Policy Discussion:

Healthcare workforce development –
a focus on mental health

Monday, 12.45 – 4.00 pm
Kiva B-C
Monday, May 20, 2002

Policy Discussion: Healthcare workforce development – a focus on mental health

“21st Century Behavioral Healthcare: Closing the Gap between What We Know and What We Do in the Delivery of Quality Care”

In its landmark series of reports Crossing the Quality Chasm, the Institute of Medicine (2001) argues that we must improve the capacity of our clinical education and training programs to prepare health care professionals and allied staff to operate in today’s rapidly changing environment. There is a significant gap between the skill sets many training programs develop in their students/trainees and the demands of the workplace and practice environment. What’s more, in terms of time, the gap between the development of exemplary practices and their adoption by academia and the practice field is over a decade.

According to the Institute of Medicine, a more responsive, state-of-the-art educational system is needed, one that would train health professionals to handle a number of essential tasks: to synthesize the growing knowledge base, communicate with patients, combine knowledge and patient preferences in selecting and tailoring treatments, use decision support tools to minimize overuse and underuse of care, employ a broad variety of treatment approaches, identify errors and hazards in care, continually measure quality in terms of process and outcome, and work collaboratively in treatment teams. This will mandate a fundamental shift in our current system of graduate and continuing professional education for both behavioral health and other healthcare professionals.

The formal panel presentation at the WICHE Commission meeting in Santa Fe in May 2002 brings together a distinguished group of behavioral health professionals experienced in higher education, policy, and practice to discuss this issue. Panel members – who have recently completed a comprehensive review of what is necessary for public mental health systems to succeed in addressing the “quality chasm” – will provide an overview of the issues and specific recommendations for the WICHE Commission’s consideration.

The meeting also will offer a unique joint meeting with the WICHE Mental Health Oversight Council, made up of the state mental health program directors from the WICHE states, and afford the opportunity for dialogue and focused response to the presentations from both public mental health and higher education leaders.
Moderator: Michael A. Hoge, associate professor of psychology, Yale University School of Medicine

Michael Hoge is an associate professor of psychology in the Psychiatry Dept. of the Yale University School of Medicine. He is the director of Managed Behavioral Health Care at Yale and the chief executive officer of Yale Behavioral Health, the university’s managed behavioral health care program. In January 2002, he was appointed director of Behavioral Health Services for the Connecticut Mental Health Center and executive director of the Managed Service System, a network of 14 public mental health agencies. His responsibilities for mental health and substance abuse services in the Greater New Haven area include strategic planning, program development, and program management. He is the author of numerous articles and chapters on professional education and training, mental health service delivery, the treatment of severe mental illness, and managed care. He is currently vice-president of the Academic Behavioral Health Consortium and a member of the Board of Directors of the American College of Mental Health Administration.

Neal Adams currently serves as medical director for the California Dept. of Mental Health. He is board certified in general psychiatry and holds subspecialty certification in addiction psychiatry. He is currently the president of the American College of Mental Health Administration and served for two years as the chair of the college’s Accreditation Organization Workgroup. He received his M.D. from Northwestern University in 1978 and his M.P.H. from Harvard University that same year.

Allen Daniels is a professor of clinical psychiatry at the University of Cincinnati, chief executive officer for Alliance Behavioral Care, and executive director for University Psychiatric Services. He is the president of the Academic Behavioral Health Consortium.

John A. Morris is a professor of clinical neuropsychiatry and behavioral sciences at the University of South Carolina School of Medicine and the founding director of the SC Center for Innovation in Public Mental Health, a partnership between the
School of Medicine and the South Carolina Dept. of Mental Health. In addition, Morris is a visiting professor of mental health policy at the George Warren Brown School of Social Work at Washington University in St. Louis, where he was named a distinguished alumnus in 1996. He serves as the principal investigator or co-investigator on several federal grants. Morris is immediate past president of the American College of Mental Health Administration and is a former state mental health executive. He serves on the National Advisory Council to the Georgetown Technical Assistance Center for Children’s Mental Health as well as the Kentucky Center for Mental Health Studies and is serving a three-year term on the Standing Review Committee on Knowledge Application for the Center for Mental Health Services.
The Training Gap: An Acute Crisis in Behavioral Health Education

By Michael A. Hoge
Yale University School of Medicine

Author Note. This work was supported in part by grant number R13 HS10965 from the Agency for Healthcare Research and Quality. An earlier version of this article was presented at the Annapolis Conference on Behavioral Health Workforce Education and Training, Sept. 10, 2001. Correspondence concerning this article should be addressed to Michael Hoge, Ph.D., Yale Dept. of Psychiatry, 25 Park Street, Room 604, New Haven, CN, 06519. Electronic mail may be sent via Internet to michael.hoge@yale.edu.

