

TRAINING AND EDUCATION NEEDS OF CONSUMERS, FAMILIES, AND FRONT-LINE STAFF IN BEHAVIORAL HEALTH PRACTICE

John A. Morris and Gail W. Stuart

ABSTRACT: Much of the behavioral health care delivered to people with serious mental illnesses and chronic addictive disorders is provided by front-line or direct service mental health workers. Issues related to the qualifications, training, and ongoing evaluation of the competencies of this important provider group have received scant attention in the behavioral health field. This paper explores the educational needs and best practices of the consumers and families who carry much of the burden of caring for disabled populations, as well as the front-line staff, many of whom are employed in state psychiatric hospitals and community mental health or addiction treatment systems. Within the overall context of culturally competent behavioral health care, specific recommendations are proposed in an attempt to move the field forward.

KEY WORDS: consumers; families; front-line staff; public sector.

The dramatic changes in the health care environment described by our colleagues as they relate to pre-service (Hoge, Jacobs, Belitsky, & Migdole, 2002) and continuing education (Daniels & Walter, 2002) have also had a significant impact on other important stakeholders: consumers of mental health services, their families, and front-line behavioral health staff. These include direct-care providers such as registered nurses, some categories of social workers and counselors, licensed practical nurses, nurses' aides,

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technicians, and volunteers. Consumers and families are included in this “workforce” paper because they are one of the priority workforces: consumers as they drive their own recovery, and families as they assist in that process. The expertise of these two groups has often been unappreciated and undervalued, as has their special need for support from their workforce allies. Yet failure to value the roles of consumers and families will clearly impede any effort at significant educational improvement for the field. Similarly, the needs of front-line public-sector staff have received minimal attention from the behavioral health community—often to the detriment of quality patient care and improvements in the delivery of behavioral health care. Organizations must consider the costs and benefits of not providing the necessary training to these groups.

This paper addresses the educational needs of these groups within the overall context of culturally competent contemporary behavioral health practice. It reviews changes in the field and identifies some examples of training or teaching innovations that are especially appealing in this changing health care environment, and closes with a series of recommendations that are designed to provoke thought and discussion.

THE CONSUMER VOICE

Formal organizations of consumers and concerned allies, such as Mental Health America, the National Empowerment Center, the Mental Health Consumer Clearinghouse, and the National Association of Consumer/Survivor Mental Health Administrators, were created to provide national vehicles for influencing policy and practice. Many interventions that have been the bedrock of the public mental health sector (such as civil commitment, involuntary medication of patients, and seclusion and restraint) have come under intense scrutiny in large measure because of consumer expressions of dissatisfaction, and occasionally even outrage. This has had a direct impact on all provider groups and has contributed to changes in both the standards of major accreditation organizations as well as in federal regulations of policies and procedures. In a broader context, consumer perception of the quality of care has become accepted as a significant performance indicator for both public-sector (through the Mental Health Statistics Improvement Project [MHSIP]) and commercial systems of care (Campbell, Dumont, & Loder, 2001; American College of Mental Health Administration [ACMHA] 1998, 2001; Morris & Adams, 2001).

Consumers of mental health services have emerged not only as important policy voices, but as service providers as well. The consumer empowerment and recovery movements are reshaping the conceptualization of service design and delivery (Ahern & Fisher, 2000). For example, it would

be unusual to conduct a public meeting on behavioral health issues without significant involvement of consumers of mental health services. Another emerging issue is consumer-operated services (Dixon, Kraus, & Lehman, 1994), which now exist in sufficient numbers to be the subject of scientific inquiry. This is evidenced by the Consumer-Operated Services Multi-Site Research Initiative Coordinating Center, which is a Substance Abuse and Mental Health Services Administration (SAMHSA) Cooperative Agreement under the direction of Jean Campbell, Ph.D., at the Missouri Institute of Mental Health. Dr. Campbell has also focused attention on the role of primary consumers in identifying outcome indicators for behavioral health (Campbell, 1996).

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The influence of consumers in the development of educational curricula is harder to gauge, but experience suggests that the impact has more often been a change in semantics rather than a change in content for traditional education and training programs of mental health providers. For example, the Surgeon General's Report on Mental Health (Department of Health and Human Services [DHHS], 1999) discusses the accomplishments of consumer organizations. This report mentions consumer involvement in self-help groups, mental health policy, protection of individual rights, utilization of consumers as employees in mental health systems, and involvement in research. However no mention is made of consumer involvement in the training or educational programs of mental health providers. This report also does not mention another topic—what consumers have identified as their own unmet needs for education about their illness, best practices, and provider competencies (Uttaro & Mechanic, 1994). The consumers have moved to fill the gap through their own resources and energies—often with a major impetus from the availability of information on the Internet.

THE VOICES OF FAMILIES

A corollary to the emerging influence of consumers of mental health services is the voice of their families. Organizations such as the National Alliance for the Mentally Ill (NAMI), the Federation of Families for Children's Mental Health (FFCMH), and the National Mental Health Association (NMHA) are now major players in both state and national policy venues. Although the target populations are somewhat different, these or-

ganizations are similar in their devotion to advocacy, family support, research, and public awareness. As previously noted with consumer input, however, it is unclear how widespread the impact of the family perspective is on preparing providers of mental health care to be sensitive to the particular needs and concerns of families.

