



National Association of State Mental Health
Program Directors (NASMHPD)

NASMHPD Policy Brief

Workforce and the Public Mental
Health System

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I. BACKGROUND

There has been a widely recognized workforce shortage in the field of behavioral health for many years. It involves both specialty-level providers in mental health and addictions as well as primary care providers who frequently are needed to respond to persons with behavioral health needs. According to the Health Resources and Services Administration (HRSA), 77 million Americans live in areas that are not adequately served by substance abuse or mental health professionals, the majority of which are rural and remote.

That shortage will enter a crisis phase as the practical implications of parity and healthcare reform roll out over the coming months and years. The role of the specialty behavioral health sector will continue to change and modify, as it has in recent decades, but perhaps with more rapidity. The need for behavioral health services within primary care settings will be in much higher demand. The fact that so many individuals may have access to a new insurance benefit does nothing to change the reality of access to and availability of comprehensive and competent health services. Coverage does not equal availability.

In their review of behavioral health policy over the last fifty years, Frank and Glied summarized that the services and supports for people with serious and persistent mental illnesses were being performed “better but not well.” (Frank & Glied, 2006)¹. Taken together, this suggests that both capacity needs and competency must be considered.

Effective workforce development strategies must address the following challenges: (a) recruitment and retention; (b) accessibility, relevance, and effectiveness of training; (c) staff competency in integrated care, evidence-based practices, and recovery-oriented approaches; (d) attitudes and skills in prevention and treatment of persons with mental and substance use conditions; (e) leadership development; and (f) workforce roles for persons in recovery and family members (Hoge et al., 2007).²

At this critical juncture, the Substance Abuse and Mental Health Services Administration (SAMHSA) and HRSA have engaged in a new partnership focused on developing national technical assistance capacity to support workforce development and the integration of behavioral health and primary care. It can be anticipated that there will be considerable growth in the provision of behavioral healthcare within primary care settings, including but not limited to Federally Qualified Health Centers, but there will also be the need for highly specialized services for adults with serious and persistent mental illnesses (especially those with co-morbid substance use conditions) and for seriously emotionally disturbed children, youth and their families. It is essential in the coming cascade of change that we address both of these environments and that we sustain the gains the field has made in its understanding of the importance of recovery and resilience for those historically served by the public behavioral health systems.

In this very fluid environment, it is anticipated that there will be a swirling confluence of vectors that will interact simultaneously, but the two most powerful may well be structural issues (how services are designed, administered, delivered and regulated) and how those services and supports are financed. Will reform push for unidirectional integration of behavioral health specialty competencies into primary care

¹ Frank, RG & Glied, SA. (2006). *Better But Not Well: Mental Health Policy in the United States Since 1950*. The Johns Hopkins University Press, Baltimore, MD.

² Hoge, M. A., Morris, J. A., Daniels, A. S., Stuart, G. W., Huey, L. Y., & Adams, N. (2007). *An action plan on behavioral health workforce development*. Cincinnati, OH: The Annapolis Coalition on the Behavioral Health. (Available on-line at www.annapoliscoalition.org or at http://www.samhsa.gov/matrix2/matrix_workforce.aspx)

settings? Will benefit plans push primary care skills into traditional behavioral health provider organizations? Will more formal partnerships reflect a bidirectional integration that leaves each sector separate as they have historically been? Unfortunately, the answer is likely to be “All of the above.” Gawande (2009)³ posits that health care reform is essentially “path-dependent”, and is most likely to continue to follow existing pathways (or ruts) as it moves forward, which is certainly consistent with its history in the United States.

II. AN OVERVIEW OF SELECTED HEALTHCARE REFORM COMPONENTS

The following selected highlights from the Affordable Care Act (ACA) either (a) have some direct relevance to workforce issues for states, or (b) reflect the direction of the healthcare environment (incentives) and the potential size of the market to which states may have to respond.

- Insurance companies barred from dropping people from coverage when they get sick;
- Lifetime coverage limits eliminated and annual limits restricted;
- Young adults able to stay on their parents' health plans until age 26;
- Health plans no longer can exclude people from coverage due to pre-existing conditions;
- A new program under Medicaid that allows states to offer home and community based care for the disabled that might otherwise require institutional care;
- A new State Plan option under Medicaid that provides health homes for enrollees with chronic conditions, including substance use disorders and mental health conditions;
- Physician payment reforms in Medicare to enhance primary care services and encourage doctors to form Accountable Care Organizations;
- The Centers for Medicare and Medicaid Services (CMS) begins tracking hospital readmission rates and puts in place financial incentives to reduce preventable readmissions
- Medicare pilot on payment bundling to encourage doctors, hospitals and other care providers to better coordinate patient care;
- Individuals with income up to 133% of the federal poverty level qualify for Medicaid coverage;
- Healthcare tax credits available to help people with incomes up to 400 percent of poverty purchase coverage through insurance exchanges;
- Most people required to obtain health insurance coverage or pay a tax if they don't;
- Employers with 50 or more workers who do not offer coverage face fines if any worker receives subsidized insurance on the exchange;
- Medicare creates a physician payment program aimed at rewarding quality of care rather than volume of services.