In press, Administration and Policy in Mental Health. Do not circulate.

Abstract. Changes in health care have outpaced changes in the educational programs offered to the behavioral health workforce. The result is a training gap that leaves graduate students, working professionals, and other direct care providers inadequately prepared for practice in the current health care environment. This article is based on a keynote address delivered at the Annapolis Conference on Behavioral Health Workforce Education and Training. Major changes in health care are reviewed, followed by a description of the training gap as an acute crisis that impedes the delivery of effective and efficient mental health and addictions services. The author describes a national initiative to narrow the training gap and calls for collective action by the varied groups and organizations that have a stake in this agenda.

The Changing Face of Health Care
What an extraordinary time in the history of health care. The revolution seemed to begin a decade and a half ago with the introduction of managed care. This has had enormous impact on the provision of mental health and substance abuse services, producing changes that appear to be far greater than in any other health care specialty. Managed care has challenged traditional assumptions and changed traditional practices regarding the location, intensity, and length of treatment. It has dramatically controlled or reduced expenditures on behavioral health care in both the private and public sector and constrained provider autonomy in selecting and delivering treatments (Hay Group, 1999; Ross, 2001). Managed care may be losing what one unnamed observer called “the war of anecdotes,” but it continues to expand its reach, covering an ever-increasing percentage of the American population (Fox, 2000).

The changes in health care, however, have involved much more than managed care. The debates between advocates of traditional “quality” and advocates of cost containment have fostered a growing awareness of the need to turn to research findings to determine the appropriateness, effectiveness, and cost benefit of different services. Practicing evidence-based treatment has been proposed as the new gold standard in service delivery when a relevant evidence base exists (Institute of Medicine, Committee on Quality of Health Care in America, 2001; Drake, Goldman, et al., 2001). Delivering care in accord with practice guidelines and identified best practices is the standard being promoted in the absence of an adequate evidence base (Glazer, 1998; Zarin, Seigle, Pincus, & MacIntyre, 1997). This has placed a growing burden on providers to digest a rapidly expanding and increasingly complex body of knowledge about mental and addictive disorders and their treatments.

The clamor is for providers to offer treatments that are not only effective but also safe. The Institute of Medicine’s (IOM) report, To Err is Human, brought to the nation’s attention the staggering rate of medical errors, which cause up to 98,000 deaths in America annually (Kohn, Corrigan, & Donaldson,
In the field of mental health, the death of a young boy, restrained by an inadequately trained aide led to a series of investigative newspaper reports on the injuries and deaths that result from seclusion and restraint (Busch & Shore, 2000; Weiss, 1998). This sparked new safety standards regarding these practices and a resurgence of interest in alternative techniques to prevent and manage aggressive and self-destructive behavior. The IOM report has called on providers to incorporate safety principles, programs, and reporting throughout their work (Kohn, et al.).

Consumerism has emerged as another enormous force of change that now pervades many aspects of behavioral health care (Robinson, 2001). The recipients of services and their families are demanding information about treatment options, treatment effectiveness, and side effects. They are insisting on meaningful participation in or control over treatment decisions. They are seeking and obtaining powerful roles on governing boards, jobs within provider and managed care organizations, and the resources to run consumer-operated services in which they can promote their philosophy of recovery and empowerment. And as consumers have gained a stronger voice, they have clamored for treatments that are relevant to them – to their gender, to their race, to their culture, and to their age (U.S. Dept. of Health and Human Services, 2001).