Of special note in this context are two related but distinct concentrations within the educational, and other, concerns of families. The priority needs of families with adult children who have severe and persistent mental illnesses (the traditional and primary focus of NAMI) are significantly different from the priority needs of families with young children. This latter group has most often been represented by the Federation of Families for Children's Mental Health, and by Children and Adults with Attention/Deficit/Hyperactivity Disorder. Because young children's disorders may not be as easily or readily diagnosed, and because there is an inevitable need to involve more than one system (be it schools, primary care/pediatrics or juvenile justice), these families have needs for professional supports and assistance not required for adults. Again in this area, there has been a significant lack of training for workers preparing to deal with these cross-systems interventions. (Morris & Hanley, 2001).

FRONT-LINE STAFF

The third group of interest is the front-line or direct service mental health workers. This group includes non-degreed or paraprofessional staff employed in mental health delivery systems. In 1994 the 145,000+ mental health workers accounted for 25% of the total mental health workforce. Registered nurses were the next largest group at 82,620 or 14.3% of the workforce, followed by social workers at 41,326 or 7.2%. The sites of employment of these individuals were most interesting. In private psychiatric hospitals, other mental health workers constituted 8.7% of the total staff, as compared with state and county mental hospitals where they constituted 40.9% of the total staff. State and county mental hospitals also employed more nurses, 11.4%, and social workers, 3.6%, as compared with private psychiatric hospitals, 7.2% and 2.7%, respectively (Center for Mental Health Services [CMHS], 2001). Thus it is readily apparent that the public sector employs the vast majority of this group of providers.

Less apparent, however, are the qualifications of these mental health workers, as well as the nature of any programs or standardized training offered to or received by these individuals. One fears that many may find themselves, in the words of a field leader in rehabilitation counseling, "Well trained but unprepared" (Kress-Shull, 2000), or worse yet, neither well trained nor prepared. A review of the literature found no reports of

any aggregated data on their qualifications for employment, nor were there any standardized training programs that have been adopted on a regional or national level. Furthermore, given the financial constraints experienced by most public-sector mental health departments, one must wonder what resources, if any, are dedicated to the educational/occupational training needs of this staff group.

Public-sector financial constraints also have a serious effect on the recruitment and retention of skilled workers. The labor force is shrinking. By 2020 the number of people over 50 will increase 74%; those under 50 will increase by only 1%. Restrictions on immigration and a high employment rate further reduce the potential employee pool. Even where entry-level staff can be recruited, retention is undermined by the absence of career paths through competency-based training that leads to a valued credential, and other forms of recognition as well as opportunities for higher wages (Taylor, 1999). Changes in these players and systems have had a distinct impact on the behavioral health field. Legislators and policy makers are learning a different calculus of power and vulnerability as the needs of the following groups are increasingly being heard: professional organizations (such as the American Psychiatric Association, the American Psychological Association, the National Association of Social Workers, and the American Psychiatric Nurses Association), trade organizations (such as the National Association of Psychiatric Health Systems, the National Association of County Behavioral Health Directors, and the National Council for Community Behavioral Healthcare), and public-sector administrators (the National Association of State Mental Health Program Directors and the National Association of State Alcohol and Drug Abuse Directors).

THE CULTURAL CONTEXT OF CARE

Superimposed on these developments is the emerging awareness of the mandate to translate the contemporary rhetoric of socio-cultural competence into clinical, programmatic, and administrative reality. This issue has tremendous implications for clinical practice, such as formulating accurate diagnoses that include an assessment of socio-cultural variables and the development of medication regimens that account for sexual, racial, and ethnic variations, as well as for the education and training of staff. In addition, the issue of the mental health care setting is critically important, as evidenced by the problems of access to mental health services in rural America (Mohatt, 2000). The characteristics of non-metropolitan areas raise unique problems for staffing and service provision. This article will highlight the particular educational needs of consumers, families, and non-

degreed staff, the latter being large in number, disproportionately representative of social, cultural, ethnic and linguistic minorities, and frequently victims of a highly stratified culture of professional elites.

EDUCATIONAL NEEDS OF CONSUMERS, FAMILIES, AND FRONT-LINE STAFF

Consumers, Survivors, Ex-Patients

The consumer movement in behavioral health care has grown steadily in the past decade. Early, disparate efforts have led to the increasing organization and formalization of the consumer voice (Chamberlin, 1998), and the concept of recovery has taken hold as an organizing principle (Anthony, 1991; Deegan, 1988). Recovery refers to both *internal* conditions experienced by persons who describe themselves as being in recovery—hope, healing, empowerment, and connection, and *external* conditions that facilitate recovery—implementing the principle of human rights, a positive culture of healing, and recovery-oriented services (Jacobson & Greenley, 2001).

Therefore, one might ask, “What are the educational implications of the concept of consumer recovery?” Consumers report that one of their highest priorities is to get effective education about their illnesses and the essential role they themselves play in their self-care and recovery. In an early attempt to learn from consumers about what made a difference for them in their recovery process, Sullivan (1994) identified several elements of successful recovery. The list included knowledge about medication, community supports, vocational activities, spirituality, the illness itself, acceptance of the illness, mutual aid groups and supportive friends, and significant others. The role of education is particularly highlighted: “This area, learning about the illness and accepting one’s situation, quite possibly undergirds all of the domains listed previously” (p. 24). Consumers also need to recognize quality mental health care and to self-manage their own health behavior.

The involvement of consumers in curriculum design, and education and training of staff remains in its infancy.

