

Health Reform and the Mental Health Workforce

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Key Secular Trends

- The rise of mental health exceptionalism
- The demise of the “Mental” Institution
- The promise and pitfalls of the community mental health center
- The rise of behavioral health managed care
- The hopes for parity and health care reform

Percent of
1955 Census

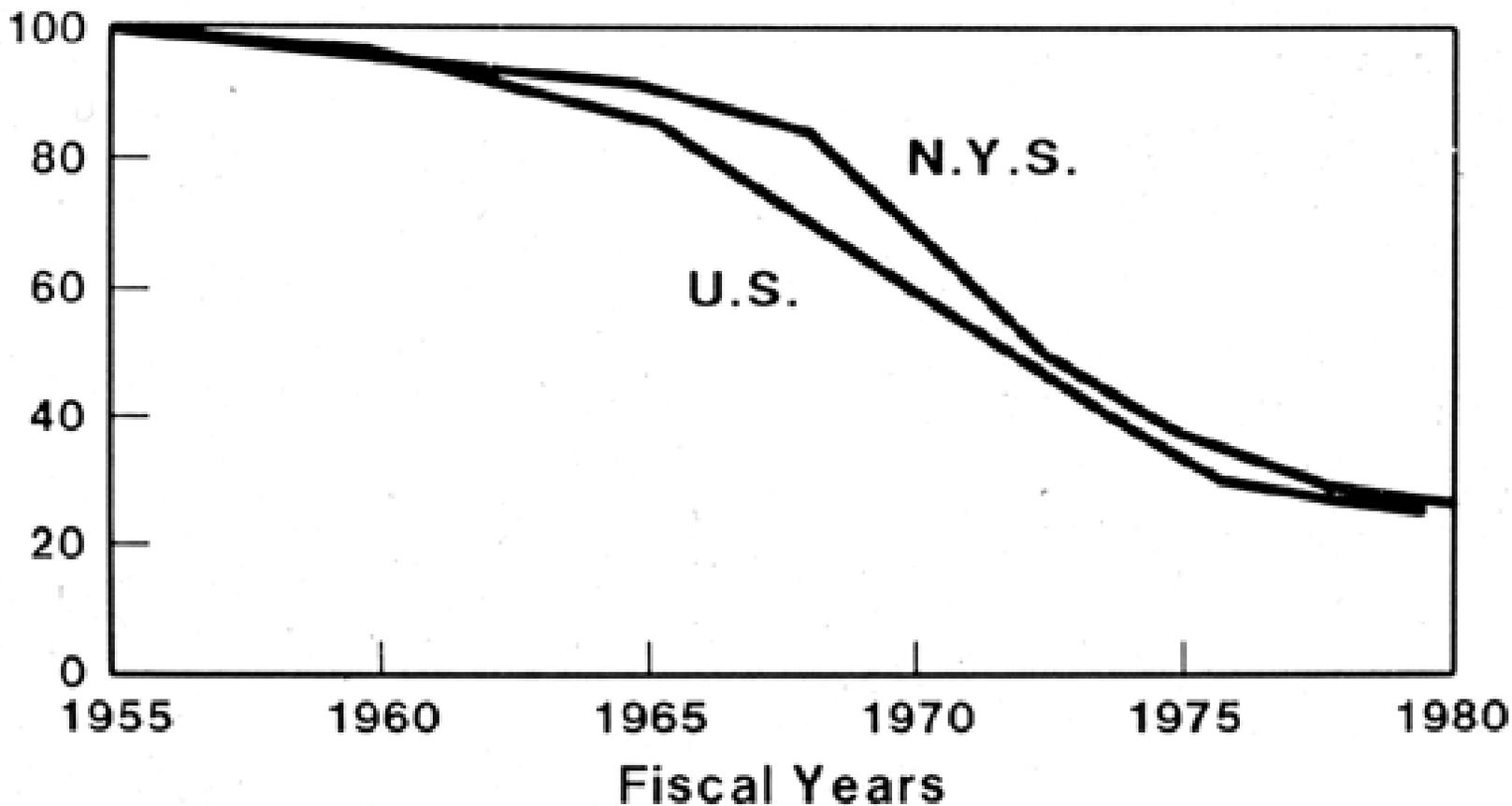


Figure 2. Percent of 1955 census state psychiatric centers in United States and New York. From New York State Office of Mental Health, 1981.

