

# **Innovative Practices in Behavioral Health Workforce Development**

**Final Report**

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**A Project of the Annapolis Coalition on the Behavioral Health Workforce**

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# Innovative Practices in Behavioral Health Workforce Development

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## **Introduction**

With funding from the Substance Abuse and Mental Health Services Administration, this project involved the third national search by the Annapolis Coalition on the Behavioral Health Workforce ([www.annapoliscoalition.org](http://www.annapoliscoalition.org)) to identify innovative workforce practices. The search was organized around eight content areas, which included: (1) persons in recovery and families (adult mental health); (2) child, adolescent, and school-based mental health; (3) cultural competency; (4) leadership; (5) older adults; (6) rural; (7) substance abuse prevention; and (8) substance use disorders treatment. In each content area a senior advisor convened a panel of experts to review nominations for innovative practices in workforce development.

In August 2006, the Annapolis Coalition, with the assistance of senior advisors and panel members, distributed an electronic call for nominations to individuals and organizations across the country. A total of 86 nominations were received and routed to the appropriate expert panel for review. Selection criteria, which were adapted from the Harvard Innovation in Government Award Program ([www.innovations.harvard.edu](http://www.innovations.harvard.edu)), focused on the significance, novelty, transferability, and effectiveness of the nominated practice (see Appendix A). The most notable innovation in each of the eight categories was identified. Additional information on these finalists was obtained using multiple methods, including site visits, phone interviews, and requests for additional documentation about the innovation. Senior advisors and other workforce experts from the Annapolis Coalition provided information and consultation to the leaders of these innovative practices in an effort to lend further support to these creative initiatives.

A summary of each innovation is presented below. These reviews contain a general description of the innovation and discuss its significance, novelty, transferability, and effectiveness. Barriers to implementation and strategies used to address these barriers are also presented. Contact information is provided for each innovation since a condition of recognition was agreement by the leaders of these innovative practices to serve as resources, within limits, to others in the field.

**Core Area:  
Persons in Recovery and Families/Adult Mental Health**

## **The Bay Area Mental Health and Education Workforce Collaborative**

*Target Audience:* graduate students/psychiatric residents; practicing professionals (graduate degreed); non-degreed or bachelor degreed direct care staff; consumers; families; other healthcare or human service providers; educators

### **Innovation Description:**

The Bay Area Mental Health and Education Workforce Collaborative (the Collaborative) is a voluntary coalition of consumers, family members, providers, educators, and other stakeholders, who work together to expand mental health educational opportunities, career pathways, and the public mental health workforce in the Greater San Francisco Bay Area region. The Collaborative was initially developed by the Greater Bay Area Mental Health Directors Association, and includes thirteen county mental health departments. The Collaborative currently enjoys diverse and wide-reaching membership from both the mental health and education communities. Participants include representatives from county mental health, community-based providers, consumer and family member organizations, Mental Health Managers in Recovery, California Association of Social Rehabilitation Agencies, and the California Department of Rehabilitation. Participating educational institutions include California State University East Bay, San Francisco State University, California Social Work Education Council, Saybrook Graduate School, Northern California Consortium of MFT University Programs, Life Academy of Health and Bioscience, and representatives from several Bay Area community colleges.

The Collaborative's primary mission is to support the development of a culturally and linguistically competent, recovery-oriented workforce that includes and supports consumers and family members. The primary focus is on creating mental health educational and career pathways that begin in high school academies and continue through community college certificate and degree programs, colleges and universities, and graduate and professional schools. The Collaborative is serving as the model for the development of regional workforce partnerships across California through the Mental Health Services Act (MHSA) established under Proposition 63.

Meetings of the Collaborative are held once a month. Speakers present on a variety of workforce topics including consumer employment, cultural competency, human resources, staff training, college certificates and degree programs, and statewide workforce initiatives. Each meeting includes updates from each of the stakeholder groups. These updates are highly valued by the members as they provide useful information that is often not shared in other venues. Minutes, job announcements, project notes, policy updates, and conference reminders are distributed through an email list on an ongoing basis.

Projects are based upon regional county mental health workforce and training priorities. The Project Manager has conducted interviews with each of the mental health directors and meets with them on a regular basis to keep them informed on Collaborative activities. Key stakeholders

are involved in the actual design and implementation of each project. Project teams are composed of Collaborative members who have relevant expertise, work within the topic area, and are interested in the project. The Coordinator convenes the project team and the team identifies goals and desired outcomes. The Collaborative developed two tools to assist in project development: a stakeholder framework to ensure appropriate participation and a project matrix to ensure that each project supports strategic goals. The Collaborative recently launched two projects focused on Community Colleges and High School Academies and is working with an evaluation consultant to develop outcome indicators for these efforts.

In 2006, the Collaborative received a Zellerbach Family Foundation grant to support hiring its first full-time Program Manager. In addition, each of the participating counties has contributed funds to cover staffing and operational costs. With new support from the Department of Mental Health, plans are underway to hire a Coordinator and an Administrative Assistant. The California Institute for Mental Health serves as both the Collaborative's employer and fiscal agent. In designing a similar partnership, staff could be employees of a county, a community-based provider, a nonprofit organization, or a state agency.

The Collaborative is a freestanding partnership with voluntary participation, rather than an independent nonprofit or county agency. A Steering Committee, composed of providers, educators, consumers, and other stakeholders, provides oversight and acts as a decision-making body. To provide structure and transparency, the Steering Committee created an organizational framework to define roles and responsibilities.

A major priority of the Collaborative is expanding the participation of consumers, family members, youth, and representatives from the Bay Area's diverse communities. Consumers participate on each project team and specific efforts are underway to engage more family members. The Collaborative is actively considering creating a Consumer Employment Advisory Committee and a Multi-Cultural Advisory Committee to provide advice and counsel.

The Collaborative has learned some key lessons over the past 5 years, which have contributed to its success. Organizational champions from within the service delivery and education systems have provided essential leadership and support from the very beginning. Relationships between the participants have developed over time. Participants comment that they feel people "leave their egos at the door" when they participate in Collaborative meetings, which reflects the trust that has developed among the members. A staff person to lead the effort is essential. Members are engaged and committed, but don't have the extra time to lead projects. Agendas need to provide opportunities for sharing and discussions and encourage contributions from all participants.

**Significance:**

The Collaborative brings partners together to broker relationships between providers and educators; identifies opportunities for collaboration; connects technical experts with partners who need their services; communicates workforce information to members; convenes task forces and project teams; identifies best practices and replicable models; serves as a liaison between

local agencies and state decision-makers; and plays a statewide leadership role with policymakers, providers, and funders.

**Novelty:**

The Collaborative is a unique mental health-educational partnership and is serving as the model for California's regional partnerships, which are mandated by the Mental Health Services Act. The California Department of Mental Health has identified the Collaborative, and regional partnerships, as the state's primary vehicle for education, training, and workforce efforts.