One attempt to explore these needs was undertaken by the South Carolina Center for Innovation in Public Mental Health in collaboration with Vicki Cousins, Director of the Office of Consumer and Family Affairs. It consisted of a six-part series of educational programs, entitled *Perspectives on the Mystery of Recovery* (Center for Innovation in Public Mental Health and The Office of Consumer and Family Affairs, 2000–2001), broadcast

via SC Educational Television on the DMH TeleNetwork. On these programs, the consumers repeatedly reported that they learned about their illnesses from the Internet, from reading, or from other consumers—the professional community was almost non-existent for them in the educational process. From the consumer perspective, providers often did not communicate even the most basic information (about diagnoses, medications, reasons for medications and their side effects) in ways that these consumers experienced as understandable or useful. These consumers also described a parallel need to be involved in the education of their caregivers, whether those caregivers are family members, graduates of traditional professional training programs, or the wide array of other mental health workers with whom they interact to sustain their recovery process. Yet the involvement of consumers in curriculum design, and education and training of staff remains in its infancy.

Families

Families of people diagnosed with mental illnesses report many of the same experiences as consumers. They are unclear about what is happening to their loved one or what their role is in the recovery process. Problems identified by family members include increased family stress and conflict; members blaming each other for the illness; difficulty in understanding or accepting the illness; tension during family gatherings; and a disproportionate amount of family time, energy, or money given to the ill member (Doornbos, 1997). Families may experience alienation from the consumer, with whom normal familial tensions may be complicated by extremely volatile issues, such as involuntary commitment (Hatfield, 1993). They also can experience barriers in the treatment setting due to professional bias against families based on past exposure to family systems courses, which suggested that families in some way caused the illness; family attitudes that equate all family interventions with past, unwelcome experiences with family therapy; professional fears that an alliance with the family will endanger confidentiality and threaten the therapeutic alliance with the patient; and administrative restraints in a managed-cost environment that makes services to families (as non-patients) the lowest priority (Conn, 2001). And, as is noted on page 379 in this article, the National Alliance for the Mentally Ill has taken a leadership role in developing specialized training in mental health issues for its membership.

For parents of younger children identified as having serious disorders, the issues are even more complex because of the likelihood of multiple system interventions, such as schools, pediatricians, and juvenile justice.

Further complicating all these issues for families are larger societal problems, including those that relate to access to care (availability of psychiatric and support services in any given locale, poverty and educational depriva-

tion, etc.), and the impact of third-party payment on the quantity and quality of care that is possible for a loved one. This latter concern has seen the national family movement's active engagement in the fight for parity in insurance coverage for mental illnesses (Libertoff, 1999). Families also have entered the policy arena with strong calls for the use of evidence-based interventions, the most significant example of which may be NAMI's endorsement of the Program of Assertive Community Treatment (PACT) model of community-based treatment for persons with severe and persistent mental illnesses (Allness & Knoedler, 1998), and also their leadership in disseminating information on the schizophrenia Patient Outcomes Research Team (Lehman, 1999).

Front-Line Staff

Since the 19th century and the days of the psychiatric hospital as asylum, state departments of mental health (and, in some states, their successor county or regional authorities) have been the primary non-family caregivers for persons with mental illnesses. They and their staff represent the third major constituency that has been impacted by the shifts in health care financing and delivery. The needs of public mental health systems of care, even those that have been heavily impacted by managed care, are distinctly different from commercial insurance-supported or private systems of care (National Alliance of Direct Support Professionals, 2000).

One of the most compelling differences lies in the management of state hospitals, which continue to be a major presence in spite of 50 years of deinstitutionalization and downsizing, and the necessity for managing these historic institutions in volatile, politically charged, and highly visible contexts. For example, the fact that many state hospitals were built in rural communities in which they quickly became the largest employer and the single most powerful economic force has made their abandonment less a clinical/policy issue and more a political/economic issue.

Public-sector hospitals traditionally have been staffed by large numbers of non-degreed employees, for whom training has tended to focus on issues driven by licensure concerns (fire and life safety issues, organizational policies, human resource rules), demands of accrediting organizations, seclusion and restraint techniques, elopement procedures, or other system-specific needs. The differences in staffing patterns between public and private psychiatric mental health institutions, as it relates to those staff not recognized in the traditional professional disciplines, has been previously noted. It is important to underscore, however, that these individuals comprise a large mental health workforce whose training and education needs have rarely been systematically addressed at the national policy level. This is in contrast to the United Kingdom, for example, which has systematically addressed issues of competency and career advancement for direct-

care workers in a variety of human services through the National Vocational Qualifications (NVQ) system (NVQ-UK, 2000). The NVQ system provides a national competency framework for improving the quality of care through on-the-job skill recognition and baseline standards to guide hiring and promotional decisions.

The inadequacy of training for care-giving staff is exacerbated by a perverse incentive that offers funding for entry-level training but not for continuing competency.

One U.S. organization that advocates a somewhat similar competency framework is the National Alliance of Direct Support Professionals (NADSP) at the Institute on Community Integration. NADSP wishes to see a voluntary credentialing system that is based on mastery of nationally validated “best practice” competencies and ethics that are rigorously assessed both in the classroom and on the job. NADSP prioritizes credentials that are highly transportable and creates a goal toward which direct service professionals can aspire, rather than establishing a minimum standard that they should meet to get a job.

It is true that years of public policy and federal civil rights cases (such as *Dixon v. Weinberger* [1975] and *Wyatt v. Stickney* [1972], to name two prominent and long-lasting consent decrees augmented by the recent *Olmstead v. LC and EH* [1999] Supreme Court decision) have exerted downward pressure on state hospital census figures. However, in spite of the impact of years of deinstitutionalization, significant numbers of individuals continue to reside in these facilities at some time during the year (Lamb & Bachrach, 2001) and, as such, they need state-of-the-science mental health care. Unfortunately, much of that daily care will be provided by workers whose training needs have escaped the detection, description, or dedication of most educational curriculum development initiatives at either the regional or national levels. This leads one to ponder exactly what quality of care is being provided by these mental health workers, under what level of supervision, and with what demonstrable skills and measurable competencies. The Direct Care Alliance, in describing the problems of a poorly trained workforce, asserts that “mandated training hours for school crossing guards and cosmetologists . . . and even dog groomers are greater than those required by HCFA [Health Care Financing Administration] for entry-level certified nursing assistants or home health aides” (Direct Care Alliance, 2001). The Alliance points to “missed core competencies” in clinically informed problem-solving and decision-making skills, as well as the communication and interpersonal skills required in a multicultural environment. The inadequacy of training for care-giving staff is exacerbated

by a perverse incentive that offers funding for entry-level training but not for continuing competency. These are serious issues to be contemplated in the current climate of increased accountability for clinical outcomes and increased liability for adverse health care events.

