be visible
- c. Creating value for all participants<sup>1</sup> has to be a hallmark; benefits have to accrue to all stakeholders in order for sustainability over time
- d. Cultural and linguistic competency must be operationalized for Iowa in concrete, practical, and effective ways.
- e. Technology has to be used to help overcome barriers created by geography in a state as rural as Iowa.

The Annapolis Coalition team provides these brief thumbnail descriptions as background information for further discussion and investigation. They reflect a range of organizational structures, missions, and levels of financial support.

## **Louis de la Parte Florida Mental Health Institute (FMHI)**

Parent Institution: University of South Florida

Location: Tampa, FL

Organizational structure: Status as a College within USF, headed by a Dean.

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<sup>1</sup> E.g., the state must get answers to questions that matter; academics must have research topics and teaching opportunities that are relevant to their missions; consumers and families must feel that the actions make a difference in their lives; providers have to feel that their staff are more effective; etc.

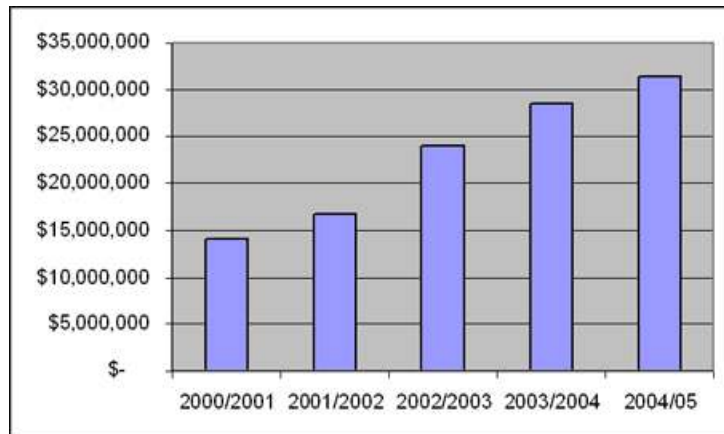
Overview: FMHI is one of the models that emerged from an inpatient service, and it is housed in the former hospital buildings on the campus of USF. They have some modest base funding, but have a very successful track record of pursuing research dollars; they also have a number of contracts with the State of Florida for training (much of it distance-education), staff development, research, evaluation and policy work. They have nationally recognized expertise in both adult and children's mental health, and mental health and law.

Director/CEO: Junius J. Gonzales MD, MBA

Website: [www.fmhi.usf.edu](http://www.fmhi.usf.edu)

Budget: Approximately \$31,000,000.00. See chart below

Since 1986, FMHI's contract and grant activity has grown from \$2 million to over \$31 million. Funding has been awarded for research and development projects from federal and state agencies, private foundations, and corporate sponsors. The history of sponsored research for the past five years is shown in this chart. (Source: FMHI website, 11/14/06.)



### **Missouri Institute of Mental Health (MIMH)**

Parent Institution: University of Missouri (Columbia)

Location: St. Louis, MO

Organizational Structure: Semi-independent unit within the University's Provost Office. Also has linkage to the School of Medicine.

Overview: MIMH also grew out of a large teaching hospital affiliated with the St. Louis State Hospital, and it is housed in one of the historic buildings on that campus. MIMH has been a center of research on consumer-operated mental health services, and is the host for the Internet-based Policy Information Exchange (PIE-on-Line). They pursue federal research and implementation dollars, and have significant contracts with the state for training (much of it distance education), research, evaluation and policy.

Director/CEO: Danny Wedding, PhD

Website: [www.mimh.edu](http://www.mimh.edu)

Funding: Approximately \$5,700,000.00

### **California Institute for Mental Health (CiMH)**

Parent Institution: CiMH is an independent, 501 (c) 3 not-for-profit organization.

Location: Sacramento, CA

Organizational Structure: CiMH was founded by the county behavioral health directors of California to be their research, training and policy support.

Governance is provided by a board of directors, a majority of who are members of the California Mental Health Directors' Association.

Overview: Because California's behavioral health system is largely county-driven; CiMH has historically focused on community-based interventions. They also have many contracts with the state office of mental health, and conduct much training and staff development activity for the state system. One of CiMH's strongest areas has been research and program development focused on the needs of multi-cultural populations. CiMH is currently playing a major role in the implementation of the California Mental Health Act (Proposition 63), which includes significant set-asides for training and workforce development activities.

Director/CEO: Sandra Naylor-Goodwin, PhD

Website: [www.cimh.org](http://www.cimh.org)

Funding: Approximately \$4,500,000.00

### **Nathan S. Kline Institute for Psychiatric Research**

Parent Institution: New York Office of Mental Health

Location: Rockland Psychiatric Center, Orangeburg, New York

Organizational Structure: The Nathan Kline Institute is part of the New York Office of Mental Health.