There have been other changes in health care as well. There are increasing demands on providers by accrediting bodies and health care purchasers to demonstrate the quality of care through the assessment of patient satisfaction and treatment outcomes (Daniels & Stukenberg, 2001). There is a press to improve the detection and treatment of addictive disorders and to integrate mental health and substance abuse treatment for those individuals who are dually diagnosed (Drake, Essock, et al., 2001; Karam-Hage, Nerenberg, & Brower, 2001). Recognition of the enormous unmet need for treatment has led to pressure to expand access to care through outreach and through collaboration with primary care providers (American College of Mental Health Administration, 1998; Katon et al., 2001; Nickels & McIntyre, 1996; Rosenheck et al., 2001).

**The Training Gap**

The Critical Role of Education. The Institute of Medicine, in a second report titled *Crossing the Quality Chasm*, has argued that clinical education and training must prepare providers for the changing environment (Institute of Medicine, 2001). Provider education is portrayed as an essential tool for improving what the IOM deems to be the poor quality of the U.S. health care system – a system that has significant negative effects on Americans’ health, functioning, dignity, and comfort.

The authors of the IOM report outlined key tasks for a state-of-the-art educational system. It must teach health professionals to synthesize the growing knowledge base, communicate with patients, combine knowledge and patient preferences in selecting and tailoring treatments, use decision support tools to minimize overuse and under-use of care, employ a broad variety of treatment approaches, identify errors and hazards in care, continually measure quality in terms of process and outcome, and work collaboratively in treatment teams (Institute of Medicine, 2001).

Graduate Education. Unfortunately, while health care has changed dramatically over the past decade and a half, our educational systems have not. Graduate education and training programs are a first concern, with over a 100,000 students enrolled in such programs annually. Table 1, which is abstracted from *Mental Health, United States, 2000*, details the distribution of those students across disciplines (Peterson et al., 2001).
Table 1. Number of Trainees by Disciplines

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Number&lt;sup&gt;a&lt;/sup&gt;</th>
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<tbody>
<tr>
<td>Psychiatry</td>
<td>5,934</td>
</tr>
<tr>
<td>Psychology</td>
<td>23,088</td>
</tr>
<tr>
<td>Social Work (MA &amp; PhD)</td>
<td>37,425</td>
</tr>
<tr>
<td>Psychiatric Nursing (C.S.)</td>
<td>1,274</td>
</tr>
<tr>
<td>Counseling</td>
<td>20,637</td>
</tr>
<tr>
<td>Marriage &amp; Family</td>
<td>9,277</td>
</tr>
<tr>
<td>School Psychology</td>
<td>8,123</td>
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</tbody>
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Note. Adapted from Peterson, West, Tanielian, et al., 2001. Refer to that publication for definitions and interpretation of data.

<sup>a</sup>Includes full & part-time trainees. Estimates are for a single year between 1996-2000 and the year varies by discipline.

Graduate programs are imbedded in universities and health systems, which are often tradition-bound, highly bureaucratized, and slow to evolve. Faculty members are typically promoted for their research and compensated for their clinical work. Teaching activities are seldom the basis for advancement or compensation. Thus, there is little incentive within faculties to excel or innovate in the education arena (Himelein & Putnam, 2001).

To some extent, faculty members and the programs that they manage have been buffered from recent changes by the large systems in which they work. Driven by faculty interests and independence, academic clinical programs may be maintained and subsidized even after losing their competitiveness in the marketplace. Thus, students may train in programs that fail to mirror those in which they will be employed after graduation and frequently are exposed to faculty mentors modeling negative and demoralized attitudes toward the practice of health care. Too seldom, students are educated about the complex and competing demands that shape behavioral health care and the intriguing challenges and dilemmas that face our field. Too often, they are given simplistic explanations that portray the forces of “good,” represented as traditional approaches, battling the forces of “evil,” usually represented as managed care.

There are a host of other concerns about our graduate education systems. Evidence-based and guideline-based practice is not emphasized in many programs. Essential skills required for working in managed care environments are not taught or learned, in part because of the exclusion of students from the ambulatory networks of managed care organizations. Training continues to occur in silos by discipline, despite the trend toward multi-disciplinary and multi-specialty collaboration in practice, and in the face of compelling evidence that team approaches, such as PACT, are optimal for some consumers.