Finally, cultural competence issues are powerful and pervasive among all of these constituencies. Consumers' and families' experience of care, and even their willingness to access services, are influenced by both subtle and overt socio-cultural framing. A critical element in addressing this is the attention given to the training needs of staff in public systems, and especially those who do not have access to the levels of education and training offered in traditional academic programs. Davis (1995) makes the case this way: "State mental health systems have historically taken a laissez-faire approach to the general issues of professional education, training, recruitment and development. Few states have paid adequate attention to the need to invest in human resource development generally and even fewer have focused their efforts on minority human resources" (p. 29) or socio-cultural knowledge, communication skills, or culturally appropriate practices.

EDUCATIONAL BEST PRACTICES

A discussion of educational best practices is challenging at best for the focus groups of this article. This section highlights selected best practices related to consumers, families, and the front-line staff of public-sector departments of mental health. This is not intended to be an exhaustive review, but rather a sampler of intriguing programs that offer promise for improving education in these arenas.

Consumer Education Issues

Consumers have developed a number of strategies for educating one another and the general public. The access to Internet web sites, the use of web site chat rooms, and the development of clearinghouses for consumer-centric information have been core strategies. Some of the more prominent organizational initiatives have been developed by the National Mental Health Self-Help Clearing House (an early user of Internet-based communication for consumers), the National Empowerment Center (which has developed training materials for both consumers and professionals), the Kentucky Center for Mental Health Studies (a consumer-operated research group), and Mental Health America (which publishes a national newspaper and has created a national organizational structure for consumer voices).

A few of the particularly creative initiatives have approached education

from novel perspectives. Dr. Pat Deegan's "Hearing Voices That Are Distressing: Training Simulation and Self-Help Strategies" (National Empowerment Center, undated) is a provocative experiential training that exposes individuals to the experience of interacting with the "normal" world while wearing headphones that simulate unpleasant and intrusive auditory stimuli. Another public education strategy that has caught the attention of people around the country and both focused public awareness and created opportunities for consumer activism is the cemetery restoration project initiated by Larry Fricks and the Georgia Consumer Network. Begun by Fricks in response to the abandoned graves of thousands of mental health consumers at the Milledgeville State Hospital, it has become a national movement to identify and restore the cemeteries in which states' buried the people who died in their care. The work has now received funding from the Center for Mental Health Services and is part of anti-stigma efforts in a number of states. The use of the human interest "hook" of forgotten, nameless patients has focused attention on the lack of voice and dignity experienced by consumers for decades.

Vicki Cousins, Director of Consumer and Family Affairs for the South Carolina Department of Mental Health, has engaged in a series of consumer-driven educational activities, one of the most powerful being a series on recovery (Center for Innovation in Public Mental Health et al., 2000–2001) designed to educate both consumers and clinicians about principles of recovery. Using a satellite-based technology, consumer leaders (Dan Fisher, Pat Deegan, and Laurie Ahern from the National Empowerment Center; Paul Weaver from MH America and the Kentucky Center for Mental Health Studies; Wilma Townsend from the Office Support Agency in Ohio; and Bonnie Pate from SC SHARE) presented different conceptual models of recovery and interacted with clinicians and consumers statewide. This work has involved a partnership among the state's educational television network (SC ETV), the public mental health department, and a university-based policy and training center (the Center for Innovation in Public Mental Health).

Family Education Issues

NAMI, in particular, has taken on the issue of education for families with multiple strategies such as organizational support for local peer-support and educational activities, publication of a members' newsletter (*NAMI Advocate*), an annual national conference, and public policy advocacy. Four NAMI efforts are worth noting: the NAMI Anti-Stigma Campaign, the creation of the NAMI Family-to-Family Education Program (Burland 1998), the NAMI Provider Education Program (Burland 1995), and the NAMI Competencies for Mental Health Workers (1997).

NAMI's Anti-Stigma Campaign has not only included development of

educational materials in non-technical/accessible language for lay audiences, but it has also included local media-watch councils. These groups are alert for stigmatizing portrayals of mental illnesses on television, radio, and in the print media.

The Family-to-Family (Burland, 1998) effort is consistent with NAMI's origins as a self-help/support organization of parents of adult children with major psychiatric disabilities. It is a 12-week peer education program taught by two trained NAMI family members who offer the free course to other families with mental illness in their home community. Developed by NAMI Vermont in 1990, the program has been sponsored by NAMI since 1998. Now offered by NAMI state organizations and local affiliates in 45 states, this program has graduated over 75,000 family members across the nation.

The NAMI Provider Education Program (Burland, 1995) is a 10-week course that is designed to be taught to employees of community mental health agencies by consumers and individuals who have or had mentally ill family members. The idea is that anyone who has had any contact with consumers or their families should be exposed to the principles and philosophy of family collaboration and consultation. The team that presents this program consists of 5 individuals: 1 professional provider who is also a family member; 2 family members; and 2 consumers. The team is a true partnership with no one designated as the spokesperson, and with classes being taught collaboratively by all the team members (Mohr, Lafuze, & Mohr, 2000).

