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Assessment #3

Developing a Behavioral Health Workforce Equipped to Serve Individuals with Co-Occurring Mental Health and Substance Use Disorders

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Developing a Behavioral Health Workforce Equipped to Serve Individuals with Co-Occurring Mental Health and Substance Use Disorders

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Abstract

A large number of individuals with co-occurring mental health and substance use disorders do not receive treatment for both simultaneously. The mental health and substance use fields are both experiencing workforce shortages and few providers are trained to provide *both* mental health and substance use treatment. The focus of this paper is to review current programs/trends that could be useful in increasing the number of providers that can effectively serve individuals with co-occurring disorders (COD) using evidence-based practices. Specific policy recommendations to develop the workforce and more effectively track trends over time are provided.

Introduction

Historically, behavioral health systems have been thwarted from providing robust services to individuals in need of care due to policy limitations, funding barriers, and siloed business operations. A lack of streamlined services has resulted in individuals in need of care having to navigate convoluted pathways within the behavioral healthcare system to access treatment services. In the past, much of the complexity that surrounded access to these services stemmed from rules/policies that were unique to this sector of healthcare. Yet over the past decade, key policy changes have occurred resulting in improved access to behavioral healthcare services.[1-6]

In 2008 the Mental Health Parity Addiction Equity Act (MHPAEA) was enacted to prevent insurance companies from placing financial and/or treatment restrictions on behavioral health benefits (mental health and/or substance use) that are more stringent than the restrictions that are in place for the plan's medical/surgical benefits.[5-7.] While MHPAEA helped remove restrictions on behavioral healthcare coverage, it was not until the Affordable Care Act (ACA) was passed in 2010 that a larger proportion of individuals with behavioral health disorders received access to care.

The expansion of Medicaid which was enabled by the ACA[4-6] resulted in an additional 17 million citizens gaining access to healthcare services (including behavioral health services) between 2013 and 2018.[4] Section 1115 Medicaid Demonstration waivers are used by states to test programs that can broaden eligibility for Medicaid, modify how services are paid, and reform how healthcare services are delivered. As of April 2019, CMS had approved 29 §1115 waivers to fund the provision of behavioral healthcare across 27 states, further enabling access to these types of services for Medicaid beneficiaries.[8]

MHPAEA, ACA, and Medicaid waivers have proven to be successful policy levers to improve access to behavioral healthcare. Yet due to the high prevalence of individuals in need of care, the capacity of the system has not been able to keep up with demand. It seems as though the system is experiencing a "perfect storm"; by increasing access to care, there has been an increased demand for services which, in turn, has increased the need for behavioral health providers.[3]

There is a wealth of literature focused on staffing shortages and retention in both the mental health system and substance use disorder treatment fields. Research from the federal Health Resources and Services Administration (HRSA) suggests that both fields will continue to see shortages in their workforces over the next five years.[9] As the behavioral health field moves towards integrating these services, away from separate and siloed mental health and substance use disorder service systems, the need for cross-trained providers arises.[10-14] The focus of this paper is to review current programs/trends that could be useful in increasing the number of providers that are able to serve individuals with COD and provide specific policy recommendations to develop this workforce.

Prevalence Estimates of Co-Occurring Mental Health and Substance Use Disorders

Self-reported data collected in the 2017 National Survey on Drug Use and Health (NSDUH) suggests that 46.6 million adults 18 years of age and older (18.9% of the population) reported having a mental health disorder, 18.7 million adults (7.6% of the population) reported struggling with a substance use disorder, and 8.5 million (3.4% of the population) reported having co-occurring mental health and substance use disorders.[15]

Of the 8.2 million individuals with COD, approximately 42 percent reported living below the 200% poverty level. The most common insurance provider reported was private insurance (56 percent).[16] Medicaid was the second most commonly reported insurance provider (24 percent). It is also worth noting that 1.2 million (15 percent) reported not having any insurance.[16] In sum, nearly 40 percent of individuals with COD are reliant on public sector providers, highlighting the need for public behavioral health services to be responsive to COD concerns. Yet individuals with COD have a high rate of not receiving treatment services. According to the NSDUH's 2017 data, only 8.3 percent of adults with COD reported that they received treatment that addressed *both* their mental health and substance use disorders.[17] These data clearly demonstrate the increased need for combined COD treatment services.

Locating dually trained treatment providers is a challenge. Of the facilities that offer COD services, many of these facilities are private psychiatric hospitals or Veterans Administration medical centers.[17] As a result, many individuals with COD must receive mental health and substance use services separately.