**Transferability:**

The Collaborative's organizational components were designed as replicable models that can be modified to meet local needs. Each project team is systematically documenting and categorizing their work. Regional workforce projects are being identified and summarized in a master directory, to be shared with providers and educational institutions across the state.

**Effectiveness:**

Members commend the Collaborative for playing an essential role in developing strategic partnerships and identifying opportunities for workforce development. Two new projects, with high school academies and community colleges, were recently launched. We are meeting with program evaluation experts to design evaluation tools and methods for use in these projects.

**Implementation: Barriers and Strategies:**

- 1. Funding is needed to hire staff.** Innovative leaders, who had many ideas for projects and initiatives, founded the Collaborative. However, major initiatives could not go forward without a dedicated staff person. The Collaborative applied for a grant to support hiring a Program Manager, received contributions from the regional county mental health directors, and recently received funding from the state's Department of Mental Health.
- 2. The scope of work needs to be realistic.** Given its commitment to expand the size, diversity and capabilities of the mental health workforce, there was a great deal that the Collaborative hoped to accomplish. Guiding principles were developed to build consensus and to align activities with long-term objectives. A work plan was created to help define workforce needs and to identify projects. Today, we evaluate the Collaborative's role, sphere of influence, and accountability for outcomes in each initiative and focus on a small number of discrete projects.
- 3. Relationships take time.** As a voluntary effort, the Collaborative consists of people representing dozens of agencies and institutions. Participants have their own interests and agendas. It takes time to develop trusting, working relationships. Today, participants comment that the monthly Collaborative meeting is "the place to be" and the one meeting that is not eliminated from their busy schedules. The Collaborative adds value to their work, but it took time to reach this point.

4. **Collaboration and joint projects require consensus and structure.** The Collaborative had some early challenges with changing agendas and shifting priorities, which reflected variation in who was attending meetings. As a voluntary effort, attendance changed monthly. Some participants felt that the meetings were unfocused and didn't see their value. The Steering Committee believes that this was part of the learning process and helped to define the Collaborative's purpose. The Steering Committee and the Program Manager developed an organizational framework to provide structure, build capacity and support decision-making. Agendas and presenters support strategic priorities and projects.
5. **Consumers and family members are the key partners in creating a recovery-oriented mental health workforce.** Consumer and family member education and employment are critical components of California's Mental Health Services Act. The Collaborative works closely with many individual consumers and consumer-led organizations, but needs to increase both consumer and family member participation. Consumer and family member advocates are playing a critical role in making these connections and inviting people to the Collaborative.
6. **The Collaborative needs to increase the cultural and linguistic diversity of its members, to reflect the diverse communities that it serves.** Increasing cultural and linguistic competency in public mental health is another critical component of the Mental Health Services Act. The Collaborative focuses on high schools and community colleges as points of entry for culturally diverse students. Culturally diverse providers and faculty members have recommended strategies to increase diversity, including the creation of a Multi-Cultural Advisory Committee, which the Collaborative anticipates developing in early 2007.

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**Core Area:**  
**Child & Adolescent / School-Based Mental Health**

**The Youth Experiencing Success in School (Y.E.S.S.) Program**  
Department of Psychology at Ohio University

**Target Audience:** graduate students/psychiatric residents

**Innovation Description:**

The Youth Experiencing Success in School (Y.E.S.S.) Program is a school mental health program that offers multi-tiered, interdisciplinary training for graduate students at Ohio University in the clinical child specialty area of the Psychology Department and social work students. The Y.E.S.S. program was developed through a university-community partnership to enhance the use of evidence-based interventions in schools, improve academic and behavioral functioning of children, enhance home-school collaboration and support services for parents, provide ongoing collaborative consultation for teachers, augment inter-agency care coordination, and conduct program evaluation. The Y.E.S.S. program blends resources and expertise from multiple perspectives to provide evidence-based services that optimize development for youth with early-onset behavioral difficulties.

With funding from the Ohio Department of Mental Health (Residency and Training Program) and the Health Resources and Services Administration (Quentin Burdick Program for Rural Interdisciplinary Training), Dr. Owens and her colleagues have developed a multi-tiered, interdisciplinary training program within the Y.E.S.S. Program to achieve the following aims:

- Tier I involves a year-long, intensive field placement in which graduate students from psychology and social work provide evidence-based practices in collaboration with community agencies and elementary schools. In this field placement, students are in the schools for 15 -20 hours per week, engaging in interdisciplinary assessment, treatment planning, consultation, and intervention delivery. The services provided are those that have substantial empirical support for improving academic and behavioral functioning in children with inattentive and disruptive behavior problems (i.e., behavioral parenting sessions, classroom interventions such as the daily report card, collaborative teacher consultation). This tier involves both interdisciplinary teamwork as well as collaborative partnerships among school personnel, university personnel, community providers, and families.
- Tier II involves a series of interdisciplinary seminars on topics relevant to interdisciplinary practice in schools. Competencies being developed through this series include understanding and valuing the unique contributions of different disciplines (e.g., education, speech, medicine), knowledge of laws and policies affecting schools, the ability to blend scientific evidence from multiple disciplines, and knowledge that facilitates the integration of mental health into the school culture.

- Tier III involves an interactive, interdisciplinary videoconference training series with psychiatry faculty and residents from the Cleveland Clinic Foundation. This series provides an innovative medium for discussing evidence-based practices within each discipline and culturally competent care within rural and urban settings. It also develops interdisciplinary consultation and collaboration skills.

Students are given experiential training opportunities through which they build competencies that prepare them for research and clinical practice in an interdisciplinary climate. Broadly, the training program uses case-based learning and innovative technology to achieve several aims: enhance knowledge and skills associated with delivering and evaluating evidence-based practices in community settings; develop competencies related to interdisciplinary collaboration in the context of university-community partnerships; educate pre-professionals about rural mental health practice; and expose trainees to innovative technology. All of these contribute to retention of professionals in Ohio and in rural communities across the nation.

Given the national shift taking place in mental health service delivery, the Y.E.S.S. Training Program provides innovative training experiences to better prepare professionals for new models of service delivery.

**Significance:**

National initiatives are calling for enhanced delivery of school mental health services, as well as cross-discipline, coordinated care mechanisms. The Y.E.S.S. Program engages in both of these innovations and simultaneously provides experiential training in interdisciplinary research and practice. Successful strategies for retaining mental health professionals in rural communities include providing training experiences in rural settings and enhancing professional's comfort with technology that facilitates collaborative care. The Y.E.S.S. Program exposes students to service delivery in rural Appalachia and to videoconference technology in hopes of enhancing retention in rural communities.

**Novelty:**

The Y.E.S.S. Program departs from business-as-usual in several ways. First, students are not trained in isolation. Weekly, psychology and social work trainees interface with professionals from multiple disciplines and engage in interdisciplinary assessment, treatment planning, intervention and problem solving. Second, the Y.E.S.S. Program continually examines the effectiveness of evidence-based practices in community settings. Thus, students learn how to simultaneously engage in research and practice in real world settings. Third, students observe the processes involved in the development and maintenance of university-community partnerships. Finally, by providing experience with videoconference technology, we teach students how to be early adopters of innovation.

