**SUMMER 2015**

**SAMHSA REGIONAL BEHAVIORAL HEALTH WORKFORCE WORKGROUP MEETINGS: *A SUMMARY***

Substance Abuse and Mental Health Services Administration (SAMHSA) Regional Administrators hosted and led regional behavioral health workforce workgroup meetings for each of SAMHSA’s 10 regions from August through September 2015. Below is a summary of the common themes, needs, and requests across each of the regions as well as unique situations of particular States.

 **Common Themes and Requests**

**Acceleration of Collaborative Learning**At each meeting, participants stressed the need to continue these collaborative sessions both at the regional level and in smaller groups. One concern raised was that there are innovative practices going on in some States that cannot be leveraged if others do not know about them.

**Related Requests**Participants stressed the need for a better, more comprehensive mechanism to help share information among the regions. This would likely have both a meeting component (some mentioned quarterly phone calls) as well as an online component. For the latter, suggestions included the creation of a new secure website or the utilization of an existing resource such as Dropbox, SharePoint, or VSee to provide a place where information could be aggregated and easily accessed. Information on such sites might include:

* Presentations and documents referenced in these regional meetings
* A list of available funds, grants, and partnerships
* Cultural competency information
* Access to other States’ roadmaps and strategic plans
* A matrix showing what each State and region have to offer
* A compiled research guide
* A guide for youth recruitment
* Guidance on how States and regions can build their learning collaboratives
* A calendar for upcoming trainings and a repository for past trainings (e.g., recorded webinars by type)
* Standardized factsheets on various topics (e.g., preservice, peer recovery support specialists, etc.)

**Need for Better Data and Improved Technology**Participants noted the problems of limited or unavailable data, difficulty comparing existing data, and technology systems that do not “talk” to other systems (e.g., Medicaid).

**Related Requests**

* Need for monitoring tools and guidelines to standardize the data being collected
* Help with aggregating data and comparing data sets (e.g., information that helps treat the whole person or sheds light on what is going on with the opioid crisis)
* Guidance on the use of new technologies (e.g., telehealth, webinars, etc.)
* Help building infrastructure (e.g., telehealth, eConsult, eManagement, VSee)
* Ratios for the behavioral health workforce (e.g., social workers vs. nurses)
* Data that support funding, including shared data for regional clients
* Workforce projection models

**Peer Recovery Support Specialists**
Meeting participants discussed the importance of peer recovery support specialists and the lack of consistency in titles, licensing, pay, training, etc., for this field. Some States and territories (e.g., Connecticut, Ohio, Puerto Rico) noted the need to further develop their peer recovery support specialist programs, whereas some other States (e.g., Rhode Island, Kansas, North Carolina) were cited as having strong peer recovery support specialist programs.

**Related Requests**

* Provide information on how some States are using peer recovery support specialists
* Produce standardized factsheets on peers
* Help with bridging the gap between lived experience and formal education
* Develop a regional or national standard for peer credentialing and licensing
* Create supervision standards and training for peers
* Provide guidance on how to expand the peer role (e.g., in some States they are used in substance abuse but not in mental health; how would a State expand its role to both?)

**Credentialing/Licensing and Reciprocity Issues**Participants were in agreement on the challenges that licensing and credentialing pose to workforce growth and retention. Many raised the need for reciprocity. It is particularly an issue in telemedicine because services are provided across State lines.

**Related Requests**

* Have in place a compact agreement for licensing
* Ensure consistent certification standards (e.g., for substance use disorder [SUD] counselors)
* Provide professional licensing reciprocity for continuing education credits
* Help States (e.g., via workgroups and meetings with outside experts such as the U.S. Department of Defense and the U.S. Department of Veterans Affairs [VA], which have tackled this issue) come up with a strategy to address reciprocity
* Promote the creation of national professional licenses or credentials

**Workforce Shortages and Retention Issues**
Each State has challenges in recruiting and/or retaining workers in multiple roles: Low salaries, much paperwork, rural locations, brain drain to other fields, lack of reimbursement, an aging workforce, competition from other employers, turnover (particularly among younger workers), and a lack of strong retention strategies were some of the reasons cited.

**Related Requests**

* Create a shortage area designation for mental health, including technical assistance and other aid to strengthen the case for this
* Employ a best-practice guide for retention
* Help public providers strategize how they can compete with the VA and managed care entities for staff members
* Focus on messaging for what it means to work in behavioral health
* Use a workforce recruitment campaign that includes mental health
* Establish more loan forgiveness programs and provide more information about existing programs
* Propose strategies for reaching out to minority communities, which may be an underutilized source of health care workers
* Help determine who has the greatest need in order to make the best use of a limited workforce
* Provide core competency training for SUDs and help providers find low-cost training to help them leverage their existing staffs to support these services
* Communicate with the Center for Medicare & Medicaid Services and State Medicaid offices about supporting flexibility in staffing (e.g., when States start integrating their service teams)
* Help connect providers to fill in needed strengths between organizations
* Provide best practices and materials for attracting high school and college students into the pipeline (e.g., influence HOSA to have a special focus on behavioral health in 2016)
* Raise awareness of the Personal Care Assistant (PCA) role
* Ensure that the National Health Service Corps covers substance abuse professionals
* Share a comprehensive list of grant programs that impact the workforce
* Help with staff wellness programs. Providers face a range of difficulties. What expectations are reasonable in terms of what is expected from treatment providers? How can staff members be better supported?