Finally, NAMI and the Human Interaction Research Institute of Los Angeles collaborated on a Center for Mental Health Services funded project, which identified seven core competencies that professionals need in order to involve families as partners in treatment. These competencies include: 1) developing a collaboration with the family; 2) offering information on mental illness; 3) enhancing family communication and problem solving; 4) helping with service system use; 5) helping family members meet their own needs; 6) addressing special issues concerning the patient; and 7) addressing special issues concerning the family (CMHS, 1998).

Thus, one might conclude that a significant amount of work has been done, which relates to the indications for and implementation of family education strategies. This is true for education directed at family members. However, what is not clear is the precise impact that the NAMI programs have had on changing clinicians' attitudes, values, or behaviors. For example, one survey of state mental health programs was conducted to determine the extent to which states are facilitating the delivery of services to families of those with severe and persistent mental illness. This survey found that of the 44 responding states, 73% did not have a policy about types of services delivered to families (Dixon et al., 1999). Another survey of 719 persons with schizophrenia found that fewer than 1 in 10 of their

families received even minimal education and support (Lehman, 1998). Thus major issues remaining to be addressed relate to meeting the educational needs of families of persons with mental illnesses.

Front-Line Staff Education Issues

In the public sector, the 1980s saw considerable effort invested in public-academic linkages. However these tended to focus on enhanced relationships between public mental health systems and academic departments of psychiatry. Scant attention was paid to front-line clinicians who lacked professional degrees. Vaccaro & Beaudin (2001) call for an “extensive retooling of our educational and training institutions so that they offer didactic and practical” content to offset a deficit in penetration of best practice skills and competencies in the workforce (p. 83). In fact, there are almost no “educational best practices” to report on for non-degreed or paraprofessional workers in mental health.

An experiential learning program is reported by Goldman and colleagues (1993) who described an innovative venture that was jointly sponsored by a state NAMI organization, a public mental health system, and an academic department of psychiatry. The program design has adults with serious mental illnesses spend a week at an ocean-side camp with staff and trainees. Staff and trainees experience consumers in a relaxed informal and normalizing environment (as opposed to a clinic or hospital), living, eating, and engaging in activities together. Another skill-based staff training program was developed by Reid and Parsons for direct-care staff who work with individuals with moderate and severe disabilities (Reid & Parsons, 1994). The Teaching-Skills Training Program consists of three phases: 1) classroom-based instruction, 2) “on-the-floor” monitoring and feedback, and 3) maintenance and generalization. A similar program was developed by Devereux’s Institute of Clinical Training (McCurdy, Ludwowski & Mannella, 2000). It incorporates multiple opportunities for staff trainees to observe skill demonstrations, practice skills, and receive instructor feedback on staff performance. The program incorporates content-based pre- and post-tests, as well as performance-based observational post-tests. It is unique because it is the first attempt to use a standardized training package across a multi-site national agency.

Participants consistently report that experiencing the Step Into My Shoes program radically altered their sense of what they had learned from texts and lectures.

Another partnership between a state system and an academic institution is the Step Into My Shoes program (South Carolina Department of Mental

Health, 1996). This program, which was designed by psychology graduate students at the University of South Carolina as a class project, offers graduate students and faculty in the major mental health disciplines to go through the full admission process to a state mental hospital, and then spend 2½ days living, eating, and sleeping in the hospital with hospitalized consumers. They attend group sessions, and are generally immersed in the daily life activities of the patients. Patients and staff are aware that the students and faculty are not inpatients, but the fact that they wear ID bracelets, receive “medication” (candy in dose cups) and take part in activities soon blurs the lines. Participants consistently report that the experience radically altered their sense of what they had learned from texts and lectures.

A different type of initiative has developed under the leadership of Dr. Roy Wilson, former Commissioner of Mental Health in Missouri. It is reflected in the vote of the National Association of State Mental Health Program Directors (NASMHPD) on June 2, 2000, to embark on a multi-year concentration on cultural competence (NASMHPD, 2000). “These efforts may include, but are not limited to: developing and disseminating information and technical assistance on best practices in culturally competent services; providing forums for state and national dialogues on the need for and effective provision of culturally competent mental health and addictive disorders services; and cooperating with other state and national organizations to develop research, education, training and performance-based initiatives to ensure the provision of culturally competent mental health services” (NASMHPD 2000). Specifics of the implementation are still being developed.

A more local demonstration that preceded the NASMHPD policy statement, but is certainly consistent with it, is the work of Dr. Dolores Macey, Director of the Cultural Action Center at the South Carolina Department of Mental Health. As a way to reach the department’s 6,000 employees (a significant proportion of whom are non-degreed mental health workers), Dr. Macey designed a series of educational programs that were delivered via satellite around the state. The series used a mix of expert didactic materials, role plays, and live interaction with a studio audience and callers from around the state. Resource materials are provided in printed format and archived on a web site, and the ongoing training is reinforced through a network of cultural competence committees in each community mental health center and hospital. The content and focus of the overall program are detailed in an action plan that has been sanctioned by the agency’s governing body, and which is geared to creating a floor of basic competency in dealing with specific populations served by the public system: African Americans, Native Americans, Hispanic/Latino groups, including migrant workers, the deaf community, mountain peoples, and others. Re-

sponse to this statewide initiative has been generally positive, and especially so given the sensitive nature of these discussions.