The following elements from the ACA specifically address workforce development strategies:

- Establishment of the National Healthcare Workforce Commission. Appointments were made prior to the end of FY10, and, unfortunately, based on the biographical information provided, the roster of appointees does not reveal any representation of the behavioral health field.
- \$11 billion in dedicated funding for community health centers.
- \$1.5 billion in dedicated funding for the National Health Service Corps from 2011 to 2015.

³ Gawande, A. (2009) Testing, testing. The health-care bill has no master plan for curbing costs. Is that a bad thing? Medicine Department, *The New Yorker* December 14, 2009.

- Reauthorization of Section 747 of Title VII of the Public Health Service Act, the only federal program that provides funds to academic departments of family medicine and family medicine residency programs to increase training of family physicians.
- Establishment of several specific behavioral health workforce initiatives:
 - Primary Care Extension Program to educate primary care providers on chronic disease management, mental health and substance abuse services and evidence-based interventions;
 - Pediatric Specialty Loan Repayment Program provides incentives for providing certain specialties, including child and adolescent mental health and substance abuse treatment;
 - Grants to schools of social work, graduate psychology programs, and professional and paraprofessional training in child and adolescent mental health

The chart below identifies the potential reform component and explores the corresponding workforce challenge/opportunity.

Healthcare Reform: Behavioral Health Workforce Opportunities and Challenges	
<i>Reform Component or Intent</i>	<i>Workforce Opportunity/Challenge</i>
32 million additionally insured by 2019	Increased demand for services
23 million remain uninsured by 2019*	Continued need for safety net
Focus remains on employer sponsorship	Persons with disability remain with Medicaid
Increasing role of FQHC	Interface with specialty behavioral health safety net Recruitment/Retention competition for staff
Focus on development of “medical home”	Level of behavioral health integration
Integration of primary and behavioral health care	Team based care
Increased use of HIT	Adoption of technology
Expansion of the National Health Service Corps	Robust behavioral health representation
Shift to pay for performance	Integration of quality improvement, recovery cultures, & evidence based practices
Parity	Increased demand
Exemption for small employers	Continued need for safety net
Access to psychiatric hospitalization	Final shift of state hospitals away from acute care
Children remain eligible for dependent coverage under parent’s health plan	Enhanced transition between adolescent & adult service systems.
Elimination of lifetime limits on coverage	Consumers who have previously exhausted private options regain coverage.
Elimination of pre-existing condition exclusions	Reduce barriers to recovery & return to employment previously created by fear of loss of benefits
Creation of Accountable Care Organizations	Is behavioral health in or out; depth of integration e.g. housing, employment, etc.

* <http://www.csmonitor.com/USA/2010/0323/Obama-signs-health-care-bill-Who-won-t-be-covered>

When all is said and done about reform, these facts still remain:

- America is aging, and the baby boom is about to retire in great numbers over the next 15 years.
- Historically underserved rural and urban areas will continue to have difficulty recruiting and retaining human resources.

- The health care professional workforce is disproportionately Caucasian.
- The lag between science to service remains at 17 years.
- Consumers are often dissatisfied with quality of care and professionals.
- Employers are often dissatisfied with the preparation of new hires by academic training programs.

III. RECOMMENDED POLICIES AND ACTION STEPS FOR FEDERAL ENTITIES

As previously stated, effective workforce development strategies must address the following challenges: (a) recruitment and retention; (b) accessibility, relevance, and effectiveness of training; (c) staff competency in integrated care, evidence-based practices, and recovery-oriented approaches; (d) attitudes and skills in prevention and treatment of persons with mental and substance use conditions; (e) leadership development; and (f) workforce roles for persons in recovery and family members (Hoge et al., 2007).⁴ As such, NASMHPD offers the following recommendations:

- 1. Dramatically increase the use of available and emerging technology such as tele-medicine, online/web-based health care, smart phones, and electronic medical records at the community level.**

There is an urgent need to plan for the increased demand in mental health and substance abuse services, both in primary care settings, as well as in specialty clinic environments. An emphasis on and strong commitment to the use of technology must be a cornerstone to addressing this rapidly growing workforce shortage. Alternatives to face-to-face interaction must be optimized, which requires that funding to facilitate further development of technological advancements as well as adequate reimbursement for provision of such services must be considered.