Continuing Education. There are troubling concerns not only about graduate education, but also about continuing professional education of the existing workforce. Table 2 outlines the size of the workforce by discipline, which in total is over a half million strong (Peterson et al., 2001).
Table 2. Clinically Trained Workforce Size by Discipline

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Numbera</th>
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</thead>
<tbody>
<tr>
<td>Psychiatry</td>
<td>41,731</td>
</tr>
<tr>
<td>Psychology</td>
<td>77,456</td>
</tr>
<tr>
<td>Social Work</td>
<td>192,814</td>
</tr>
<tr>
<td>Psychiatric Nursing (C.S.)</td>
<td>15,330</td>
</tr>
<tr>
<td>Counseling</td>
<td>108,104</td>
</tr>
<tr>
<td>Marriage &amp; Family</td>
<td>44,225</td>
</tr>
<tr>
<td>Psychosocial Rehab</td>
<td>100,000</td>
</tr>
<tr>
<td>School Psychology</td>
<td>31,278</td>
</tr>
</tbody>
</table>

Note. Adapted from Peterson, West, Tanielian, et al., (2001). Refer to that publication for definitions and interpretation of data.

aIncludes full & part-time personnel. Estimates are for a single year between 1996-2000 and the year varies by discipline.

Most continuing education consists of attendance at lectures or conferences. There is little evidence that this activity changes professionals’ practice, let alone influences patient outcomes (Davis et al., 1999). As in all aspects of behavioral health education, participants in continuing education receive credit for “doing time” in an educational program. They are neither asked to demonstrate nor rewarded for demonstrating competence in patient care. Similarly, license and credentialing renewal are tied predominantly to the number of hours spent in educational activities. Concern about these issues is heightened because practice patterns appear to be set early in a professional’s career and to change slowly, if at all.

Direct Care Staff, Consumers, and Family Members. A third area of focus calling for attention is the training of those who may not hold professional degrees, but who comprise a major segment of the front-line workforce in behavioral health. This includes non-degreed, paid caregivers as well as consumers and their family members.

Direct care staff members without advanced professional degrees are often referred to as paraprofessionals, psychiatric technicians, aides, or mental health workers, depending on the service setting. It is estimated that this segment of the workforce comprises nearly 40% of active patient care staff in behavioral health organizations and over 60% of patient care staff in state and county psychiatric hospitals (Manderscheid et al., 2001). The orientation and training programs for these providers are often minimal, despite the size of this group and their direct care role in mental health and addictions services. The training that does occur appears limited to topics required by accreditation bodies, such as fire safety and the management of violent behavior. Training efforts for this segment of the workforce are eroding quickly as current budget pressures cause reductions in training personnel and resources, as well as tighter limits on the time available for new recruits to participate in training. The frequency of staff turnover at the front lines of our behavioral health systems makes the training of these providers a particularly pressing concern.

While not traditionally considered part of the workforce, consumers and family members have been a silent army, increasingly recognized for the role that they play in caring for those who are ill. They have their own, unique needs for timely and accurate information and skill development. There are innovative, but still scattered efforts to educate consumers and family members for the purposes of aiding their personal recovery, enhancing their capacities to help other consumers and families, and developing their abilities to teach providers about illness, recovery, and collaborative approaches to treatment (Amenson & Liberman, 2001; Burland, 1995, 1998).
Characteristics of the Training Gap
This assessment of health care reform and workforce needs leads to the conclusion that there is a “training gap” in behavioral health education. It is the gap between what is being taught and the realities that providers, consumers, and family members encounter in today’s health care systems. It is a gap between the theories and practices being taught and the theories and practices that the progressive leaders in our professional, consumer, and family organizations consider cutting edge. It is the gap between the settings in which we train and the settings in which we expect providers to practice. It is the gap between teaching students to lament the past and teaching them to embrace the future – with curiosity and with conviction about the importance of the work they will do and the enormous contributions they can make to the quality of life for persons they serve. It is the gap between the dollars we spend on human resources, generally estimated as 75% of all behavioral health expenditures, and the minimal funds expended to educate and train this workforce. Most important, it is the gap between the norm in our educational systems and a vision of what a state-of-the-art, or perhaps state-of-the-science, education could be.