Shelter

Food

Medical Care

Income

Psychiatric Care

Activities

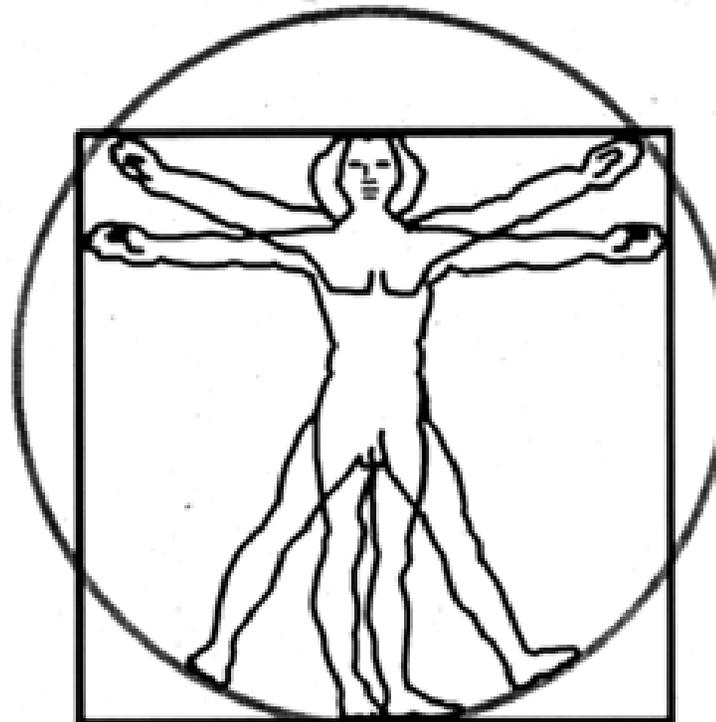
Dental Care

Work

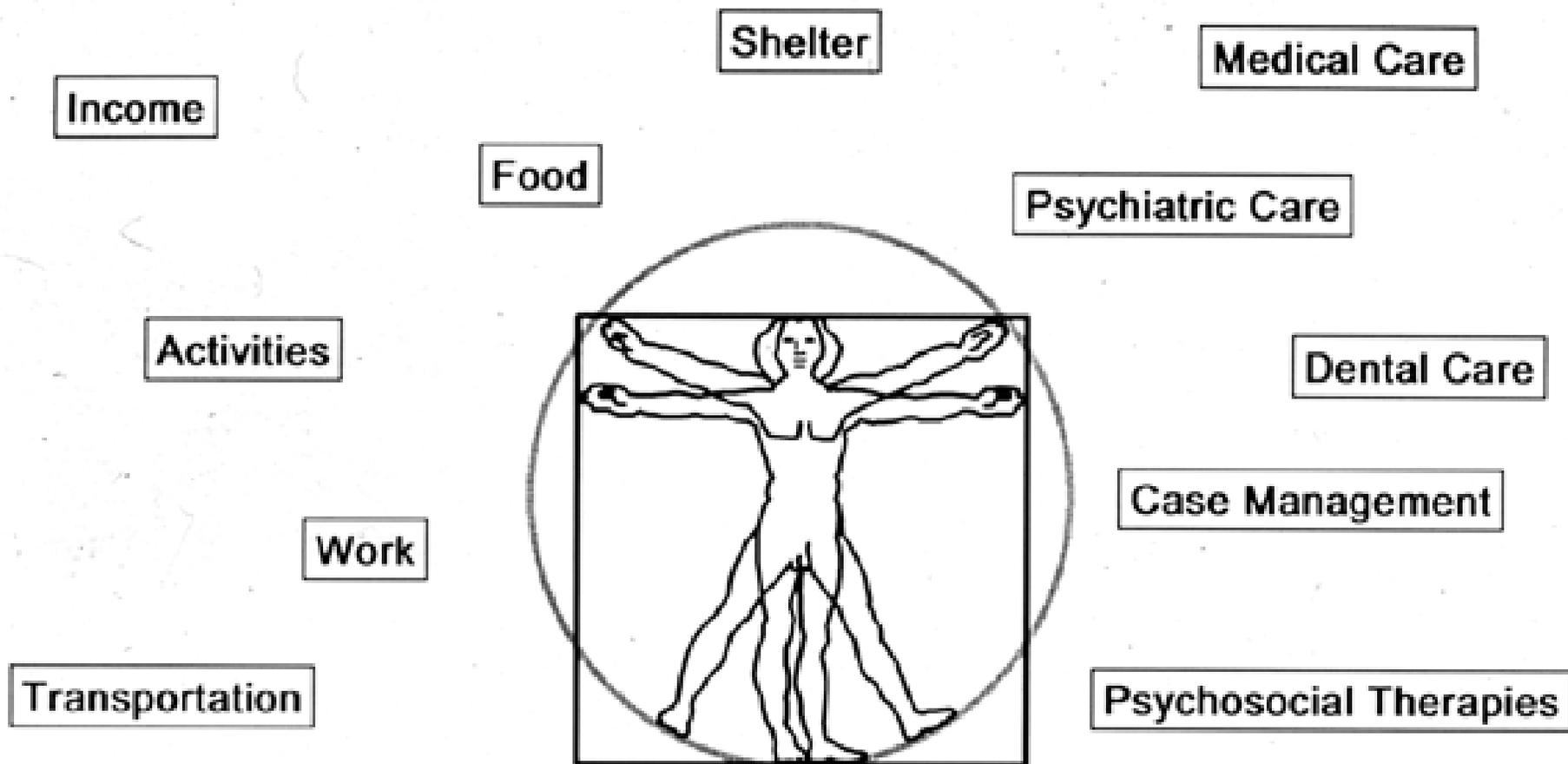