Unfortunately, the preconditions of these programs may restrict individuals with COD from being eligible to participate. For instance, a substance use program may require that the patient not be on psychoactive medications, but these medications may be required to manage psychiatric symptoms.[18] In general, the most common method for receiving these services is receiving them in succession (one after the other).[18] Research demonstrates that receiving treatment services separately is inefficient. By receiving treatment for one disorder, the underlying factors that are causing the individual to experience both disorders are not being addressed adequately. Treating COD separately can lead to the individual deteriorating and/or relapsing.[11]

Insurance Coverage for Treatment for Both Disorders

According to NSDUH data, one of the biggest factors driving why individuals with mental health disorders or substance use disorders (in general) do not receive treatment services is the cost of those services. Forty percent of individuals that reported having mental health disorders and thirty percent of individuals that reported having substance use disorders stated that the cost of healthcare was a reason for not receiving treatment services.[16] This matter can be more complex for individuals with COD.

While the ACA expanded MHPAEA's provisions to Medicaid, small group health plans, and individual health plans, this does not mean that insurers will cover the provision of both services (one service may be covered but not both), nor does it mean that the insurer will cover all of the treatment cost.[4,5,19-21] Many insurers will not cover treatment services for serious mental illnesses and/or substance use disorders since both disorders require treatment that can last over an extended duration of time. Insurers are able to not cover these services since the ACA and MHPAEA do not require insurers to cover long-term services.[5] Data from the NSDUH suggest that 10.5 percent of individuals with substance use disorders and 23 percent of individuals with mental illnesses noted that their healthcare did not cover the treatment services that they needed or that their coverage only covered some of the costs for treatment.[16]

Workforce Development Strategies

Defining the Behavioral Health Workforce

It is important to define what is meant by "behavioral healthcare workforce." In this paper, the term refers to a group of individuals that provide mental health and/or substance use services to individuals with mental health and/or substance use disorders. A behavioral health workforce can be composed of licensed clinical providers, certified providers, and unlicensed or non-certified providers. Licensed clinical providers (*e.g.,* psychiatrists, psychologists, advanced practice psychiatric nurses, social workers, licensed professional counselors, marriage and family therapists, and licensed addiction counselors) are able to diagnosis and treat patients with mental health and/or substance use disorders. Certified providers (*e.g.,* certified addiction counselors, prevention specialists, peer recovery specialists) can provide direct care to clients and/or support the licensed providers. Finally, unlicensed or non-certified providers (*e.g.,* psychiatric aides) tend to act in supporting roles.[9, 22]

Within the behavioral health workforce, the role of each type of provider varies. State have different laws/regulations regarding what services different types of behavioral health professionals are able to provide. [9, 22] The services that different behavioral health providers are authorized to provide may be very distinct in some instances and overlap in others. For example, the role of a psychiatrist in diagnosing serious mental illness, prescribing medication, and providing psychotherapy to clients is distinct from the role a peer support specialist plays in treating serious mental illness, yet overlaps with the role a psychiatric nurse practitioner may play in diagnosis and treatment, particularly in states with less restrictive scopes of practice for advanced practice nurses.

Individuals that provide behavioral healthcare services, in certain instances, may be non-behavioral health providers. Other types of healthcare professionals (*e.g.*, primary care physicians) may provide behavioral healthcare services to individuals with mental health and/or substance use disorders. This is particularly relevant for healthcare providers operating in rural areas that lack specialty providers. There are also healthcare models that charge primary care providers with conducting early screening and brief interventions, providing medication, and coordinating care with co-located behavioral health specialists.[23] Considering these providers in behavioral health workforce development strategies is important.[24]

Education

Finding providers with the skills and experience needed for integrated practice to treat COD is challenging. The number of educational programs (*e.g.,* graduate degree concentrations) that have been developed to cross-train students to provide both mental health *and* substance use services is limited, potentially compounded by the fact that these fields have historically different treatment philosophies.[12, 20, 25]

Individuals with COD may face issues with housing, employment, and maintaining bonds with friends/family.[18] As a result, they often require a broad array of services (*e.g.,* housing, supportive employment, assertive community treatment, and/or medication management) to support recovery.[26] Despite these services being recognized as evidence-based practices (EBPs) by the Substance Abuse and Mental Health Services Administration (SAMHSA), very few behavioral health education programs formally train students on how to provide these EBPs.[10, 27-28] Within the field, the use of EBPs are of limited availability for patients with COD. As of 2017, only 53.9 percent of behavioral health treatment facilities across the nation provided the evidence-based practices (*i.e.,* integrated dual diagnosis treatment) that have been shown to be effective for treating patients with COD.[17, 20] EBPs are of limited availability for patients with COD, both because of the various barriers they face due to their unique behavioral health conditions[20] and because the emerging behavioral health workforce is not being adequately trained in EBPs. The necessitated training and oversight of new employees strains the scarce human resources available at most provider agencies.[12]