The training gap is not new. Medical education, for example, was revamped in the early 1900s following the release of the Flexner (1910) report. There have been at least 20 subsequent reports calling for the reform of medical education, citing the types of weaknesses described above (Christakis, 1995; Enarson & Burg, 1992; Institute of Medicine, 2001). The existence of the training gap in the mental health field was lamented by Feldman (1978) over two decades ago.

But what was a chronic problem in behavioral health care education is now an acute crisis. The gap has become glaring because the pace of change in the field has accelerated dramatically and is not expected to slow in the foreseeable future. The perception of a crisis grows as time passes and we see so little change in either the process or the content of clinical education.

Many naively thought that our education programs would be forced to “turn on a dime,” teaching students practical skills for surviving and thriving in health care systems that were dramatically altered by managed care. As time wore on, it seemed certain that our educational programs would at least “turn on a decade,” responding, albeit slowly, to the many faces of health care reform. Paul McHugh, the former Chairman of Psychiatry at Johns Hopkins University, has argued that our field actually “turns on a generation,” with changes in philosophy, practice, and education occurring only in 25-30 year cycles (McHugh, 2001). In a science-driven and cost-driven society, we cannot accept this pace of change in our educational systems and hope to remain relevant as a field.

At a broad conceptual level we have two main challenges. One is to update our educational programs, making them more current and relevant. But more daunting is the task of rethinking our approach to education. Just as the drive for productivity, efficiency, accountability, and demonstrated outcomes has swept business, industry, and health care, so too will it undoubtedly sweep the field of education.

Selected universities and organizations are experimenting with educational innovation, such as web-based learning (National Council for Community Behavioral Healthcare, 2002; University of Phoenix, 2002). However, many institutions of higher learning strongly oppose such approaches, viewing them as departures from tradition that violate basic educational principles. What seems certain is that we will need to find more efficient and effective strategies for disseminating the growing knowledge base and developing core competencies in the workforce. As our field becomes more complex, we cannot simply keep adding to a growing list of mandatory requirements that burden training directors and faculties, unless we simultaneously provide fresh strategies for achieving educational goals.

Obstacles to Change
The process of change is always complex. Educational systems are linked to and partially driven by their host universities and health systems, applicable accreditation standards, licensing requirements, and the systems for financing education. Each of these elements of the educational landscape restricts the
degrees of freedom in efforts to revamp training approaches, even for those who are interested in change.

Further obstacles to achieving progress on this agenda are the many differences amongst those who work in this field. There are competing views of illness, treatment, and recovery, and discipline-specific differences over “scope of practice” issues. Many even disagree over what nomenclature to use when referring to those who provide and those who receive behavioral health services.

The old adage that “where you stand depends on where you sit” clearly applies to this agenda. Your view on the relevance of current education programs and the need for reform is undoubtedly influenced by your role as educator, student, provider, consumer, family member, accreditor, or representative of a professional association. Making progress on this agenda will require finding some common ground among these diverse constituencies (Adams & Daniels, 2002).

Unfortunately, a “call to action” is too often viewed as a “call to arms.” It is taken as a criticism or as a threat to those responsible for the status quo. It seems impossible to claim that we can and should do better, without offending those who are working diligently to train the workforce. Exasperated by the slow pace of change, those calling for reform may overstate the magnitude of the problem, further polarizing the debate. The challenge is to find the appropriate language and a constructive tone, recognizing the need for change and respecting the long and strong traditions in our educational systems.

A National Initiative on Behavioral Health Education and Training

Concerns about the training gap have been of interest to numerous groups and organizations. These include the American College of Mental Health Administration (ACMHA), a national interdisciplinary organization with a 20-year history of working to improve the quality of behavioral health care, and the Academic Behavioral Heath Consortium (or ABHC), a relatively new organization comprised of departments of psychiatry seeking innovative responses to recent changes in clinical care, the management of care, and education.

These two organizations had begun to focus independently on the workforce education agenda. Recognizing the benefits of joint action, they entered into a collaboration on a national initiative to address the training gap. That collaborative process led to the concept of a multi-phase, interdisciplinary initiative that would begin with a national meeting of stakeholders to build consensus and develop an agenda for change.