Case Management

Transportation

**Psychosocial
Therapies**



COORDINATION OF SERVICES IN THE STATE HOSPITAL



COORDINATION OF SERVICES IN THE COMMUNITY

Value of Behavioral Health Benefits, 1988-1998

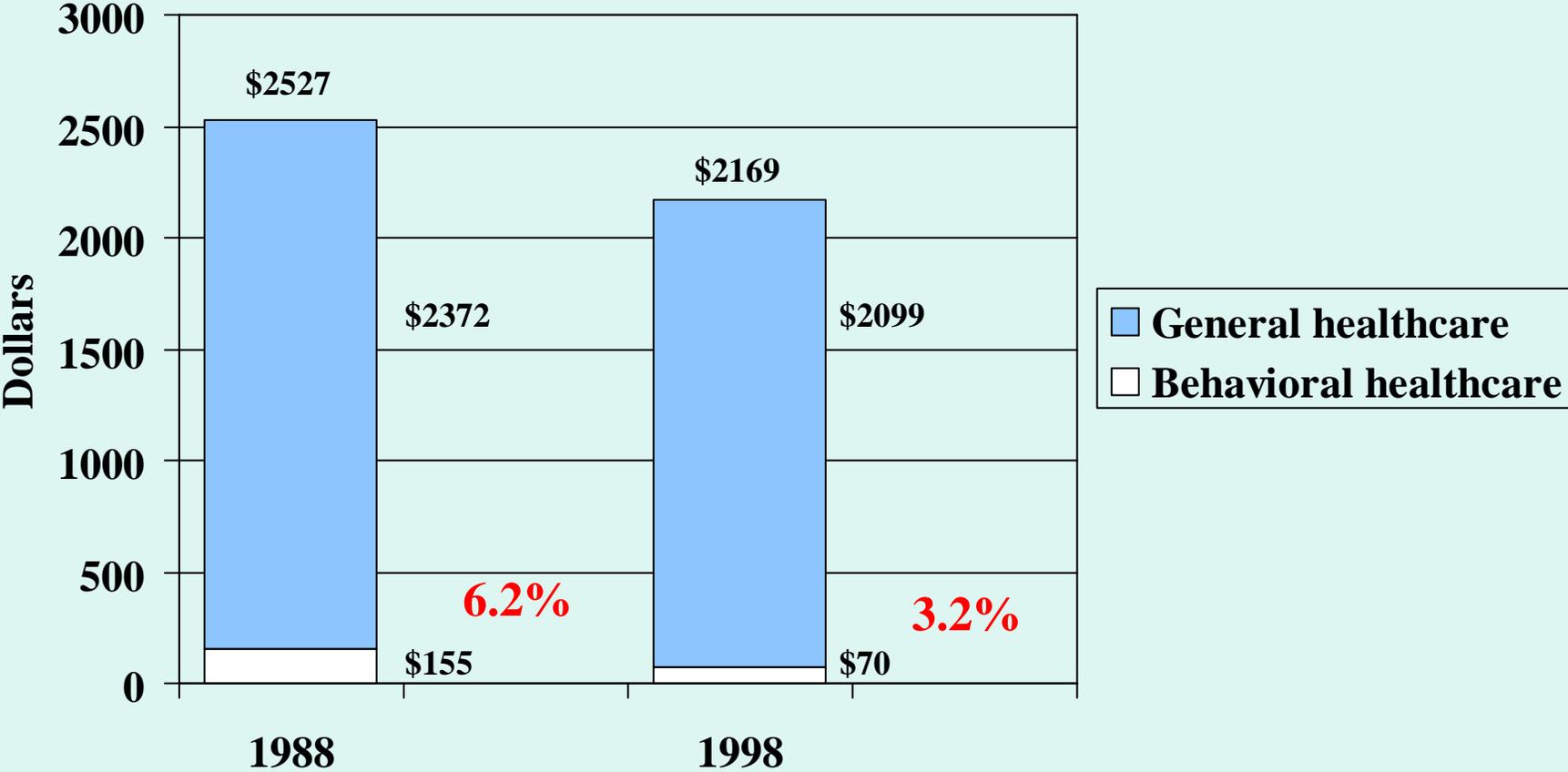
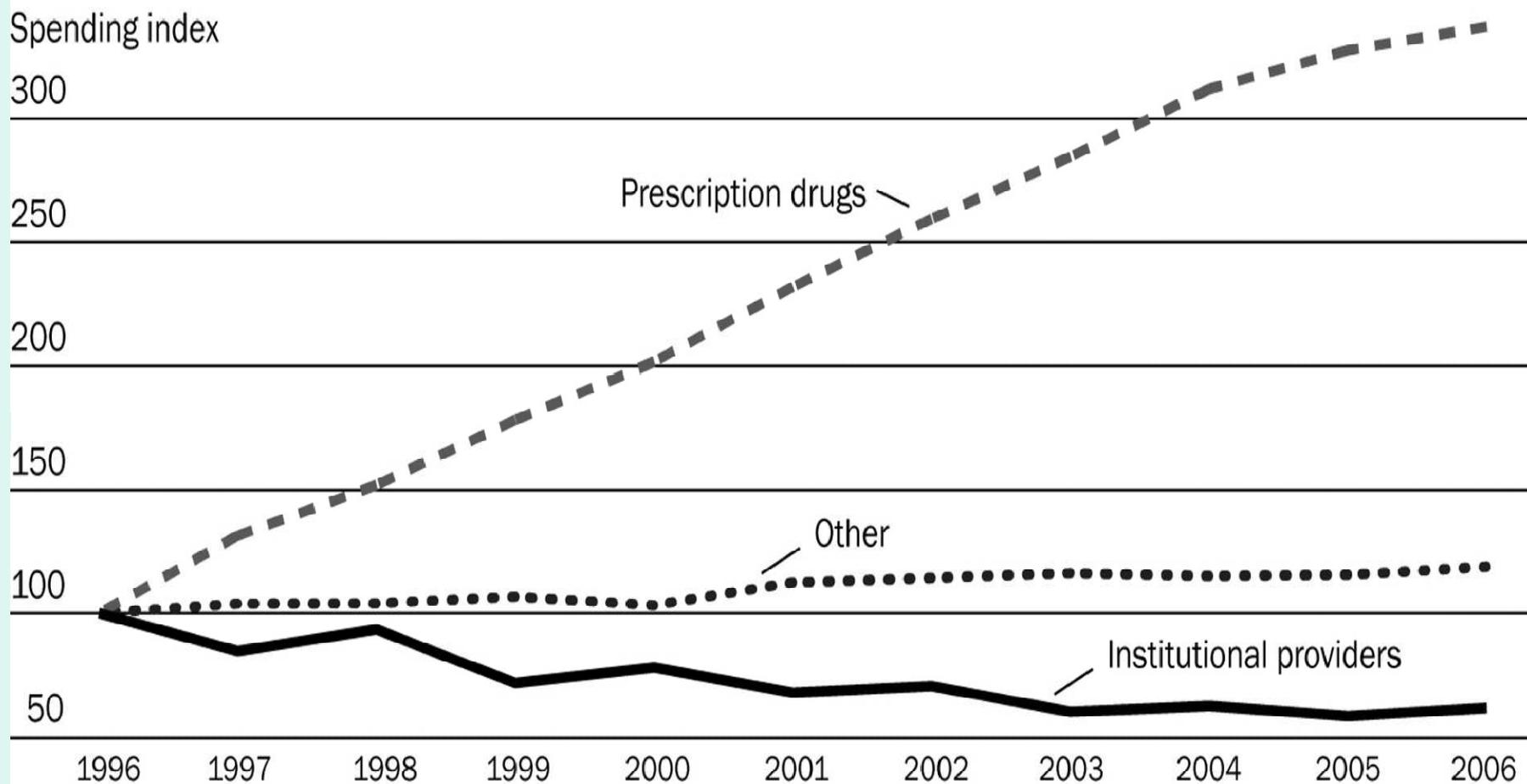