**Transferability:**

The Y.E.S.S. Program continues to develop the clinician training manual to guide interdisciplinary delivery of evidence-based practices for youth with disruptive behavior

problems in schools. The model is currently being tested for delivery by community mental health professionals. Through this dissemination process, we are obtaining data and learning valuable lessons to enhance the transferability of the training and service delivery model. Selected seminars from interdisciplinary training series have been videotaped and available upon request. Paper content discussed in the interactive videoconference series and interdisciplinary trainings is available for transfer.

### **Effectiveness:**

The training program is valued by the Ohio Department of Mental Health as evidenced by three years of funding. In evaluations associated with Tier I, trainees report enhanced knowledge of evidence-based practices, and enhanced awareness of the value of school-mental health partnerships and interdisciplinary approaches to care. Trainees report that the videoconference series increased their comfort with technology, the likelihood of using technology in the future, their appreciation of other disciplines, the likelihood of consulting with other disciplines in the future, and their understanding of the challenges associated with service delivery in rural areas. To date, 71% of program completers have remained in Ohio's mental health workforce.

### **Implementation: Barriers and Strategies:**

There are several barriers associated with providing experiential interdisciplinary training in school mental health.

1. The first set of challenges is associated with engaging in school-based service delivery. Initiating a university-community partnership can be challenging because often times schools have had past experiences with universities that are less than desirable (e.g., in the context of research; when grant funding ends and programs terminate). Once a relationship with the school district has been initiated, it is critical that the perceptions and needs of multiple stakeholders within the system (e.g. superintendent, principals, and teachers) are considered. For example, when it comes to behavioral interventions for disruptive behavior problems, teachers are considered front line providers of evidence-based interventions. Thus, it is critical to find creative solutions to engaging teachers in the context of the many competing demands for their time and attention. While school mental health has many benefits (e.g., early identification), one draw back is that teachers are likely the first person to bring the problem behavior to the attention of the parents. Thus, parents may not be aware of or may not agree that their child's behavior deviates from the norm. These beliefs likely have a significant impact on parents' willingness to initiate treatment. Thus, additional attention and resources may need to be devoted to addressing early parent engagement. Further, when student interns are providing on-site services in schools, space is tight and inter-professional turf issues may present challenges to service provision.

We have addressed many of these challenges by engaging in a year-long planning process before service implementation began and by engaging in monthly Y.E.S.S. Program partnership meetings to facilitate open communication across stakeholders about program implementation and modifications, shared space, avoiding redundancies in services, mechanisms for program sustainability, and addressing inter-professional challenges. To

address high demands on teacher's time, the school district hires a floating substitute teacher who is available on a bi-weekly basis throughout the year to allow teachers to schedule undivided consultation time with the Y.E.S.S. Program clinician. During this time, clinicians and teachers engage in ongoing assessment, intervention design and modification, and cross-education to maximize effectiveness of treatment planning. To address parental engagement, we have created programming materials that are free of pejorative and stigmatizing language, and we have educated teachers, principals and student clinicians about methods of communication that are welcoming to parents, that communicate a team approach, and that address early parent concerns or hesitations.

2. The second set of challenges is associated with transforming training within a clinical psychology doctoral program. In order for students to meet professional training standards and university requirements, the graduate level curriculum and student schedules can be fairly inflexible. Additional challenges include paying for student stipends, paying for student travel to schools, and obtaining quality supervision from an appropriately credentialed professional.

We continue to grapple with these issues, but to date have addressed these challenges through multiple mechanisms. First, we have coordinated the Y.E.S.S. Program with our department's child practicum course and off-site traineeship so that students can receive course credit for their experience in Y.E.S.S. Similarly, we have coordinated with the Department of Social Work so that social work students receive field placement credit. In addition, we have arranged for students to receive seminar credits for the additional interdisciplinary training events. We have secured funding through training grant mechanisms that pays for student stipends, faculty release time for program development and interdisciplinary planning, clinical supervisors, and manual and website development.

3. Finally, interdisciplinary care is challenging on its own. Providing quality training in the context of interdisciplinary care requires extensive planning, cooperation among disciplines, and creativity to overcome barriers that are unique to each discipline.

Using data that demonstrate program effectiveness, we have secured funding from the school district and the county juvenile court that contributes to teacher in-service trainings, the substitute teacher, student stipends, clinical supervisors, and administrative staff.

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**Core Area: Cultural Competency**

## **Center for Multicultural Human Services**

**Target Audience:** providers; program developers; consumers/persons in recovery

### **Innovation Description:**

The Center for Multicultural Human Services, located in Fairfax, VA, is an agency that offers immersion training to graduate students and pre-doctoral interns, as well as technical assistance to professionals, agencies, and communities, regarding a unique model of service delivery that addresses the multifaceted needs of immigrants and refugees in the U.S. The Center's service model involves a comprehensive assessment along with a wide range of mental health, social, educational and legal services in 35 languages. Started 25 years ago, the agency operates from a philosophical base that recognizes the reality that most immigrants and refugees seeking help have needs in multiple areas, all of which must be addressed simultaneously if they are to move from crisis to healthy functioning. The Center for Multicultural Human Services has developed an innovative assessment instrument that helps to quickly identify the client's functional level in six major domains, including acculturation. This comprehensive approach, combined with culturally sensitive staff, has proven highly successful and has been recognized as a unique model of service delivery.

This unique model of service delivery is the foundation of the training and technical assistance programs that the Center for Multicultural Human Services has developed. Currently, the agency provides training and technical assistance at three levels: the Graduate Internship Field Training (G.I.F.T.) Program; the Psychology Pre-doctoral Internship Program; and, its Technical Assistance and Training Center (TTAP), which has received funding from RWJF to further develop capacity to provide technical assistance to communities across the U.S. that wish to respond more effectively to the human service needs of immigrants and refugees.

The G.I.F.T. Program provides year long training internships to graduate students in Social Work, Psychology, Psychiatry, Art Therapy and Counseling. These students gain in-depth experience in working with highly traumatized culturally diverse populations through total immersion in provision of mental health services to ethnic and language minority populations; learning how to use the Center's service delivery model; didactic and experiential training in understanding and utilizing culture and the cultural context in mental health interventions; and, individual and group supervision. The training program has affiliations with 12 universities throughout the broader Washington, D.C. area and accepts up to 12 students per year.

The Psychology Pre-doctoral Internship Program offers a unique opportunity to a small number of students in advanced psychotherapy, psychological assessment, and program administration. Again, the program focuses on mental health delivery to immigrant and refugee populations.