The proposal to launch a national education initiative was given an unexpected boost with the release in 2001 of the IOM’s report, Crossing the Quality Chasm (Institute of Medicine, 2001). Recommendation #12 from that report stated:

A multidisciplinary summit of leaders within the health professions should be held to discuss and develop strategies for (1) restructuring clinical education to be consistent with the principles of the 21st century health system throughout the continuum of undergraduate, graduate, and continuing education for medical, nursing, and other professional training programs; and (2) assessing the implications of these changes for provider credentialing programs, funding, and sponsorship of education programs for health professionals. (p. 208)

This recommendation bolstered efforts to convene a national meeting on behavioral health education. It also clarified that the educational crisis in our field is part of a larger crisis that permeates health care education in general.

Key federal support for the behavioral health initiative was obtained from the Center for Mental Health Services and the Office of Managed Care within the Substance Abuse and Mental Health Services Administration, as well as from the Agency for Healthcare Research and Quality. With this support, this
A national initiative was launched and a group of stakeholders were convened at the Annapolis Conference on Behavioral Health Workforce Education and Training on September 10-11, 2001. The focus in Annapolis was on three workforce groups: (a) students in graduate programs, (b) working professionals, and (c) consumers, families, and front-line staff. The IOM’s recommendations regarding the six aims of 21st century health care were offered as a context for the discussions about improving the relevance of behavioral health education and training. Those six aims highlight the need for a workforce capable of delivering care that is safe, effective, patient-centered, timely, efficient, and equitable (Institute of Medicine, 2001).

**Initiative and Conference Goals**
The first goal of this national initiative and conference on behavioral health education and training was to develop specific recommendations regarding the optimal knowledge base and skill sets required by the various workforce groups to survive and thrive in the current health care environment. A variety of recommendations regarding these topics were outlined in position papers, which were distributed to conference participants in advance of the Annapolis meeting. These papers were reviewed by participants during structured dialogue sessions in Annapolis and revised based on the feedback and recommendations that emerged from those discussions. Those recommendations are published in the position papers that appear in this issue of the journal (Daniels & Walter, 2002; Hoge, Jacobs, Belitsky, & Migdole, 2002; Morris & Stuart, 2002).

The second goal was to identify “educational best practices” that appear to be effective for each of these workforce groups in transmitting knowledge, building skills, and improving treatment outcomes. Numerous such practices were identified and reported in the position papers (Daniels & Walter, 2002; Hoge, Jacobs, Belitsky, & Migdole, 2002; Morris & Stuart, 2002). In addition, four innovative initiatives were presented in Annapolis to highlight diverse educational strategies. These are showcased in the accompanying article on best practices (Stuart, Burland, Ganju, Levounis, & Kiosk, 2002). The topic is also addressed in an article in this issue of the journal that conveys the perspective of graduate students on the education agenda (O’Connell, Gill, Artar, Jones, & Vargas, 2002).

A third goal of the initiative and the conference was to identify practical strategies for overcoming the barriers to improving the relevance of our educational programs. This topic is addressed in two articles in this journal issue: a call to action (Adams & Daniels, 2002) and an analysis of strategies for catalyzing change (Huey, 2002).

**Conclusion**
Launching this initiative has, itself, been an educational experience. Each step in the process has revealed new complexities and nuances in the issues, and has highlighted the daunting obstacles to accomplishing substantive change. We have been reminded repeatedly of how difficult it is to change a system, an organization, or even a single individual.

However, this initiative has also illuminated the vast reservoir of talent, creativity, and commitment within our field. There are many individuals who care passionately about the state of mental health and substance abuse care and who are concerned about the current preparedness of the workforce. There are individuals and organizations working hard in various ways to address the gap between education and practice, although they are often working in isolation, unaware of each other’s efforts.

We must narrow the training gap despite the obstacles. For meaningful change to occur, the organizers of this initiative believe that it is essential to pursue collective action. We must make an effort to learn more about the perspectives and the initiatives of others. We must then move forward quickly on a coherent, common agenda that will result in transformed learning environments: environments informed by a scientific evidence base; environments enriched by consumer and family wisdom; and environments that are in tune with and responsive to the dynamic realities of the constantly changing health care arena.
Surely, individuals in the workforce, as well as those who rely on the skills of the workforce, deserve no less.

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