Advancements in technology offer great promise. In addition to bringing greater access to general and specialty behavioral health services in underserved areas (which will only experience even greater challenges in the coming years), technology facilitates the ability to provide culturally competent services to an incredibly diverse community and real-time access to care. Technology also dramatically increases efficiency for the workforce, allowing for greater productivity, and can offer additional part and full-time employment opportunities for providers who wish to work from home or while traveling.

NASMHPD at the national and state level can be a leading voice for the use of technology in the behavioral health field as a way to help address the gap between demand and access to services. NASMHPD urges state Medicaid agencies to expand their coverage for tele-medicine and web-based health care, while offering technical assistance in how to maintain appropriate protections for quality and competence. National Council of State Legislators and the National Governor's Association could work with NASMHPD to develop model legislation that would provide universal models for licensure of behavioral health providers (especially peer- and family-counselors) that could pave the way for greater portability of credentials nationwide and therefore facilitate greater access to the use of technology.

⁴ Hoge, M. A., Morris, J. A., Daniels, A. S., Stuart, G. W., Huey, L. Y., & Adams, N. (2007). *An action plan on behavioral health workforce development*. Cincinnati, OH: The Annapolis Coalition on the Behavioral Health. (Available on-line at www.annapoliscoalition.org or at http://www.samhsa.gov/matrix2/matrix_workforce.aspx)

2. Ensure strong behavioral health representation on the National Healthcare Workforce Commission

Appointments to the Commission were announced prior to the end of FY10; however, based on review of biographical information of the appointees, representation of the behavioral health field is missing. An identified task of the Commission includes addressing “the health care workforce needs of special populations, such as minorities, rural populations, medically underserved populations, gender specific needs, individuals with disabilities...” Furthermore, “mental and behavioral health care workforce capacity at all levels” has been identified as a high priority area.⁵ As such, it is strongly recommended that behavioral health be adequately represented on this important Commission.

3. Provide increased resources to assist provider organizations with retention and competency of staff, including continuing education opportunities, strengthening career ladders, and targeting front line supervisors.

The data on stability in the front line workforce (the backbone of public systems) suggests that if there are limited strategic actions available because of constrained resources, then those resources are best targeted at supporting the effectiveness of first line supervisory staff.

SAMHSA, HRSA, CMS and NASMHPD should collaborate to develop pilot reimbursement models that incorporate on-going training and supports (especially those linked to evidence-based practices), including reimbursement for clinical supervision, into rate structures. NASMHPD should make this a priority for its membership, and help shape national workforce policy in this direction.

In addition, traditional academic training is inadequate to sustain competence of workers in the dynamic environment of contemporary practice; that dynamism is about to increase its pace exponentially, and there is very little infrastructure in place to support state behavioral health authorities in grappling with the workforce challenges that will accompany that rapid acceleration.

SAMHSA and HRSA should explore expanding the capacities of the Addiction Technology Transfer Centers (ATTC) to enable them to provide technical assistance and training across the broad spectrum of addictive and mental health conditions. SAMHSA, the funding source of ATTCs, could drive this enhanced role of ATTCs and/or design a more comprehensive model.

4. Provide increased resources and funding for workforce needs at community mental health centers

While an emphasis on behavioral health providers in primary care settings has been addressed in the ACA as evidenced by (a) \$11 billion in funding for community health centers, (b) \$1.5 billion in funding for the National Health Service Corps, (c) reauthorization of Section 747 of Title VII of the Public Health Service Act, (d) the Primary Care Extension Program to educate primary care providers on mental health and substance abuse services, and (e) the Pediatric Specialty Loan Repayment Program to offer incentives for providing certain specialties, including child and adolescent mental health and substance abuse treatment, the reality is that many individuals with severe and chronic mental illness require the services of more specialized and intensive services at a mental health center. Secondly, individuals with chronic conditions, especially adults with

⁵ http://www.gao.gov/hcac/nat_hcwc.html

serious mental illness, are more likely to choose their mental health clinic as their health home and are assessed in that setting on a more regular basis.

The increased demands that will be placed on community mental health centers cannot be ignored. HRSA, SAMHSA, CMS and NASMHPD must work together to design and support workforce needs at community mental health centers.

5. Expand reimbursement and grant opportunities for behavioral health providers

While the ACA will award grants to schools of social work, graduate psychology programs, and professional and paraprofessional training in child and adolescent mental health, only \$35 million is dedicated to this effort between 2010 and 2013. In addition to the recommendation that more funding be dedicated to this effort, it is recommended that other behavioral health professional “extenders” such as behavioral health focused physician assistants and nurse practitioners be included.