Individual programs in the series have focused on such topics as ethnopharmacology, research findings on differential diagnoses among races and cultural groups, working with consumers who are part of the deaf subculture, working with trauma victims in a cultural context, and others. Each program utilizes a diverse faculty (in terms of discipline, race, and culture) and uses a variety of teaching methods.

In the children's area, certainly some of the most impressive public-academic linkages have occurred through state and other political jurisdictions' efforts to implement Multi-Systemic Therapy (MST), an evidence-based approach to treating behaviorally very disturbed children and adolescents, especially those who engage in antisocial behaviors (Henggeler, Schoenwald, & Pickrel, 1995). The developers of the model have been rigorous in designing the training model for MST (involving basic training, booster sessions at specified intervals, and ongoing structured supervision) and also the instrumentation for fidelity monitoring.

CONCLUSIONS

A number of existing documents suggest the competencies needed by those employed in mental health organizations. These competencies would appear to apply to all mental health providers, although they can be expected to vary in their degree of intensity based upon the education, training, and job responsibilities of the provider. Performance measures of cultural competency have been described (Table 1; Siegel et al., 2000), along with affirmation of their potential to reduce racial and ethnic health disparities (Brach & Fraser, 2000). Similarly, essential skills for mental health clinicians have been elaborated upon (Schreter, 1997). Surveys have been conducted to determine what mental health clinicians need to know to practice effectively (Shueman & Shore, 1997). A training curriculum for administrators in public mental health and substance abuse organizations has been developed (CMHS, 1997). Gaps and future directions in adult practice guidelines, standards, and provider competencies have been assessed (Coursay, 1997). Finally, core clinical competencies that pertain to community-based care of the seriously mentally ill (Table 2; Young, Forquer, Tran, Starzynski, & Shatkin, 2000) and that support the goals of consumer and family empowerment and rehabilitation have been articulated, as well as competencies for direct-service staff who work with adults with serious mental illness (Table 3; CMHS, 1998) in public mental health and managed care systems.

These carefully considered and reviewed documents undoubtedly add

TABLE 1
Domains, Levels, and Factors Related to Cultural Competency

<i>Domains</i>	<i>Administrative (Managed Care Organization/ State) Factors</i>	<i>Provider Network Factors</i>	<i>Individual Staff Member Factors</i>
Needs Assessment	Target community profile Enrollee profile User profile	Local community profile User profile	Initial screening and intake
Information Exchange	Prevention (early detection) Stigma reduction Healthcare plan contents	Prevention (early detection) Stigma reduction Healthcare plan contents Communication with informal networks Community input	CC consumer and family education Knowledge of benefits and rights
Services	Approaches for developing CC services Availability of CC services Access to CC services Costs	Approaches for developing CC services Availability of CC services Access to CC services	Approaches for delivering CC services CC referrals
Human Resources	Recruit and hire CC staff Develop disseminate CC training materials CC-trained administrative staff Employee evaluation	Hiring staff CC training Interpreter training Employee evaluation Employee retention	CC training CC performance
Policies/ Procedures	CC reflected in policies/plan Monitoring implementation of CC plan Inclusion of CC elements in management information system Periodic review of CC in provider network	CC reflected in policies/plan Monitoring implementation of CC plan Inclusion of CC elements in management information system	Involvement in CC activities
CC Outcomes	Services in managed care plan are CC Services of managed care administration are CC Utilization patterns	Services are CC Utilization patterns Clinical outcomes Diagnosis	Consumer outcome assessments

Note. CC=cultural competency. Table is from Siegel, C., Davis-Chambers, E., Haugland, G., Bank, R., Aponte, C., and McCombs, H. (2000). Performance measures of cultural competency in mental health organizations. *Administration and Policy in Mental Health*, 28(2), 98.

TABLE 2
**Core Competencies for Practitioners Providing Care to Individuals
 with Severe Mental Illness**

<i>Initial and Ongoing Assessment</i>	
1. Diagnosis	6. Cultural Factors
2. Functional Assessment	7. Client Preferences
3. Medical Evaluation	8. Risk Factors
4. Critical Stresses	9. Client Knowledge
5. Basic Needs	10. Cognitive Assessment

<i>Family and Support System Involvement</i>	
1. Client Preferences	3. Family Role
2. Information from the Family	

<i>Social and Cultural Factors</i>	
1. Social and Cultural Knowledge	2. Cultural Specificity

<i>Treatment</i>	
1. Medication Treatment	4. Hospitals and Commitment
2. Concurrent Conditions	5. Outreach
3. Crisis Intervention	

<i>Recovery and Empowerment</i>	
1. Optimism	5. Rehabilitation
2. Holistic Approach	6. Self-Advocacy
3. Goals	7. Natural Supports
4. Education	

<i>Provider-Client Relationship</i>	
1. Respect	4. Access to Care
2. Communication	5. Confidentiality
3. Stigma	

<i>Community Resource Management and Coordination of Care</i>	
1. Entitlements	3. Community Resources
2. Community Integration	4. Coordination of Care

Note. Table is from Young, A., Forquer, S., Tran, A., Starzynski, M., & Shatkin, J. (2000). *Journal of Behavioral Health Services Research*, 27(3), 321-333, copyright (c) 2000 by Sage Publications, Inc. Reprinted by permission of Sage Publications, Inc.