 **Training Challenges**

Training was noted as a common concern. Participants mentioned the need to better train administrators, physicians, social workers, peer recovery support specialists, and more. The need for leadership training, coaching, and mentoring, as well as the importance of having provider organizations involved, was also emphasized.

**Related Requests**

* Support with revamping and providing ongoing in-house coaching, mentoring, and training at the program director, supervisor, and line staff levels
* Develop and share behavioral workforce trainings
* Provide leadership training
* Replace or resurrect the Addiction Technology Transfer Center Network leadership institute
* Lead meetings of State stakeholders, provider organizations, outpatient clinics, behavioral health organizations, and others and provide training on workforce development
* Provide help in training social workers on SUDs and provide them with a leadership message
* Offer cultural competency training
* Provide medication-assisted treatment training for primary care providers
* Provide training on co-occurring disorders
* Ensure that training is portable and shareable

**Funding and Budgetary Challenges**Making more with less was a persistent theme across the States due to a lack of funding, budget cuts, and grant restrictions.

**Related Requests**

* Provide more flexibility with block grants (e.g., ability to apply funds to Narcan, new technology, prevention, etc.)
* Provide budget-neutral strategies
* Help play “matchmaker” with grant recipients. Is there any work going on across the grant programs that can be more widely leveraged?
* Provide information on payment reform and what it means for behavioral health
* Learn how to find payment or reimbursement for nonreimbursed roles (e.g., social workers, psychologists)
* Expand the Substance Abuse Service Expansion grants to include community health centers that affiliate with their local Community Mental Health Clinics
* Help facilitate discussions with State Medicaid offices about rates
* Provide notices when new grant opportunities become available

**Concerns About Parity**

Parity was noted as another common challenge. Some noted that lawsuits related to the lack of parity were pending in their States; it was also stressed that there was a strong ethical component to the problem.

**Related Requests**

* Help connect State stakeholders with State Commissioners of Insurance
* Help reduce stigmas attached both to substance abuse and mental illness
* Connect provider licensing with acceptance of Medicaid patients

**Integration of Care and Continuum of Care**The difficulty of integrating behavioral health into primary care and resources such as housing and employment and a lack of common understanding of what the continuum of care should look like are challenges for many States.

**Related Requests**

* Provide an end-to-end framework of the integrated care system
* Provide guidance on “wellness” and prevention. What exactly does each encompass? What should the States be doing?
* Use best practices on how to conduct needs assessment
* Develop a model for building public/private partnerships
* Create a “shared solutions” portal and system of care
* Employ lifespan programming (e.g., lack of behavioral health care toward the end of life)
* Provide more information on grants that can be used to enhance access, outreach, and service delivery
* Define the public health component of prevention: What should it look like? What is the role of community health vs. primary care practitioners?

**Unique Challenges, Successes, and Best Practices in Some States and Territories**

**Alaska** has a very successful internship initiative through the Western Interstate Commission for Higher Education that uses technology-created networking opportunities for interns; 76% of interns have stayed in Alaska in public mental health service after their internships. Alaska also has a strong strategy around retention and has developed the Behavioral Health Alliance, with faculty of all the behavioral health schools meeting three times a year to coordinate the curriculum.

**California** is in the midst of redesigning its SUD delivery system and has a pilot program (made possible by an Institutes of Mental Disease waiver), which extends substance abuse funding based on a continuum of care, including residential care. A special focus is building bridges between mental and physical health and collaborating with the California Department of Corrections and Rehabilitation, since 90% of parolees are eligible for Medicaid.

**Colorado** is unique in the country in that it was the first to have a State credentials process for peers.

**Connecticut** passed a gun bill that funds a group of peers that provides outreach to individuals in the probate system to help them connect with services and programs. That same legislation also funded two programs for young adults experiencing the first break of psychosis. An unrelated best practice in Connecticut is to have Medicaid personnel bring applications into the prisons and assist those who are about to be released to fill out and file these applications.

**Delaware** has set up the Governor’s Advisory Council to the Division of Substance Abuse and Mental Health. The Council has been useful in providing policy levers related to funding and legislation and includes both public and private providers as well as representatives from the areas of justice, education, and law enforcement. Delaware is also contending with a workforce shortage, especially among psychiatrists, due in part to its lack of medical schools and mostly rural setting.

**Georgia** was faced with the issue of training peers but then found that many were not able to get jobs because of failed background checks. Thus, Georgia developed a review committee to serve as an appeal process for candidates who did not pass the initial background review. The committee meets monthly to review applicants’ materials and now approves 60% of persons reviewed. Those who are not approved can reapply if their circumstances change.