EXHIBIT 6

Growth In U.S. Mental Health Spending (Indexed To 1996), By Sector, 1996-2006

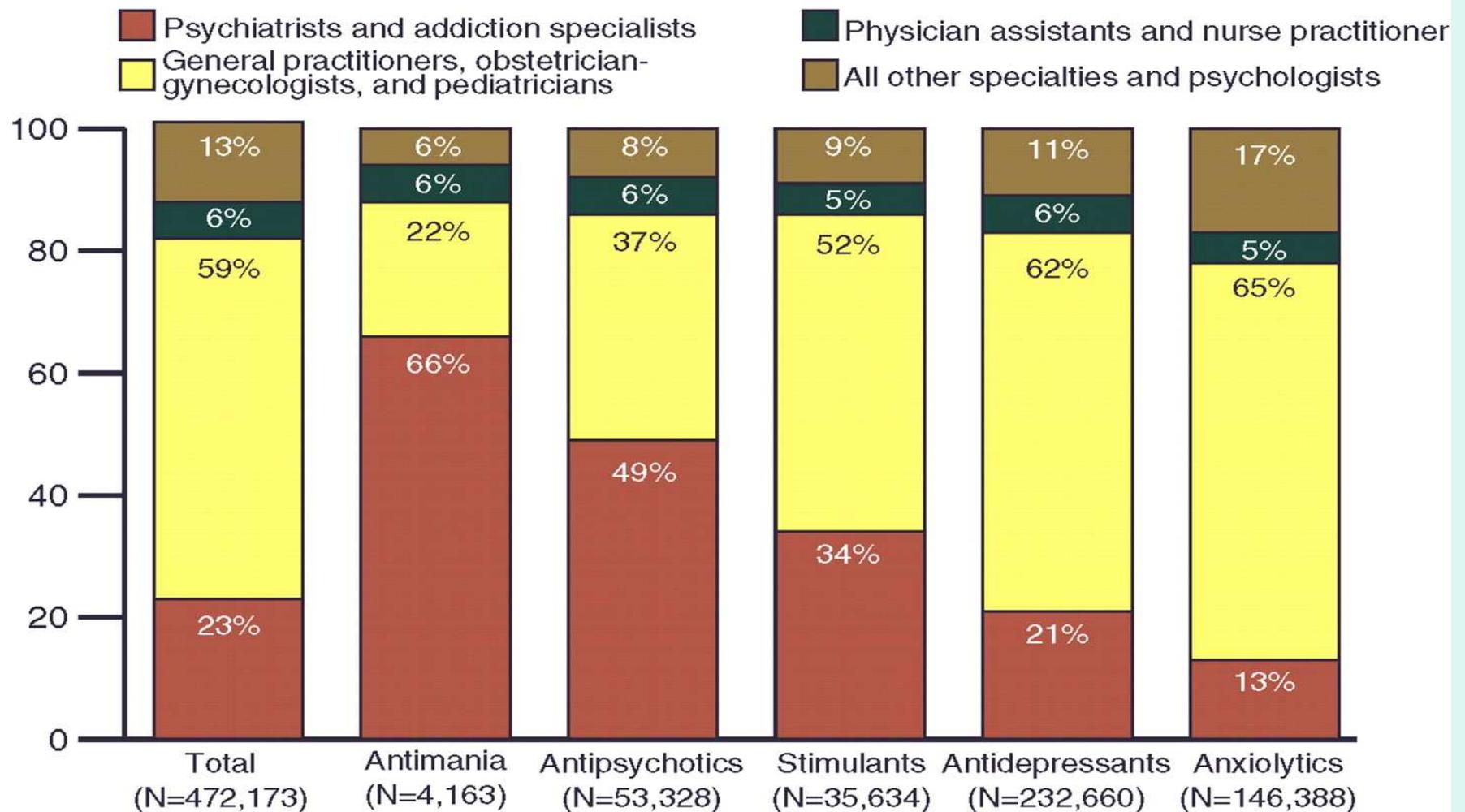


SOURCE: Medical Expenditure Panel Surveys, 1996-2006.

NOTES: Spending index constructed through regression analysis, available in the online appendix at <http://content.healthaffairs.org/cgi/content/full/28/3/649/DC1>. 100 represents mean spending in 1996 for each group. For regression details, see Exhibit 3 notes.