Finally, the TTAP Center at the Center for Multicultural Human Services offers highly practical assistance to agencies and professionals interested in developing cultural competency at the individual, agency, and organizational levels. This training and technical assistance is offered nation-wide and reaches several thousand human service providers per year.

**Significance:**

The training and technical assistance approach developed by the Center for Multicultural Human Services derives directly from its efforts to help refugee and immigrant individuals heal from the effects of severe trauma while addressing cultural and critical life issues that prevent them from making progress. There are very few training centers in the country that can offer this type of immersion training for students, supervised by a highly trained and experienced multi-cultural and multi-disciplinary staff. The Center offers a truly unique training opportunity as training and practice are intertwined within the same site.

**Novelty:**

Unlike typical community mental health service, the Center for Multicultural Human Services looks at the whole person, providing culturally appropriate mental health, case management and other services need for the individual to more quickly toward healthy life functioning. The training that students and providers receive in this environment includes not only theoretical knowledge, but also practical application opportunities to utilize the knowledge. In addition, the focus on cultural immersion and training related to understanding and utilizing the cultural context is a significant departure from business-as-usual mental health training.

**Transferability:**

The Center's model can be replicated if educational institutions place greater emphasis on immersion-type experiences in culturally diverse settings and actively recruit trainers and faculty from diverse backgrounds. In addition, CMHS has developed a highly transferable training model that includes a case study of their organization that offers lessons learned. In addition, the Center for Multicultural Human Services has a well-developed training curriculum and training materials. The site is currently in the process of completing a handbook for human service professionals who work with refugees and immigrants.

**Effectiveness:**

The Center for Multicultural Human Services has put a highly sophisticated information system in place in the last three years to help capture data to document the effectiveness of the model. It has also developed the CAFI-XC (the Current Assessment of Functioning Index - Cross-Cultural version) to document progress. There are two Ph.D. researchers on staff to design evaluation measures and track outcomes. A pre-test and post-test set of surveys is used to measure progress for each intern. Preliminary data consistently show a significant increase in interns' awareness, knowledge, and skills in cultural knowledge and their enhanced effectiveness as multicultural human service providers.

**Implementation: Barriers and Strategies:**

1. The Center for Multicultural Human Services represents a different training model than the one that has been so predominant for training mental health professionals. Most training models are university-based programs with affiliated training sites. The Center's model is

service delivery-site focused and the training and practice are united, not bifurcated. Although this “immersion” model produces significant results, both short-term and long-term, it is one that is relatively unique in mental health training programs. Like most models that do not follow a traditional mold, the Center for Multicultural Human Services has experienced some difficulty in obtaining certification of its program from American Psychological Association (APA) and obtaining funding to support it.

2. Another potential barrier to the training program is the actual number of students that might be accommodated. At this time, given staffing and the intensity of the program, the Center for Multicultural Human Services can accommodate a limited number of students. Therefore, it has sought to increase its reach through expansion of the Technical Assistance and Training Center, which offers the potential of utilizing distance-learning, intensive seminars, and other training models to reach a broader number of mental health trainees and professionals.

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**Core Area: Leadership**

**L.E.A.D.- Leadership, Entrepreneurship and Development Program**  
Aurora Mental Health Center

**Target Audience:** all staff of a mental health center

**Innovation Description:**

The Aurora Mental Health Center, a community mental health center serving the 300,000 people of Aurora, Colorado, developed the Leadership, Entrepreneurship And Development Program (L.E.A.D.) in 2000 for its own employees. The goals of the program are to:

- empower and educate employees through experiential learning;
- enhance retention of valued employees;
- facilitate the promotion of qualified individuals who are committed to the success of the organization;
- give employees a closer perspective on the Center's mission, values and goals; and
- enhance internal communication and collaboration.

A development group was charged with establishing the program and its curriculum. Since 2001, up to 12 staff members have been selected annually for the L.E.A.D. class via an application, recommendations, and personal interview process. Application and participation is voluntary, although new managers are strongly encouraged to apply. The class involves a seven-month program that begins with a three-day retreat and ends with the completion of two or more capstone projects. The class divides into groups. Each group completes one project. All Center staff members are invited to hear public presentations of the final projects.

L.E.A.D. members attend two, four-hour education modules a month for four months. Experts from inside and outside the Center teach modules. Topics include conflict negotiation, managing change, project planning and management, personality and leadership skills assessment, building and maintaining good team morale, being a great supervisor, negotiation skills, and volunteerism. Members also digest a set of required readings and attend meetings of statewide organizations with significant impact on mental health care. The classes help prepare students for the capstone projects. These involve development and management of a focused program for improvement of Aurora Mental Health Center services, programs or general operations.

The future of mental health care in the United States demands leadership of the highest caliber. Organizations can look outside for leaders and compete with other organizations for the best, but a stronger alternative is to develop leadership from within by committing the resources and effort necessary to develop leadership skills among current staff members. Such a process develops leaders for the present and the future – satisfied, empowered employees who can put effective leadership skills to use to the benefit of the organization and its consumers.

### **Significance:**

As mental health centers prepare for their future and their future leadership, organizations must have high quality, satisfied, empowered employees who have effective leadership skills. Only those committing the resources and effort necessary to develop leadership will be prepared to move proactively into the future.

### **Novelty:**

The principles and skills of sound management and leadership transcend profit and non-profit boundaries. The L.E.A.D. program represents a low-cost, highly focused leadership and management-training program that does not exist in most service organizations.

### **Transferability:**

Any organization, regardless of size or mission, can use the L.E.A.D. program as a foundation for building a tailored training program. The cost of the program also is easily tailored. The program description, goals, schedule, memos, budget and forms all are available to interested groups.

### **Effectiveness:**

Outcomes of the program so far include:

- 100% of L.E.A.D. graduates take on some type of voluntary or appointed leadership position within 6 months of graduating from the program.
- 98% of L.E.A.D. graduates rated the overall program as Excellent.

### **Implementation: Barriers and Strategies:**

1. It has been important to define leadership opportunities as more than traditional management openings. It is common misconception that leadership and management are synonymous. In any organization, the number of management positions is limited. Those factors combined to create ambivalence among potential students and their supervisors about the value of committing time and effort to the L.E.A.D. program. A discussion in which “leadership” and “leadership opportunities” were discussed and defined was incorporated into the L.E.A.D. curriculum. Further, the L.E.A.D. steering committee will be identifying ways to incorporate into the L.E.A.D. application/requirements identification of specific leadership roles, such as service on community boards and commissions. One possibility is that the applicant would identify a specific leadership opportunity either before or during L.E.A.D. training and his/her supervisor would offer written support for the applicant’s participation in that opportunity.
2. As indicated above, supervisors were initially resistant to L.E.A.D. because of the employee time it took away from their programs. This was especially true with respect to administrative staff because their duties do not easily accommodate rescheduling. L.E.A.D.’s reputation as a valuable program has reduced the resistance, but some remains – especially

within programs that are particularly lean in staff and whose absence cannot be completely “covered.” The steering committee will be working in the coming year to address this issue.