To address these issues, higher education programs and accreditation bodies have been prompted to expedite curriculum reform, adopt common competencies around integrated care, and incorporate inter-professional education and practice into training programs.[24,29] Competencies supporting integrated practice have been circulating for several years and provide a foundation on which trainings could be based.[30-31] Specific training approaches teaching the mental health workforce how to engage in evidence-based practices have been detailed in the literature. They point toward using multiple, overlapping techniques that include didactic content, critical thinking, and peer collaboration.[32]

The extent to which these workforce development strategies have been formally incorporated into education and training initiatives across the field is unknown. However, there are examples of programs that aim to ensure trainees have exposure to and practice in integrated settings. One such example is the HRSA-funded Behavioral Health

Workforce Education and Training program, which has supported training of nearly 10,000 students through 2017 in both professional and paraprofessional behavioral health occupations in an effort to develop and expand the behavioral health workforce serving populations across the lifespan, particularly in rural and medically underserved areas.[33] A key component of this program includes development of field placements and internships in settings that integrate both mental health and substance use services into primary care, thus establishing early exposure for trainees working in collaborative care models to integrated care for COD.

While progress is being made to develop education/training programs for the treatment of patients with COD, the number of graduates entering the field may not be enough to sustain the need for COD trained providers.[10,25] Across the entire field of behavioral healthcare there has been an increase in the number of providers nearing the age of retirement.[10-11,22,34] According to the American Hospital Association, in 2016 over half of practicing psychiatrists were over the age of fifty-five but only four percent of medical school graduates were completing training in psychiatry.[10] In order to bolster workforce competencies to reflect the prevalence of COD, credentialing agencies should develop a nationally recognized credential for COD providers which would prompt universities to develop a COD curriculum in their behavioral health programs.[18] The development of a COD credential would permit more students/graduates to become certified in providing COD treatment.

Licensing Requirements

Gaining the educational background to provide COD treatment is only one piece of the puzzle. In order to become a COD provider, a student/graduate/provider must complete a number of supervised hours and, to maintain his/her license to provide COD treatment, continuing education credits.[22] Ability to train the existing workforce relies in part on accessibility of training programs. Licensed and certified providers have continuing education requirements as part of their credential renewal process. The required hours and training content vary by state and by profession. Furthermore, requirements for hours of training under supervision differ between the mental health and substance use fields.[22]

Siloed educational experiences mean that providers not only need to be taught different skills to support collaborative care, but that the organization must also institute a culture of collaboration and successfully onboard new providers to that model. Although short-term continuing education training opportunities may be plentiful for behavioral health workers, the time and resources to engage in such training may not be. In settings that are short-staffed on behavioral health providers, it may be difficult for those workers to engage in training activities during work hours. Infusing a culture of learning into facilities employing behavioral health workers to promote workforce development is a major goal of SAMHSA's Technology Transfer Centers.[35]

A limited number of providers are licensed as a joint mental health and substance use provider, and it is difficult to track those who are.[22] The licensing requirements for mental health providers can be very different from those of substance use disorder providers.[36-37] Many states require mental health clinicians to have at least a Master's

degree. Conversely, state educational requirements for substance use clinicians are usually lower, requiring only a Bachelor's degree.[20]

Over the next five years, it is critical that a systematic workforce monitoring system be developed to collect standardized data on the size and characteristics of the current workforce across professions. Available data yield insufficient, or incongruent, supply and demand estimates for the behavioral health workforce. Data on entrants into the field and projected retirements or intention to leave the field are sparse. This results in a system of workforce planning that relies on piecing together multiple data sources that represent pockets of the workforce and inhibits the ability to engage in workforce planning that centers on clients and population needs rather than siloed professions.[38]

Steps should be taken to develop a system that tracks the number of behavioral healthcare, licensed or unlicensed, operating in the United States.[28] The system should be designed to collect standardized information on the size and characteristics of the current behavioral health workforce, including the areas in which they specialize. Using this system, information could be compiled on how workers are trained and licensed, whether they are actively practicing, and whether they are permitted to perform activities to the full scope of their training. This information would help identify programs that provide COD training, states that have a COD license or allow for providers to receive both a mental health *and* substance use license, where the highest concentration of COD providers are located, and how long COD providers remain active. This dataset could be developed using elements from the minimum dataset that was developed to collect standardized information on the behavioral health workforce by the University of Michigan's Behavioral Health Workforce Research Center.[39]