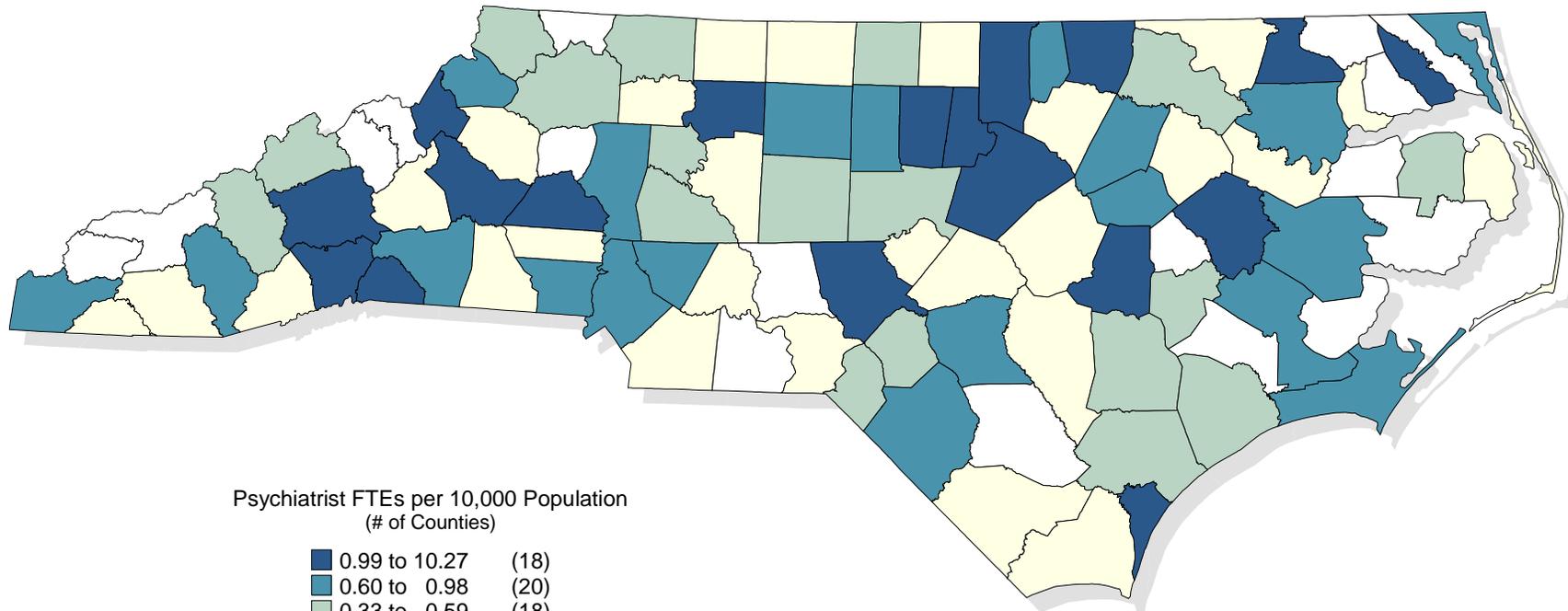
Figure 1

Percentage of U.S. retail psychotropic prescriptions written from August 2006 to July 2007, by type of provider^a



^a Ns represent prescriptions in thousands

Psychiatrist Full-Time Equivalents per 10,000 Population North Carolina, 2004



Psychiatrist FTEs per 10,000 Population
(# of Counties)

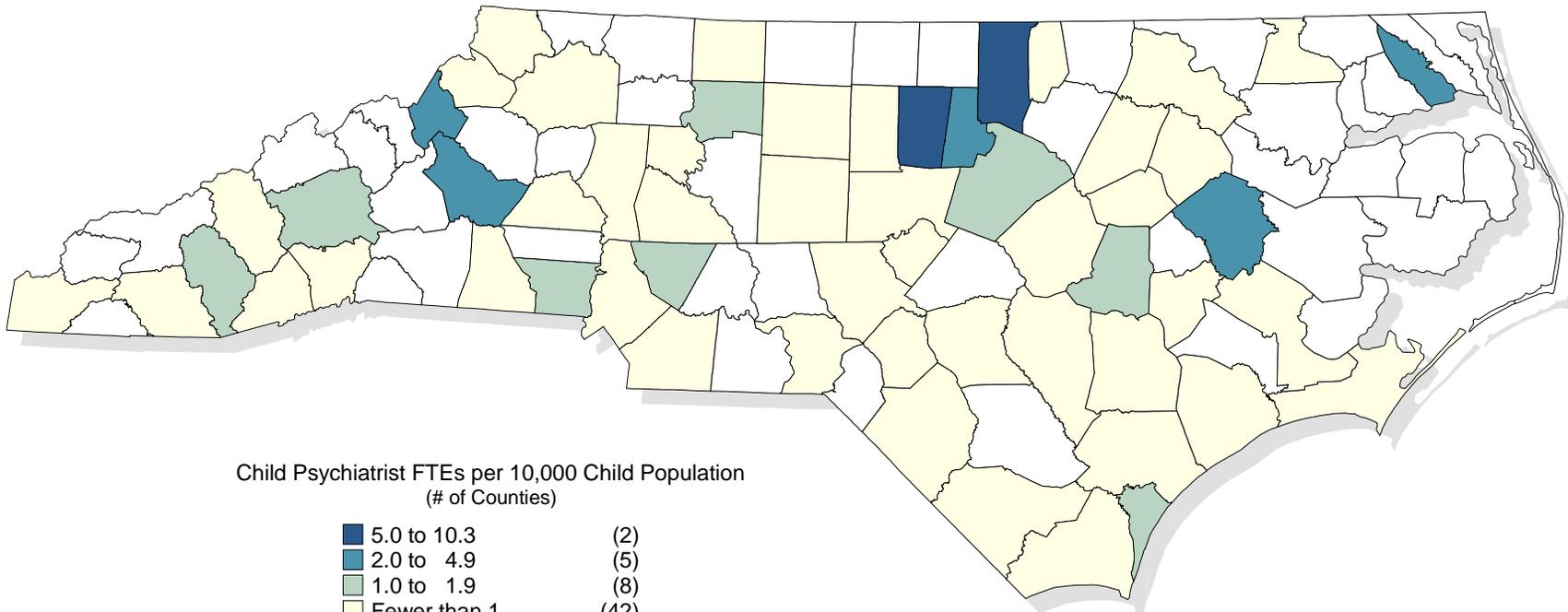
	0.99 to 10.27	(18)
	0.60 to 0.98	(20)
	0.33 to 0.59	(18)
	0.01 to 0.32	(27)
	No Psychiatrists	(17)