3. Choice of capstone project topics initially was left almost exclusively to the imagination and choice of L.E.A.D. student groups whose knowledge of Center issues and needs was limited. Executive guidance concerning significant Center issues was insufficient to guarantee that the subject and results of a project would be of significant value. As a result, some projects appeared to have no impact and to fade away, never to be heard from again – an obvious detriment to morale and motivation.

This year, a member of the Center’s executive committee will be assigned to advise each capstone group in an effort to ensure that the project will have impact. Further, the project and its results will receive wider publication within the Center.

4. Many L.E.A.D. graduates have expressed an interest in establishing a program or method for utilizing L.E.A.D. alumni as a group to further the Center’s interests. The steering committee will be studying the idea.
5. Complacency and stagnation can creep into any process. The L.E.A.D. steering committee has determined that term limits for committee service are appropriate and will be studying how to implement them.

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**Core Area: Older Adults**

## **Project IMPACT (Improving Mood-Promoting Access to Collaborative Treatment)**

University of Washington/ IMPACT Coordinating Center

*Target Audience:* practicing professionals (graduate degreed); non-degreed or bachelor degreed direct care staff; other healthcare or human service providers (primary care providers, school personnel, etc.)

### **Innovation Description:**

Project IMPACT is a program that employs a variety of innovative approaches to train primary care physicians and mental health providers in an evidence-based model of care for geriatric depression in settings where older adults seek and receive care.

The IMPACT program ([www.impact-uw.org](http://www.impact-uw.org)) is an established evidence-based intervention, based on results of a randomized controlled trial with 1,801 depressed, older adults from 18 primary care clinics in 8 diverse health care organizations across the United States from 1999 - 2004. The IMPACT program consists of a depression care manager who is co-located in a primary care clinic. This staff member educates patients about depression, monitors treatment outcomes, works closely with the primary care provider and a consulting psychiatrist to revise the treatment plan when patients are not improving, and offers a brief course of psychotherapy called Problem Solving Treatment in Primary Care (PST-PC). Based on promising results of the clinical trial, IMPACT was recommended as a model treatment program by the President's New Freedom Commission on Mental Health. Several health care organizations in the United States and Canada have trained staff in the IMPACT model and adapted the program to care for a wide range of patients including teens, adults of all ages, and adults with chronic medical illnesses.

Project IMPACT strives to train service providers in the IMPACT model of care through a variety of materials and training programs directed at broad-based dissemination and implementation. A typical training consists of a day of training in depression care management, followed by a day of training in problem solving therapy (PST). However, it is possible to participate only in the training in depression care management. For long-distance learning by web-based technology, two four-hour sessions are provided. Finally, it is also possible to obtain self-paced training through a program that is available at the IMPACT website. It has eight or nine modules that include animated Powerpoint presentations and videos demonstrating skills. Continuing education credits are available for any of these training formats.

Project IMPACT has provided training at the University of Washington, at national conferences, and at treatment sites such as large health maintenance organizations, federal qualified health centers, and community mental health centers. Project IMPACT has used a variety of innovative training approaches to increase the workforce with skills in implementing depression treatment and care management in older adults. Specific approaches to training include approximately 908 individuals receiving in-person training (on-site or at the University of Washington); 150 who engaged in webcast training; 212 who were trained through web-based independent study; and 10 individuals who participated in audio independent study. In addition, scores of individuals

have been trained through a “train-the-trainer” approach in which local experts have achieved proficiency in as trainers in the IMPACT program and have then proceeded to train clinicians in their own organizations.

**Significance:**

Most older adults in need of mental health services do not seek treatment in specialty mental health clinics. For this reason, an effective approach to improving access to mental health services for older adults is to train clinicians in primary care settings. Project IMPACT has developed multiple methods of training providers in the IMPACT model of care, which develops two important new roles for trained professionals:

- (1) A depression care manager who augments the primary care physician’s capacity to treat depressed patients in their practice. This role can be performed by social workers, psychologists, and nurses.
- (2) A psychiatrist who provides consultation and supervision in the treatment of geriatric mental disorders.

**Novelty:**

IMPACT uses trained professionals such as nurses, clinical social workers and psychologists, and consulting psychiatrists in new roles to help primary care physicians effectively care for a caseload of depressed patients in their practice. Project IMPACT provides training through a variety of venues including two-day workshops, distance learning through interactive webinars, and self-paced learning through modules that are available on the IMPACT website.

**Transferability:**

A standardized training program (with manuals, educational video, a network of trainers, and a web-based training program (<http://impact.son.washington.edu>) is available ([www.impact-uw.org](http://www.impact-uw.org)). Over the past 2 years, over 1,200 clinicians from over 50 diverse health care organizations in the United States and Canada have been trained in the IMPACT care model. IMPACT training has been provided to clinicians working in large primary care HMO’s, Federally Qualified Healthcare Centers (FQHCs), academic health care settings, public clinics, group practices, home health care organizations, and in community mental health centers.

**Effectiveness:**

Results of the original, randomized control trial show that across eight diverse health care systems, the IMPACT program more than doubled the effectiveness of usual care for late-life depression. Substantial improvements were also observed in physical and social functioning and quality of life; even 12 months after IMPACT resources were withdrawn. Since the trial, over 35 manuscripts describing the effectiveness of the model have been published in peer reviewed medical journals over the past 5 years. For details, please see [www.impact-uw.org](http://www.impact-uw.org).

Since the beginning of Project IMPACT, over 1,230 clinicians and trainers have participated in workforce development training. These direct multidisciplinary trainings include 585 primary care providers, 457 mental health clinicians, and 238 disease management clinicians.

### **Implementation: Barriers and Strategies:**

There have been a variety of barriers to implementing IMPACT training.

1. First, training in IMPACT is intended to be interdisciplinary and generalizable to different types of providers. Given the right amount of training and practice, nurses, psychologists, or social workers can be trained in depression care management and problem solving therapy. However, many organizations have defined roles for these different disciplines and barriers to allowing different professionals to having similar roles. For example, an organization may allow a nurse to talk to the primary care physician about considering increasing the dose of an antidepressant, but not a social worker. Similarly, it may be acceptable for a psychologist to provide a manualized brief psychotherapy intervention such as problem solving therapy, but not a nurse.

Developing a truly interdisciplinary approach requires tactfully questioning these assumptions and showing organizations data from prior studies or implementations that clearly demonstrate success, regardless of the discipline of the provider. Another accommodation has been to divide training into care managers who are trained in depression care management only, and training of clinicians who will be able to provide the full model of both care management and problem solving therapy.