**Hawaii** has problems with adequacy of coverage and access to services, especially on the neighboring islands beyond Oahu and particularly due to Hawaii’s island geography. There is a great need for telemedicine and virtual case managers. There are not enough such personnel in Hawaii, which creates interjurisdictional issues.

**Idaho** settled a class-action lawsuit, which has mandated more availability of treatment for children, including statewide screening and assessment and a family health care professional team approach. The focus is on maximization of licensure and scope of practice to make better use of qualified alternative workers. Idaho also has a State Healthcare Innovation Plan, which includes the integration of behavioral health into primary care.

**Indiana** has developed a proposal through its Attorney General’s office to provide loan repayment. The program has received more than 275 applications and targets psychiatrists, psychologists, nurses, and addiction counselors. The program funded 65 applicants for approximately $600,000.

**Iowa** has a variety of transitions happening simultaneously, including the addition of four new managed-care companies and conversion from a county-coordinated system to a regional one. There is a State Innovation Models Cooperative Agreement, and the State is moving toward a Healthy Homes model. This makes it difficult to keep people in the field and deters recruitment.

**Kansas** makes peers available in an emergency department (ED) at an acute-care hospital, where they are responsible for making “warm handoffs” to treatment. In a cohort of patients that resulted in 600 visits, ED visits dropped to fewer than 100. The peers received a 75% engagement rate on the first encounter.

**Maryland** integrated mental health and SUD services 2 years ago, which required much effort to garner buy-in as well as competency-based training plus additional work to implement behavioral health with primary care. Maryland’s Behavioral Health Administration (within the Maryland Department of Health and Mental Hygiene) has a Workforce Development Committee to help navigate the change. They also partner with the University of Maryland, which has an evidence-based practice center. Maryland’s strong advocate system helps with the overall mission, including legislation such as a recent bill on loan forgiveness.

**Massachusetts** has the highest percentage of mental health clinicians in the country and the lowest percentage of clinicians who accept insurance of any kind. The Commissioner of the Department of Mental Health (within the Massachusetts Executive Office of Health and Human Services) found that these clinicians left the field because of the heavy administrative burden and rates.

**Minnesota** is dealing with a shortage of master’s degree-level counselors.

**Missouri’s** preemployment transition program is a pipeline for 14- to 15-year-olds interested in behavioral health work.

**Nevada** has been designated as a mental health shortage area. There is a focus on increasing Medicaid reimbursement for telehealth and psychiatric nursing.

**New Jersey** has made strides in treating mental illness in the prison population. The warden of the Hudson County Correctional Facility (HCCF) has radically changed the intake process and requires every inmate to receive a biopsychosocial assessment. The State also has an initiative to provide behavioral health services that integrates mental health and substance abuse services on the HCCF premises. The State also offers a Certification as a Recovery Support Practitioner. Certified peers are used in the 24-hour hotline. New Jersey needs to do more in terms of incorporating peers on the substance abuse side.

**New Mexico** is the first State to give prescription authority to psychologists but requires passing a rigorous program to become a prescriber.

**New York** is unique in providing peer recovery support specialists for drug courts (both civilian and veteran), and the State is strong in credentialing substance abuse peers and developing a career ladder.

**Oregon** faces a shortage of psychiatry professionals in rural areas and a lack of children’s mental health professionals. The biggest shortage is at the supervisor level.

 **Pennsylvania** has worked on integration at all levels, including between mental health and substance abuse across the lifespan and across agency departments and providers. The State also provides interdepartmental trainings. All State correctional officers must take a mental health first-aid course. Any officer assigned to a mental health unit must have Crisis Intervention Team training. The State is the first in the Nation to offer halfway houses with mental health services. The State also offers “behind-the-walls” certified peer training, which includes specializations such as services for veterans, older inmates, youth, and hearing-impaired persons.

**Puerto Rico** has unique economic challenges and political issues compared with the States. There is a fiscal crisis, and neither government nor private-sector wages are competitive. Puerto Rico has great universities, but people tend to leave the Island when seeking employment.

The **U.S. Virgin Islands** has a particular strength in cultural competency in terms of dealing with the Caribbean population but continues to contend with constant changes in the political environment. A U.S. Virgin Islands participant noted that some States might consider the U.S. Virgin Islands as being rural or third world. The U.S. Virgin Islands’ population has a significant gambling addiction problem.

**Vermont** has created the Vermont Cooperative for Practice Improvement & Innovation, whose focus is on implementing new practices or sustaining practices (e.g., reducing restraint in hospitals, Dialectical Behavior Therapy). Because it is an independent entity, participants are more likely to identify what their issues are.

**Virginia** has been through two transformations in service, and workforce development is part of the organizational development of the agency. The State also has a new recovery services division. The Commissioner has launched a population health initiative that has three primary focuses: cultural competency, value/cost of care, and patient-centered/individual care.

**Washington**’s State legislature has mandated that substance abuse treatment be integrated into managed care by April 2016 and primary care by 2020.