TABLE 3
**Outline of Competencies for Direct Service Staff Who Work
 with Adults with Serious Mental Illness in Public Mental Health/
 Managed Care Systems**

1. Regards adults with serious mental illness as persons with dignity and competence and engages them as full collaborators in service planning, delivery, and evaluation
 - A. Uses language and behavior that consistently reflect and enhance the dignity of individuals with mental illness
 - B. Fosters client empowerment
 - C. Fosters consumers' recovery
 - D. Demonstrates holistic understanding of adults with mental illness
 - E. Works in partnership with service recipients in all aspects of service planning, treatment and support activities
 - F. Provides needed information and education
 - G. Helps clients achieve a normal lifestyle
 - H. Works to diminish stigma
2. Where relevant, includes family members and caring others in all aspects of service planning, delivery, and evaluation
 - A. Understands the unique issues facing family members of persons with mental illness
 - B. Engages families in the treatment and rehabilitation process
 - C. Knows about family support resources and intervention strategies
 - D. Addresses the expressed needs of individual families
3. Demonstrates current knowledge of issues related to mental illness
 - A. Demonstrates up-to-date knowledge of different characteristics and courses of mental illnesses, as well as risk factors, and how people are affected
 - B. Recognizes the unique needs of individuals with mental illness and co-occurring disorders (e.g., substance abuse, developmental disabilities, physical disabilities, personality disorders, trauma, brain injury)
 - C. Knows about issues pertaining to society, culture, race, gender, and other issues related to mental illness and its treatment
4. Knows and uses best practices of intervention and support strategies
 - A. Demonstrates basic communication and other intervention skills
 - B. Teaches both simple and complex skills, including physical, social, cognitive, emotional, and other relevant skills
 - C. Knows a variety of program models and their philosophies
 - D. Knows about a range of crisis prevention and crisis intervention approaches

TABLE 3 (*Continued*)

-
- E. Understands the principles of community support, rehabilitation, and managed behavioral health care
 - F. Knows about psychotropic medications
 - 5. Designs, delivers, and documents highly individualized services and supports
 - A. Encourages and facilitates personal growth and development toward recovery and wellness
 - B. Routinely solicits personal goals and preferences
 - C. Designs personal growth/service plans based on individual choices and preferences
 - D. Ensures individualized services and supports
 - E. Facilitates and supports natural support networks
 - F. Designs, delivers, and documents services that meet the requirements of state, regulatory, and funding agencies
 - 6. Effectively accesses and employs community resources
 - A. Identifies, develops, and maintains good relationships and linkages with a wide range of community resources
 - B. Knows about entitlement and benefit programs
 - C. Integrates community resources and entitlement programs into service planning and delivery
 - D. Participates in public education and advocacy
 - 7. Demonstrates knowledge of legal issues and civil rights that are relevant to work setting and occupation
 - A. Knows about legal issues applicable to provider's mental health setting
 - B. Knows about individual rights
 - C. Recognizes ethical guidelines and boundaries for community support work
 - D. Knows about and connects individuals to legal and advocacy resources as needed and/or requested
 - 8. Works collaboratively within and across the service system (e.g., with other professions, with agency and interagency teams, managed behavioral health care organizations, state and county systems, community boards, all in the best interests of the client)
 - A. Demonstrates knowledge of own agency and its place within the mental health care system
 - B. Assists in building positive working relationships within and across the service system (e.g., agency and interagency teams, family members, service recipients, concerned others)
 - C. Knows about and skilled in working within a managed behavioral health care framework

TABLE 3 (*Continued*)

-
9. Conducts activities in a professional and ethical manner
 - A. Adheres to recognized ethical and other relevant standards
 - B. Performs work in a positive manner
 - C. Shows commitment to professional development
 - D. Values accountability and observes appropriate procedures
 10. Conducts activities in a culturally competent manner
 - A. Understands and values cultural and racial differences, their alternative perspectives on mental illness, help-seeking, and alternative healing practices, as well as lifestyles, goals, family and community life
 - B. Able to clearly understand and communicate effectively with the client
 - C. Makes diagnoses that are culturally informed
 - D. Makes assessments that are culturally informed
 - E. Develops treatment plans that are culturally informed
 - F. Provides culturally competent treatment
 11. Knows methods of evaluation and applies them appropriately to own work
 - A. Knows research findings applicable to position
 - B. Uses evaluation and feedback in own work
-

Note. Outline is from the Center for Mental Health Services (1998), *Managed care initiative: Adult panel summary report*.

value to the field. However they all suffer from common limitations. First, they do not always identify which type of clinician population (professional or paraprofessional) is the focus of their clinical expectations, nor are they designed to address the unique learning needs of these very different clinician populations. Second, they do not develop processes or strategies for the achievement of these competencies. Third, there is no discussion of how individuals will be evaluated to determine if these competencies have been achieved. Fourth, they have not led to the initiation of any type of organized or consensus plan for their implementation. For these reasons they are viewed as potentially useful to the field, but also detached and perhaps irrelevant to the everyday lives of the current mental health work force.

Reviewing the data and supporting evidence for the topics addressed in this paper has been a daunting and somewhat discouraging task, largely due to the paucity of attention given to these areas of inquiry. There are exceptions, such as the work of Minkoff and Pollack (1997) who describe tips for surviving managed mental health care in the public sector. How-

ever, few of the innovative programs described in these pages have yet to be rigorously evaluated and widely disseminated in the field. Nonetheless, certain recommendations can be made with a sense of expectancy and enthusiasm for the potential of the field to make a significant contribution to the educational needs of consumers, families, and public-sector staff. That enthusiasm is driven in large part by the freedom in these arenas from existing structures of licensure and accreditation, which, whatever their contributions to creating a floor of basic competency, can also become shackles that inhibit rather than foster educational innovation. It is also well recognized that curriculum change in academia moves at a glacial pace. Hopefully educational changes among consumers, families and public-sector staff can proceed with fewer restrictions, more openness to the realities of the clinical environment, and greater willingness to engage in innovative and less entrenched educational processes.

Structures of licensure and accreditation can also become shackles that inhibit rather than foster educational innovation.