Overview: The Nathan Kline Institute is one of the last remaining public mental health focused institutes that remains both part of the public mental health system and providing inpatient services. Their website references three priority focus areas: patient-oriented research programs emphasizing the causes,

diagnosis, treatment, prevention, and care of severe and long-term mental disorders; clinically-relevant, basic research on physiological and biochemical aspects of mental disease; and research on the cost, quality, and effectiveness of services for patients in mental health programs certified, operated, and/or funded by New York State.

Director/CEO: Harold S. Koplewicz, MD, Director

Website: [www.rfmh.org/nki](http://www.rfmh.org/nki)

Funding: Budget information not readily available. Core funding comes from the NY Office of Mental Health and the Research Foundation for Mental Hygiene, Inc., an affiliated not-for-profit. The Institute also competes for federal and foundation grant support.

### **Dartmouth Psychiatric Research Center (PRC)**

Parent Institution: Dartmouth School of Medicine

Location: Concord, New Hampshire

Organizational Structure: The Dartmouth Psychiatric Research Center

Overview: The PRC conducts interdisciplinary research on services for individuals who have serious mental illness, primarily schizophrenia spectrum and bipolar disorders. The PRC specializes in developing effective interventions under research conditions, then translating these interventions into actual mental health service practices and evaluating their effectiveness in routine practice settings. PRC research incorporates multiple scientific perspectives, such as clinical, economic, and ethnographic. The PRC works with efficacy and services researchers to address the needs of multiple stakeholders through effectiveness research in routine practice settings. They have been instrumental in developing the SAMHSA funded toolkits for sic evidence-based adult interventions, and consult to state and local behavioral health authorities on a range of best practices.

Director/CEO: Robert M. Drake, MD, PhD

Website: [www.dms.dartmouth.edu/prc](http://www.dms.dartmouth.edu/prc)

Funding: Dollar amount not readily available. Mix of some base funding from NH Mental Health Department and Dartmouth; much support from competitive grants and contracts for training, staff development, etc.

### **Ohio Coordinating Centers of Excellence**

Parent Institution: Ohio Department of Mental Health.

Location: 7 Coordinating Centers of Excellence located at various sites throughout Ohio:

**Illness Self-Management and Recovery CCOE**  
(Medical University of Ohio)

**Clusters CCOE**  
(Synthesis, Inc., Columbus)

**Substance Abuse/Mental Illness CCOE**  
(Case Western Reserve University, Cleveland)

**Mental Health/Criminal Justice CCOE**  
(Summit County ADAMHS Board, Akron)

**Ohio Medication Algorithm Project (OMAP)**  
(Center for Quality Innovations & Research, Cincinnati)

**Center for Innovative Practices – Multi-Systemic Therapy (CIP-MS)**  
(Stark County Mental Health Board, Canton)

**Center for Learning Excellence (CLE)**  
(Ohio State University, Columbus)

Organizational Structure: Each is slightly different, as some are university affiliated and others are based in local not-for-profit organizations

Overview: Beginning in 1992, the Agency for Health Care Policy and Research and the National Institute for Mental Health funded the Schizophrenia Patient Outcomes Research Team (PORT) to develop and disseminate suggestions for the treatment of those living with schizophrenia, based on existing scientific evidence. These recommendations, published in their final form in 1998, were based on in-depth and comprehensive reviews of the "treatment literature" as well as a focus on the treatments that established a substantial evidence of efficacy, or effectiveness. Subsequently, the Ohio Department of Mental Health established seven (7) Coordinating Centers of Excellence to systematically disseminate and implement evidenced-based practices (EBPs) through Ohio's community mental health system. (Source: Ohio DMH website.) Additional description of the model can be accessed in Munetz, MR; Morrison, A; Krake, J; Young, B and Woody, M. (2006) State Mental Health Policy: Statewide Implementation of the Crisis Intervention Team Program: The Ohio Model, *Psychiatric Services*, Vol. 57, 1569-1571, November, 2006.

Director/CEO: Lon Herman, MA, ODMH Director of Residency, Training and Learning

Website: [www.mh.state.oh.us/medicaldirdiv/clinicalbp/clinicalbp.ccoes.html](http://www.mh.state.oh.us/medicaldirdiv/clinicalbp/clinicalbp.ccoes.html)

Funding: Blended funding, with significant state dollars supplemented by federal grants, training contracts, etc.

## **SUMMARY**

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None of the above models is recommended for Iowa, which should develop its own model to meet its unique needs, but they provide examples of structures and designs that have proven successful in assisting states to improve the quality of services.