2. Another major challenge in the dissemination of IMPACT has been the practical constraints of reimbursement policy, especially under Medicare. A clinical nurse specialist or a psychologist or social worker can usually bill for their sessions, sometimes independently. However, services provided by a bachelor's level nurse or a masters-level clinician are often not reimbursable. In a fee-for-service system this may drive the decisions that need to be made in hiring staff, based on the qualifications and degrees that allow reimbursement. Even under these conditions, there are components of the IMPACT model that are often not reimbursable. For example, although treatment services directly provided to the patient are usually reimbursable, care coordination and communicating with the prescribing physician usually cannot be billed under Medicare. However, under some circumstances Medicaid reimburses for case management that is related to the activities of IMPACT. In contrast to fee-for-service settings, these issues are not as much of a barrier in managed health care settings or at Veteran's Administration Health Care settings. Depending on the setting, there are clearly financial barriers with no simple answers.

One strategy to address this is to find an organization with a similar financing structure that has successfully figured out how to implement IMPACT, and then pair it with the new organization that is seeking billing and reimbursement solutions. In addition, researchers from IMPACT and other collaborative care studies are meeting with representatives of the Center for Medicare and Medicaid Services to promote policy changes that would allow for same-day billing that would accommodate models of collaborative mental health care.

3. Finally, a potential barrier or challenge to broad-based implementation and training has been the capacity of the IMPACT trainers to meet the demand. Early in the implementation phase that followed the research study showing substantial effectiveness, leaders of Project IMPACT became aware there was a significant risk that they could not keep up with the demand for on-site training, resulting in a possible bottleneck in attempting to meet the goal of broad dissemination and implementation.

In response to this potential obstacle, Project IMPACT developed a variety of approaches to training that created efficiencies and options. Substantial effort and resources (supported through the Hartford Foundation) were committed to developing web-based approaches to delivering training. Development of webinar materials (including animated presentations, videotaped examples of skills, and interactive training and knowledge assessment) as well as development of self-paced web-based training curricula were major innovations that have addressed some of the challenges of achieving training resource efficiencies. In addition, a train-the-trainer approach has been developed to train master teachers for large health care organizations. In this instance, the organization selects a clinician for advanced training who will become the organization's own trainer, with supervision and consultation support from IMPACT program.

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**Core Area: Rural**

**Ph.D. Program in Clinical Community Psychology with  
Rural, Indigenous Emphasis**

University of Alaska Fairbanks and University of Alaska Anchorage  
(UAF-UAA)

*Target Audience:* rural population, indigenous to Alaska; graduate students in psychology; Alaska native elders

**Innovation Description:**

The UAF-UAA Ph.D. Program in Clinical-Community Psychology with Rural, Indigenous Emphasis is a joint program between the University of Alaska-Fairbanks and the University of Alaska-Anchorage that prepares Ph.D. students to provide culturally-relevant behavioral health services through the use of innovative technologies. Two of the most challenging aspects of providing culturally relevant behavioral health research and services in rural communities are (1) the distance between service providers, researchers, and the communities they serve, and (2) lack of culturally relevant training. Unfortunately, most behavioral health care providers are hampered by inadequate cross-cultural training and discomfort with the technology that would enable them to better serve rural communities.

Enjoying its inaugural year, the UAF-UAA program addresses these challenges through its Rural Indigenous Emphasis and in its reliance on advanced technology. Every course is embedded with cross-cultural considerations, and every course is taught via high definition videoconference on both campuses. The program is rich in culture and integrates Alaska Native Elders as co-instructors and mentors who are also learning to use this advanced technology. This unique educational setting provides an ideal circumstance for preparing students to become culturally aware and technologically astute service providers. Fifteen Ph.D. students in the UAF-UAA Program attend classes on the Fairbanks and Anchorage campuses. The cohort of students are all Alaskans, with one exception. The program specifically is seeking to “grow their own” as a formal strategy to address long-standing shortages of psychologists in Alaska. The doctoral program is a fully integrated component of a broader University System initiative to address the behavioral health education and training needs of the State of Alaska and its rural and indigenous people. Students in the doctoral program have Assistantships that involve them across these university workforce initiatives, as well as with major initiative partners such as the Alaska Mental Health Trust Authority and the Alaska Division of Behavioral Health.

The program incorporates culture with its inclusion of Alaska Native Elders in courses, an annual cultural immersion experience, a cultural advisory council, recruitment of indigenous faculty and students, and inclusion of cultural issues in each course. The program also embraces technology by utilizing the highest quality video conferencing for all classes and meetings and web cams for small group meetings. Students are already becoming experts in the technology they will use to provide services and conduct research in their professional careers.

**Significance:**

Training behavioral health service providers and researchers to be culturally aware and technologically competent will enable them to effectively reach individuals and groups in rural communities. This program will make behavioral health services available to thousands of people who would otherwise have extremely limited access to this level of care.

**Novelty:**

We are unaware of any other program that integrates rural, indigenous, and cultural issues into every course. The use of video conferencing in behavioral health is rare, in part because the high definition video conferencing that makes this innovation useful for behavioral health applications first became available in January 2006.

**Transferability:**

Our curriculum and protocols for developing cultural awareness could be shared with and adapted by other educational institutions. We could also provide to others a listing of the important elements to include in a quality high definition video conferencing system that could be used by other educational institutions or service delivery systems.

**Effectiveness:**

We know from personal experience that our students and Native Elders are enthusiastically embracing the opportunity to share knowledge. We also know high definition video conferencing is effective in providing psychology education across great distances because the technology makes it possible to observe the nuance of expression and body language.

**Implementation: Barriers and Strategies**

1. Developing a new Ph.D. program that combines not only community and clinical psychology, but also provides a rural indigenous emphasis has presented significant challenges. A variety of strategies are in place to meet the needs of the program. Rural internships are currently being identified to provide students with an opportunity to conduct research and provide services in rural communities in Alaska. Students also have many opportunities to participate in rural research and service through their Research Assistantships. For example, this year two students are research assistants for the Alaska Behavioral Health Training Academy. In that role they help organize and attend trainings designed for rural behavioral health professionals. These trainings provide invaluable exposure to the issues confronting rural behavioral health professionals in Alaska.
2. The indigenous emphasis is also addressed through a number of strategies. All courses include readings and activities that directly address cultural issues. Native Elders are co-instructors for the Clinical/Community/Cultural Integration Seminar. A Cultural Advisory Council made up of Native leaders from the various regions of Alaska has been organized.

Each incoming cohort of students is required to attend a cultural immersion experience prior to the beginning of courses.

3. The program has also been faced with IT challenges. Because all courses are video conferenced across the two campuses, the program requires dedicated classrooms properly designed for video conferencing. It would have been helpful to have an IT specialist at the beginning of the planning and development for this aspect of the program. UAA has recently hired an IT support staff member, and UAF is in the process of hiring similar personnel.