Provision of Medications

Medications can be an important treatment component for individuals with COD.[18] Unfortunately, there is a shortage of active psychiatrists, who are the primary behavioral health prescribers, in the United States and the number of active psychiatrists is predicted to drop over the next few years.[9-11,22, 34]

Psychiatric nurse practitioners (PNPs) have authority to prescribe medications in all 50 states and the District of Columbia, but some states require that they be supervised by a physician.[9-10, 40] This is problematic for individuals with behavioral health disorders and COD living in rural areas, since they may not have access to a psychiatrist.[41]

Reimbursement

Low reimbursement rates have resulted in many behavioral healthcare providers not participating in insurance networks, further limiting access to care.[34] A 2017 study by the consulting company Milliman indicates that more patients use out-of-network providers

for behavioral healthcare than do for physical/medical healthcare.[42] The reason is that medical/surgical providers are reimbursed at rates that are approximately 20 percent higher than behavioral healthcare providers providing similar services.[42] That behavioral health services are most often found out-of-network increases the difficulty that individuals with COD face in accessing treatment since their treatment will not be covered (fully or partially) by their insurance provider.[6,42] Insurance providers should consider expanding their networks to include more behavioral healthcare providers, specifically those trained to treat individuals with COD. Insurance providers should assess the scope of their current behavioral health network (*e.g.,* types of providers included, locations, areas of specialty), their provider inclusion requirements/standards, and their reimbursement rates.[42]

Integrated Care

Stemming from the wealth of evidence that individuals with behavioral health disorders have a high likelihood of physical co-morbidities, primary care providers (PCPs) are a logical alternative to the limited number of specialty behavioral health clinicians.[6,10-14,18] Despite a rising number of patients with behavioral health disorders, PCPs are rarely cross-trained to provide behavioral health services and, even if they are cross-trained, they may feel uncomfortable treating behavioral health disorders.[6,10-14,34]

In order to ensure access to integrated care for individuals with COD, efforts should be taken to co-locate health services, rather than obliging individuals to see multiple providers to address all of their needs.[10-13] A centralized location of care would improve access for individuals with COD to all of the treatment services that they require. Collaborative Care models and Certified Community Behavioral Health Clinics (CCBHC) are two promising models for co-locating services.

Collaborative Care Model

Collaborative Care models involve the use of a treatment team to monitor a patient's health conditions (behavioral and/or physical). Collaborative Care teams are primarily composed of a PCP, a care manager, and a psychiatrist.[43-44] Psychiatrists act as consultants in the Collaborative Care model to provide insight into the patient's mental status, prescribe psychiatric medications if necessary,[34,43-44] and advise PCPs about how to effectively treat individuals with mental health, substance use, or COD with more confidence. Assuming a consultative role to PCPs allows psychiatrists more time to focus on clients with complex treatment needs. The Collaborative Care model can help PCPs acquire the support that they need from psychiatrists to become more comfortable in treating patients with COD.

Training modules have been developed by the University of Washington's AIMS Center to help agencies/organizations implement the Collaborative Care model. [43,45] Of course, organizations/agencies/states interested in training providers in this model may be hesitant to do so because of the cost. However, Collaborative Care model training can be accessed for free via the American Psychiatric Association. The American Psychiatric Association is able to offer free training, which is eligible for continuing education

credits, on the Collaborative Care model for psychiatrists, PCPs, and behavioral health managers as a result of CMS' Transforming Clinical Practice Initiative.[46]

Certified Community Behavioral Health Clinics

Since the Protecting Access to Medicare Act (PAMA) granted eight states the opportunity to develop Certified Community Behavioral Health Clinic (CCBHC) demonstration programs in 2014, 67 CCBHCs serving 372 locations have been created. [14] These clinics were developed to provide behavioral health services in the community, increase access (CCBHCs cannot refuse services based on residency or ability to pay), and promote care coordination between providers. All CCBHCs provide integrated treatment services for patients with COD.[47] Information collected on the 67 CCBHCs demonstrates the success of these clinics. Even though the structure, payment methods, and practices of the CCBHCs vary between states, all of the CCBHCs report using their funding to provide integrated treatment services for patients with COD. [47] CCBHCs are using their resources to increase integrated behavioral healthcare training among their providers (79 percent of CCBHCs), strengthen collaboration between their providers (79 percent of CCBHCs), and/or develop care teams that are comprised of mental health and substance use professionals (69 percent of CCBHCs).[47] To aid in the treatment of individuals with COD, 60 of the facilities (90 percent) have psychiatrists on staff who have credentials (specialty or focus) for offering addiction services.[47] These specialists could serve as a resource for PCPs seeking additional consultative support when treating clients with co-occurring mental health and substance use disorders.