Total Psychiatrists = 1,061

Source: North Carolina Health Professions Data System, with data derived from the North Carolina Medical Board, 2004; LINC, 2005.
Produced by: North Carolina Health Professions Data System and the Southeast Regional Center for Health Workforce Studies, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

*Psychiatrists include active (or unknown activity status), instate, nonfederal, non-resident-in-training physicians who indicate a primary specialty of psychiatry, child psychiatry, psychoanalysis, psychosomatic med, addiction/chemical dependency, forensic psychiatry, or geriatric psychiatry, and secondary specialties in psychiatry, child psychiatry and forensic psychiatry.

Child Psychiatrist Full-Time Equivalents per 10,000 Child Population North Carolina, 2004



Child Psychiatrist FTEs per 10,000 Child Population
(# of Counties)

	5.0 to 10.3	(2)
	2.0 to 4.9	(5)
	1.0 to 1.9	(8)
	Fewer than 1	(42)
	No Child Psychiatrists	(43)

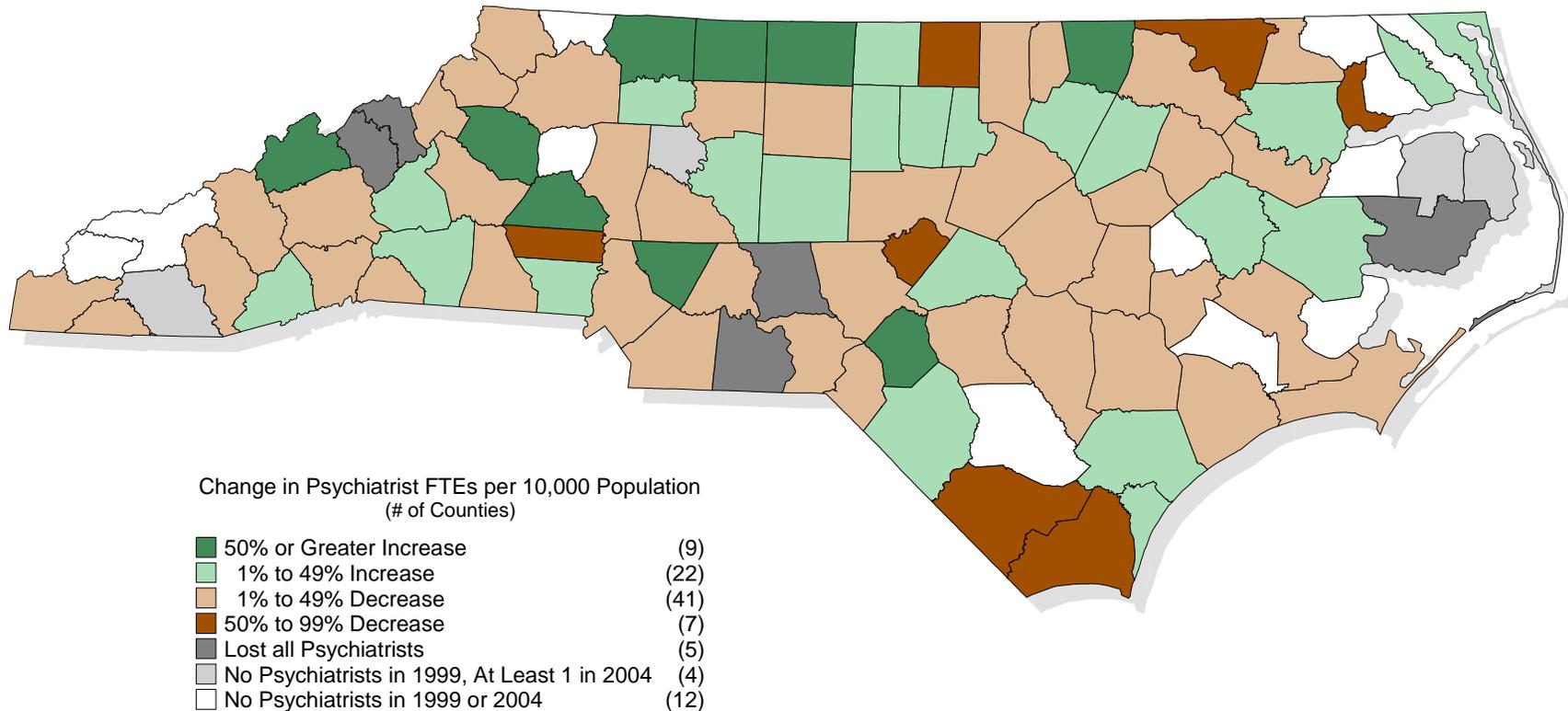
Total Child Psychiatrists = 223

Source: North Carolina Health Professions Data System, with data derived from the North Carolina Medical Board, 2004; LINC, 2005.