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**Core Area: Substance Abuse Prevention**

**Today's Tools for Tomorrow's Success: Basic Prevention Institute**  
**Florida Certification Board's Center for Prevention Workforce Development**

*Target Audience:* non-degreed or bachelor-degreed direct care staff; direct service prevention practitioners with 3 years or less experience

**Innovation Description:**

The Center for Prevention Workforce Development (CPWD) employs a competency-focused approach to meet the staff development needs of prevention specialists working in a variety of organizational settings and focusing on a wide range of problems. Until the creation of the Center, Florida's prevention specialists relied primarily on a single annual conference or an intervention-specific training program for their staff development. Little attention was paid to skills-focused training. In response to this need, CPWD developed "*Today's Tools for Tomorrow's Success: Basic Prevention Institute*", a three day skills-based course focused on macro-level skills common to prevention work in diverse settings, addressing multiple issues, and targeted at participants of any age. Development of the Institute was guided by on-site interviews and field observations with prevention specialists in a variety of settings throughout the state. Institute content was based on research in facilitating behavior change, enhancing motivation and building self-efficacy.

The target audience for the Institute is direct service prevention specialists, especially those with three or fewer years' experience, in any type of prevention work with target populations that could benefit from effective substance abuse preventive interventions. Although the Institute focuses primarily on substance abuse prevention, professionals in any prevention setting can utilize the core skills.

The Institute is focused on practical application of prevention skills to:

- Enhance motivation for changing behavior
- Activate behavior change
- Help participants move through the stages of change
- Establish positive relationships
- Manage group process
- Use specific educational strategies
- Measure participant progress

The Institute experience is highly interactive, allowing participants to practice skills and observe others as they apply the skills to their own experience. Tools such as the "Readiness Ruler" and Self-Efficacy Ratings provide participants with practical ways to apply the skills that they have learned.

Six experienced preventionists from throughout Florida with expertise in diverse settings such as delinquency prevention, substance abuse prevention, and child welfare were selected to serve as the training team. At least two trainers staff each session of the Institute. The Institute was

delivered a total of eight times between late April and late June 2006. A total of 166 participants attended the various sessions.

**Significance:**

The Institute was designed following interviews with prevention specialists in a variety of settings and is unique in its focus on skills identified as essential for successful performance of the work of facilitating behavior and attitude change. These skills are applicable in a wide range of settings with diverse participants.

**Novelty:**

No other prevention training available in Florida provides hands-on skills-focused practice in facilitating behavioral change. In addition, participants from diverse prevention settings engaged in varied types of prevention work are seldom able to gather in a single training event where they can recognize their common goals and skills and learn from each other.

**Transferability:**

The Institute has been manualized with a Trainer's Guide including Power Point presentations, a Participant's Manual and a Resource Guide. Our core team of Trainers is prepared to act as coach/mentors for new trainers.

**Effectiveness:**

Participants rated their own self-efficacy at the beginning and end of each module, provided a module-by-module evaluation of instruction and an overall evaluation for the Institute. For every skill taught in this Institute, participants gained in their levels of self-efficacy. In addition, they rated instruction and the overall Institute. Participants were asked to participate in a 90-day follow-up evaluation as well.

These "First Cycle" learners experienced a minimum perceived increase in their average self-efficacy ratings of 12%. In addition, 84% of the 166 Institute participants reported increases in their perceived self-efficacy ranging from 18% to 37%. The average increase in combined self-efficacy measures was 21%.

Participants also reported a high level of satisfaction with the Institute experience.

**Implementation: Barriers and Strategies:**

The design, development and implementation of *Today's Tools for Tomorrow's Success: Basic Prevention Institute* presented several challenges:

1. Designing instruction that was applicable to a wide segment of Florida's diverse prevention workforce. In order to be certain that the content of the Institute was applicable to a wide range of prevention specialists, the Instructional Designer conducted

extensive interviews and on-site observations of direct service prevention workers throughout the state of Florida. Based on her observation and their responses, a common list of tasks performed and skills necessary to perform those tasks was created. This task list served as the basis for identifying a list of broad, macro-level skills that were utilized regardless of the prevention settings. These skills became the focus of the Institute.

2. Creating a logical sequence of skill development. In order to create a logical sequence of skills for the Institute, we utilized the Stages of Change model created by Prochaska and DiClemente as an organizing framework. The art of prevention was described as a process of facilitating behavioral change in one of three ways:
  - avoiding a negative behavior that might otherwise be adopted
  - adopting a positive behavior
  - maintaining a positive state that might otherwise be vulnerable to change.

Skills in the Institute were sequenced in a way that preventionists might use them in helping their participants move through the stages of change from precontemplation to maintenance and relapse avoidance.

3. Measuring gains in particular skills. Participants were asked to measure their own skill gain based on their perceptions of self-efficacy for the target skills at the beginning and conclusion of each module of instruction. The self-efficacy ratings were phrased slightly differently for each module, providing learners with a “working vocabulary” for measuring self-efficacy in their own participants.
4. Avoiding dependence on a particular trainer. The Center for Prevention Workforce Development created an initial team of six (6) trainers and conducted a Training of Trainers event. All trainers are capable of training all of the Institute modules. Team assignments for each of the sessions were varied, in order to give trainers an opportunity to work with different partners. In addition, the Institute developed a detailed Instructor’s Guide that contains a PowerPoint presentation, instructional “script”, handout masters, discussion prompts and instructions for each exercise. The initial team is prepared to serve as “master trainers” to mentor new trainers in the process.

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**Core Area: Substance Use Disorders Treatment / Persons in Recovery**

**The Training Point:**  
**An uncommon learning exchange for addiction trainers**  
Addiction Technology Transfer Center National Office

**Target Audience:** new and experienced addiction trainers and educators, and/or professionals in the addiction field who train or teach as a part of their job function

**Innovation Description:**

The Addiction Technology Transfer Center (ATTC) National Office developed *The Training Point: an uncommon learning exchange for addiction trainers* to enhance knowledge and abilities in addiction training. Empowered by SAMHSA/CSAT, the ATTC Network enhances the addiction treatment and recovery services workforce by systematically transferring research-based protocols into practice through the comprehensive strategies of technology transfer. Technology transfer is the transmission of current knowledge, skills and attitudes in a manner that supports the successful use of that information by individuals, agencies and systems. While the ATTC engages in a number of technology transfer activities to achieve our mission, curricula development and training continue to be an essential means for upgrading the standards of professional practice.<sup>1</sup> The ATTC National Office understands the critical importance of training and strongly believes that treatment providers will be more likely to adopt research-based practices if they are trained on those practices by an experienced trainer using research-grounded, learner-centered educational techniques.

The course, *The Training Point: an uncommon learning exchange for addiction trainers*, is grounded in adult education theory and practice, and as such strives to be learner-centered and experiential.<sup>2</sup> The first and last three weeks of this seven-week course are held online via a Web-based learning system. The middle, or fourth week, of the course is an intensive three-day face-to-face learning exchange. Throughout all seven weeks, participants focus on the various components that create successful training experiences: the learners, the environment, the materials, and the trainer. Topics covered include learning and training styles, adult learning principles, facilitation and presentation skills, action research, and transformative learning.