Thus, the following recommendations are offered to stimulate discussion and creative thought. They will not itemize the competencies contained in the reports that have been previously cited. In fact, it would seem that listing the competencies is the easier task. The more formidable quandary is to determine how one can transform such cognitive lists of needed competencies into new skill sets and behavioral repertoires. Neither are the recommendations intended to serve as proven guideposts for success or prescriptive pronouncements that limit active debate. They may, in fact appear ambitious, unrealistic, or impractical given current realities. However if change is to occur in the behavioral health field, leaders are obligated to open the floodgates to new possibilities and to challenge both the *status quo* and the *status quid pro quo*.

RECOMMENDATIONS

1. *Learn from Direct Marketing*: The success of pharmaceutical companies and others in driving consumer choice in the marketplace and shaping provider practice has been impressive. It is proposed that strategies be developed to essentially educate consumers and families about best practices so that they in turn will approach mental health providers with evidence-driven expectations. It is optimistic, but credible, that an informed “consumerate” may do for the behav-

ioral health community what an informed electorate can do for the body politic.

2. *Use Experiential and Interactive Models:* The clinical community has been described as “a new priesthood” that jealously guards knowledge and uses arcane language as a way to retain power and cover gaps in knowledge (Whittington 2000). Strategies that put clinicians, trainees, families, and consumers together in rich, normative learning environments are essential complements to classroom, literature- and web-based learning, and traditional residencies or *practica*. In-person training is an essential component of such activities.
3. *Balance the Use of Internet Technology:* Information about mental illnesses and chemical dependency and their treatments is widely circulated on the Internet, although some of it is faulty, as Lissman and Boehnlein (2001) discovered. Web sites that provide user-friendly but refereed information about best practices will serve consumers, families, and providers well. There is also a need to create or enhance the use of Web-based formal degree and certificate programs for non-degreed mental health workers and their consumer and family allies. However, Web-based learning should be balanced with personal training and supervision.
4. *Employ Asynchronous Learning Methods:* Asynchronous learning (i.e., learning that is not time and place dependent—often referred to as “learning anywhere, anytime”) has become a buzz word in industry and, increasingly, in education. This is particularly applicable to consumers, families, and public-sector staff. Flexible learning systems are needed to disseminate information and provide opportunities for public-sector staff to master the content related to clinical competencies and best practices at a time and place that accommodates the needs of the learners. Asynchronous and self-directed content can increasingly be delivered to widely dispersed audiences both quickly and inexpensively.
5. *Provide Supervision and Support Systems:* Learning should not take place in a vacuum. Any mastery of new information should be followed by its use in actual clinical settings. In order to effectively listen to patients, clinicians must be listened to by their supervisors and system administrators. This requires the creation of formalized supervision and support systems in order to validate the application of content and to effectively shape new clinician behaviors. Provider feedback that is individualized and linked to powerful databases for self-benchmarking against peers can be an important assist to traditional supervisory and support mechanisms.
6. *Develop Competency Standards for Supervisors:* Competency standards should be developed to establish the competency requirements for

supervisors and support systems. Specifically, supervisors of mental health providers should be well aware of issues related to recovery and have a strong orientation to partnering with consumers and families. Commitment from top administration will be needed to implement this strategy. In systems that already rely heavily on peer counseling, such as the addictive disorders, new supervisory and support mechanisms may be required.

7. *Link Learning to Modified Practice by Monitoring Fidelity and Outcomes:* Education and training approaches that do not result in changed behavior (whether it be consumer, family, or practitioner) are of no value. Report cards, performance evaluations, and other feedback mechanisms, while still imprecise instruments in many ways, have potential for use as vehicles for modifying practice. Rewards and incentives should be tied directly to the acquisition of new knowledge and new skills, and to changes in actual practice efficacy.
8. *Advocate for the Creation of Genuinely Different Training Strategies:* Despite years of discussion, there are no known academic programs that simultaneously and jointly train mental health providers from multiple disciplines and at varying skill levels on the competencies related to psychiatric practice, with the involvement of consumers and families. This must be placed high on the agenda. Furthermore, no known academic program has formed a partnership with a public-sector hospital to specifically train mental health workers in a set of core clinical competencies. If academic programs are unwilling or unable to fill this need, then public-sector administrators should outsource this training to entrepreneurial programs that have proven expertise in this area.
9. *Demystify Data and Make Data Work:* Education about performance indicators, financing realities, health care management, and scientific evidence are essential elements for sophisticated consumers and providers. The field must establish the importance of the evidence base for practice and subsequently use data judiciously. Data should be accessible, understandable, and used for informed decision making. The creation of report cards and other decision-related data presentations are potential allies in this effort.
10. *Create Model Programs for Training Mental Health Workers in Core Competencies:* Given the lack of work in this area, an important first step would be to reach consensus on core competencies needed by public-sector staff. Then model programs can be designed to incorporate elements from the previous recommendations. A selected number of public-sector demonstration sites could implement the programs and evaluate their outcomes. After modification, these programs could then be broadly distributed to public-sector mental

health systems. In this new venture, truly integrated approaches to the full range of behavioral disorders should be the norm, ending the often artificial (and damaging) barriers between mental and addictive disorders.

SUMMARY

The field is ripe for a new vision of training and education for consumers, families, and public-sector staff. The changing demographics of the United States demand that that vision be focused and clarified by the lens of cultural competence. The Annapolis Conference on Behavioral Health Workforce Education and Training (September 10–11, 2001), where this paper was first presented, was but the first step in what must be a concerted effort to bridge the painful gaps in education and training for priority constituents of the mental and addictive disorders field.

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