Integrated care teams have been shown to reduce the costs of healthcare services. Approximately $38 to 68 billion could be saved by integrating the provision of behavioral health and medical care for individuals who are insured through the commercial market, Medicaid, and/or Medicare.[48] A barrier to providing integrated care is that billing for these services has policy limitations. While PCPs are responsible for billing insurers for integrated care services that is provided to the client by the team,[43-44, 49] there are certain behavioral healthcare services used in an integrated treatment setting to coordinate care (*e.g.,* Screening, Brief Intervention and Referral to Treatment (SBIRT) and Health Behavior Assessment and Intervention (HBAI) that are not eligible for reimbursement by all Medicaid plans or by a number of private insurers.[40] To increase access to care for individuals with COD, as well as individuals with behavioral health disorders in general, billing codes for these services should be accessible to PCPs who provide integrated care services.

Conclusion

In 2017, only 8.3 percent of individuals who reported having co-occurring mental health and substance use disorders (COD) indicated that they received services addressing both mental health and substance use diagnoses.[15] Less than half of behavioral health treatment facilities in the United States (43 percent) have programs designed specifically to treat individuals with COD. Even within facilities that utilize EBPs, a little more than 50 percent of these facilities have EBP programs that are specifically designed to treat the complex needs of individuals with COD. [17,-18]

Even when COD treatment services are physically accessible, they may not be affordable. Insurance coverage for both diagnoses can be limited. Additionally, low reimbursement rates discourage providers from participating in insurance networks, which means that individuals with COD who receive treatment through out-of-network providers will have to pay higher out-of-pocket costs for treatment.[4,34]

Access to COD services is impacted by the lack of a COD-trained workforce, variability in licensing procedures, state differences in who is authorized to prescribe medication, and the absence of a national database that tracks information on the nation's behavioral health workforce. This paper proposes several steps that, over the long-term, can increase access to care for individuals with COD:

1. Establishing a nationally recognized professional credential for treating COD would elevate the importance of truly integrating MH and SUD services at the clinical encounter level.

2. Steps should be taken to develop a system that tracks the number of behavioral healthcare, licensed or unlicensed, operating in the United States in order to determine the impact of new state and federal policies on the behavioral health workforce.[28]

Several of the recommendations in this paper would have a more immediate positive impact on services for person with COD. Specifically, supporting the ability of PCPs to provide integrated care is important because having combined disorders can result in additional complications. Coordinating all health and behavioral health treatment decisions under a PCP, with the support of a licensed behavioral health clinician, yields better outcomes for clients, helps increase the confidence of PCPs who are treating patients with behavioral health disorders since they have consultative support, and alleviates the workload of scarce behavioral health professionals so that they may dedicate more time to patients with complex behavioral health needs.[6,12-14,34] Treatment team billing codes should be accessible to PCPs in order to enable integrated care services.

Improved workforce development and workforce planning strategies in behavioral health rely on both state and federal leadership. Workforce policy is largely state-driven through regulatory scope of practice restrictions on practice authority. States have different criteria for educational requirements, licensing requirements, the services that can be offered by behavioral health providers, and which services can be reimbursed. The complexity of the matter is increased by the fact that these requirements differ across the mental health and substance use systems. [1,11,20,22,40]

Fraher and Brandt propose a framework for health workforce policy and planning that moves away from silo-based workforce projection models and toward inter-professional needs-based models that consider overlapping scopes of practice among professions and workforce development systems that benefit clients, communities, practices, and learners.[38] Such a framework puts emphasis on understanding provider roles and

appropriately training the workforce to competently task shift in team-based environments, including supporting clients with COD. The establishment of a national behavioral health workforce policy could lead to the alignment of criteria and procedures for licensing, credentialing, and specialization between both the mental health and substance use fields. It could also help guide states in establishing policies that support flexibility of provider roles.

Addressing the workforce shortages in COD treatment is vital. Without an adequate number of COD trained practitioners, individuals will continue to have limited access to appropriate and effective treatment. Treatment for individuals with COD is critical to helping reduce patient involvement with other systems such as emergency rooms, social services, and the criminal justice system. Adopting these recommendations would strengthen a workforce equipped to support individuals with COD towards recovery.

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