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<sup>1</sup> Stuart, G., Hoge, M. & Tondora J. (2004, February). *Theory and Evidence Based Teaching Strategies: Implications for Behavioral Health*. Paper presented at the May 2004 Annapolis Coalition meeting on Evidence-Based Teaching Strategies. Retrieved April 17, 2006 from [http://www.annapoliscoalition.org/teaching\\_strategies.php](http://www.annapoliscoalition.org/teaching_strategies.php).

<sup>2</sup> Zemelman, S., Daniels, H., Hyde, A. (1998). *Best practice: New standards for teaching and learning in America's schools*. Portsmouth, NH: Heinemann.

**Significance:**

*The Training Point* successfully addresses the need for quality trainers in the field. As the addiction treatment workforce crisis continues to unfold, the need for staff with higher levels of education and training is greater now than it was even a few years ago due to the 1) increasing complexity of the patient/client population entering treatment and 2) scientific advances in treatment. The pool of trained workers is failing to keep up with demand. Compounding these issues is the limited supply of new workers coming into the field. The National Office developed *The Training Point* in order to prepare professionals who are currently working in the treatment field to transfer their content expertise and practical experience to others who show an interest in the field, and to addiction treatment staff members who want to further develop their proficiency.

**Novelty:**

- Most “training of trainers” events focus on how to train content in a specific topic area; the *Training Point* focuses on teaching trainers the concepts and practices of adult learning that they can apply to any content area.
- *The Training Point* utilizes the principles of adult learning, which are employed in the delivery of the course itself. Participants are encouraged to learn from each other, to apply new information to “real world” circumstances, and to become reflective practitioners.
- *The Training Point* is a blended online and face-to-face learning experience; thus exposing addiction trainers to both kinds of learning environments.

**Transferability:**

In developing *The Training Point*, the National Office created two comprehensive course manuals – one for trainers and one for participants. The trainers manual provides thorough instructions for how to implement the course both from the trainers’ and project coordinator’s perspectives, detailed trainers’ scripts for the three days of face-to-face learning, and a CD-Rom containing all the electronic files the trainers need to carry out the course. The participant manual provides all-inclusive information for each of the seven weeks of the course including information on the objectives, assignments and “point” of each week.

**Effectiveness:**

*The Training Point* successfully addresses the need for quality trainers in the field. Since 2005, nearly 80 individuals have been “learners” in the course. Although no formal evaluation of the course has been completed, feedback continues to reflect that participants are overwhelmingly satisfied. Data from post-event evaluation forms indicates that 98% of participants report being satisfied with the course overall. One course graduate described his experience as, “without a doubt, one of the best training opportunities I have experienced in nearly 18 years working in the field ... The experience of participating ... kindled a passion to learn, and grow, and excel.” Other graduates have indicated similar positive experiences with the course.

## **Implementation: Barriers and Strategies:**

1. *The Training Point* is a seven-week, blended online and face-to-face learning experience. On occasion, we have met resistance to the length of the course. Much of this resistance has stemmed from a lack of understanding as to the reason for the blended nature of the course. In other words, we have been posed the question: why are the weeks online needed?

The seven-week course served two main purposes: (1) to allot enough time to the topics we felt needed to be covered in such a course and (2) to provide an opportunity for addiction trainers to experience a blending learning environment, a learning format that is becoming increasingly popular. To address the concern about the length of the course, we have taken the following additional steps:

- a. Upon initial expressed interest, provide to potential participants a detailed course description which outlines the course and the topics covered.
  - b. Require potential participants to sign a “learning contract” acknowledging that they have read the course description and that they understand the duration of the course.
  - c. Provide continuing education credit for the entirety of the course, not just the face-to-face session.
  - d. Utilize trainers that have “graduated” from the course themselves, and who, therefore, understand how the course content builds as the weeks progress.
2. As mentioned, six weeks of *The Training Point* utilize a highly interactive form of asynchronous, discussion-based online learning. We have found that a significant number of past course participants had never taken part in an electronic classroom environment prior to taking this course. As novice online learners, these participants had little knowledge about what to expect, how to navigate the course and/or how much time it would require. The unfamiliarity often led to anxiety, and sometimes to lack of participation.

In order to assist novice online learners in how to transfer their knowledge and skills in traditional classroom learning to the online environment, we took the following steps:

- a. Instituted a Web-based, PowerPoint assisted conference call for participants prior to the beginning of the course that detailed how to navigate the course, including how to read and post messages in the discussion board.
- b. Established an open, inviting and safe e-classroom environment to encourage participation and ease nervousness. Trainers invited telephone calls and personal emails from all participants. Trainers also shared their own early experiences in online learning, and encouraged everyone in the group to share such experiences.
- c. Via personal e-mail and telephone calls, contacted all participants who had not posted a message in the discussion board by the middle of the first week of the course. Walked those participants through the course and provided encouragement.
- d. Provided ongoing technical assistance throughout the duration of the course.

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**APPENDIX A**  
**SELECTION CRITERIA FOR INNOVATIONS**  
***In Behavioral Health Workforce Development***<sup>3</sup>

- Its **significance**: the degree to which the program successfully addresses an important element of behavioral health workforce education, training, recruitment or retention. For example:
  - To what degree does the innovation address a workforce issue or problem that is of national import and scope?
  - To what degree does the innovation directly impact the behavioral health workforce or consumers and their families?
  - To what degree has the innovation improved the relevance of training and education to the rapidly changing practice environment?
  - To what extent does the innovation address needs or issues identified in recent reports issued by the U.S. Surgeon General, the Institute of Medicine, the President’s New Freedom Commission, or SAMHSA and its Centers?
- Its **novelty**: the degree to which the innovation demonstrates a significant departure from business-as-usual. For example:
  - Does the program represent a fundamental change in the approach to educating students, providers, or persons in recovery and their families?
  - Does the program incorporate new recruitment and retention strategies?
  - Does the program change the core process by which education or training occurs?
  - Does the program introduce a new resource or technology?
- Its **transferability**: the degree to which the innovation, or aspects of it, shows promise of inspiring successful replication by educational institutions, service delivery systems, or other groups.
  - To what extent is the innovation packaged and readily accessible to others?
  - To what extent can this innovation be replicated by others?
  - To what extent can this innovation serve as a model that others will seek to replicate?
  - To what extent are the components, concepts, principles or insights of this innovation transferable to other disciplines or fields?
- Its **effectiveness**: the degree to which the innovation has demonstrated its utility by achieving tangible results. For example:
  - Has the innovation been formally evaluated or researched and found to be effective using either qualitative or quantitative methods?
  - Has an independent evaluation been conducted (e.g., by persons other than those who developed the innovation)?
  - Is there evidence of “satisfaction” with the innovation among consumers and families, students, or providers?

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<sup>3</sup>These criteria were adapted from those used by the John F. Kennedy School at Harvard University in selecting the Innovation in Government Award recipients, [www.innovations.harvard.edu](http://www.innovations.harvard.edu).