CMS could examine the use of “extenders” to help close the existing and worsening gap between demand and access to services. NASMHPD can provide leadership by urging state licensure boards and state human resource agencies to expand their understanding of and acceptance for a range of interventionists (with all appropriate protections for quality and competence) in behavioral health.

6. Ensure that the anticipated SAMHSA/HRSA TA Centers on integration and behavioral health workforce focus on practical assistance to states and territories (toolkits, distance education opportunities, staff licensure and accreditation approaches, etc.) that will meaningfully support NASMHPD members. In addition, provide resources and incentives to assist existing behavioral and primary care workers in the adoption of integrated practice.

Because these resources will be developed as cooperative agreements between the federal agencies and the successful vendor, it is vital that state behavioral health authorities influence the final design and parameters of the TA that is developed and delivered.

NASMHPD should be included on the TA Center’s planning group. NASMHPD in partnership with its members should also develop an inventory of recommended technical assistance tools and areas of focus of highest priority for states, to inform the new TA Center’s planning.

It seems especially critical that NASMHPD members (if they have not already) form strategic partnerships at the state level with their Primary Care Associations. They will be facing the same increased demand for basic care and will be unable to address the demand for behavioral health services that will come with that increased demand. Given that workers frequently cross back and forth across these systems—especially at the direct service workforce level—joint efforts to train and support the workforce could be beneficial in terms of both costs and client outcomes.

SAMHSA and HRSA should develop grant programs to expand the use of e-Learning strategies to strengthen and expand access to practice development curricula designed specifically to target public safety-net providers such as state behavioral health providers.

7. Increase the role of peer and family supports and recovery supports through systematic adoption of payment strategies (Medicaid and other third party insurance) that provide meaningful employment for certified peer, family and recovery workers.

Even though private sector insurers are beginning to see the benefits of peer services, state behavioral health authorities and NASMHPD have the depth of experience to lead on this issue. If the state authorities retain responsibility for such ‘deep end’ services as state hospital and forensic beds (see below) then aggressive support for increased adoption of peer operated services is necessary in the near term. The use of peer and family members in the workforce not only increases workforce capacity but also expands the use of a best practice and optimizes lower cost, community-based services.

SAMHSA, HRSA, CMS and NASMHPD should collaborate to develop pilot payment programs to demonstrate the cost and quality effectiveness of peer and family delivered services and supports to inform the establishment of model payment guidelines for CMS.

8. SAMHSA and HRSA should partner with other federal agencies to maximize workforce development opportunities at the professional and paraprofessional level.

SAMHSA and HRSA should work with the US Department of Education and relevant higher education accrediting bodies to examine recruitment strategies, ensure that curriculums are current and geared toward best practices, and to facilitate effective transitions from academia into the workforce.

SAMHSA and HRSA should also work with the US Department of Labor to explore opportunities and maximize existing tools to develop additional workforce. Examples include creative design of apprenticeship programs that could provide on the job training for potential workers, and the Ticket to Work program should be reviewed to better attract a stronger peer workforce.

These federal departments are in unique positions to support the workforce recruitment and training needs at multiple professional and paraprofessional levels in behavioral health. Potential grant or incentive opportunities with these agencies should also be explored.

9. Improve data collection about the behavioral health workforce to standardize job descriptions and create a national database on the specialty workforce.

Consistent, comprehensive workforce data in behavioral health is lacking and creates a significant policy challenge. In comparison, the fields of aging and intellectual/developmental disabilities have more comprehensive workforce data available that has strengthened their planning efforts and enabled a clearer national voice.

HRSA should engage in a cooperative agreement with NASMHPD to create a comprehensive workforce database for all members to track the public behavioral health workforce.

10. Develop funding grants for pilot educational and training efforts focused upon historically underserved areas to prepare local/indigenous residents for behavioral health careers.

The work of WICHE and the Annapolis Coalition has highlighted the untapped capacity of communities to address their own health care needs through a wide range of competency based strategies. Recognizing that people who are “place committed” to rural and frontier settings, for example, and supporting them to become behavioral health providers for their home communities

has been demonstrated to impact on retention and recruitment. (See for example *Alaskan Core Competencies for Direct Care Workers in Health and Human Services*.⁶)

NASMHPD should work with SAMHSA and HRSA on a new cycle of grants to support workforce infrastructure development in rural, frontier and tribal communities.

⁶ The Alaska Mental Health Trust, The State of Alaska Department of Health and Social Services, The University of Alaska, The Western Interstate Commission on Higher Education, and the Annapolis Coalition on the Behavioral Health Workforce. (2010) *Alaskan Core Competencies for Direct Care Workers in Health and Human Services, Version 1.0*. Available for download at www.mhtrust.org