Produced by: North Carolina Health Professions Data System and the Southeast Regional Center for Health Workforce Studies, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

*Child psychiatrists include active (or have unknown activity status), in-state, nonfederal, non-resident-in-training physicians who indicate a primary or secondary specialty of child psychiatry. Child population includes children 18 and under.

Change in Psychiatrist Full-Time Equivalents per 10,000 Population North Carolina, 1999 to 2004



Source: North Carolina Health Professions Data System, with data derived from the North Carolina Medical Board, 1999-2004; LINC, 2000 and 2005.
Produced by: North Carolina Health Professions Data System and the Southeast Regional Center for Health Workforce Studies, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

*Psychiatrists include active (or unknown activity status), instate, nonfederal, non-resident-in-training physicians who indicate a primary specialty of psychiatry, child psychiatry, psychoanalysis, psychosomatic med, addiction/chemical dependency, forensic psychiatry, or geriatric psychiatry, and secondary specialties in psychiatry, child psychiatry and forensic psychiatry.

Are Workforce Shortages Unique to NC?

**Were the shortages created by
reform?**

A Workforce in Crisis

- The workforce issues encompass difficulties in:
 - recruiting and retaining staff,
 - the absence of career ladders for employees,
 - marginal wages and benefits,
 - limited access to relevant and effective training,
 - the erosion of supervision,
 - a vacuum with respect to future leaders,
 - financing systems that place enormous burdens on the workforce to meet high levels of demand with inadequate resources.

The Nation's Behavioral Health Workforce Crisis

(Annapolis Coalition)

- **“Across the nation there is a high degree of concern about the state of the behavioral health workforce and pessimism about its future.**
- **Workforce problems have an impact on almost every aspect of prevention and treatment across all sectors of the diverse behavioral health field.**
- **There is equally compelling evidence of an anemic pipeline of new recruits to meet the complex behavioral health needs of the growing and increasingly diverse population in this country.**
- **It is difficult to overstate the magnitude of the workforce crisis in behavioral health. The vast majority of resources dedicated to helping individuals with mental health and substance use problems are *human resources*, estimated at over 80% of all expenditures. “**

Workforce Training (Annapolis Coalition)

- **“There is overwhelming evidence that the behavioral health workforce is not equipped in skills or in numbers to respond adequately to the changing needs of the American population.**
- **Most of the workforce lacks the array of skills needed to assess and treat persons with co-occurring conditions.**
- **Training and education programs largely have ignored the need to alter their curricula ... and, thus, the nation continues to prepare new members of the workforce who simply are underprepared from the moment they complete their training.”**

Maldistribution and Cultural Competence

(Annapolis Coalition)

- **“In rural America, the workforce crisis is particularly acute.**
- **More than 85% of the federally designated mental health professional shortage areas are rural and they typically lack even a single professional working in the mental health disciplines.**
- **Few training programs offer any significant focus on rural behavioral health service delivery.**
- **30% of the nation’s population is drawn from four major ethnic groups: Latinos, African Americans, Asian American/Pacific Islanders, and Native Americans.**
- **However, the behavioral health workforce lacks such cultural diversity, particularly in mental health.**

Proposed Workforce Development Taskforce Recommendations

Report of the:

**The North Carolina Commission for Mental Health, Developmental
Disabilities and Substance Abuse Services**

and

**The Division of Mental Health, Developmental Disabilities and
Substance Abuse Services**

<http://www.ncdhhs.gov/mhddsas/statspublications/reports/workforcedevelopment-4-15-08-initiative.pdf>

STRUCTURES TO SUPPORT THE WORKFORCE

- **Recommendation 1:** Create a Workforce Development Section in the Division of MH/DD/SAS.
- **Recommendation 2:** Create a consistent means to identify and report annually to policy makers the status of the North Carolina public mental health, developmental disabilities and substance abuse services workforce as a quality improvement function.

BROADENING THE CONCEPT OF WORKFORCE

- **Recommendation 3:** Create new service options for consumer directed services for all individuals with disabilities and, as appropriate, for their families.
- **Recommendation 4:** Create a workforce marketing and public awareness campaign for all types of behavioral health and developmental disability staff positions.

STRENGTHENING THE WORKFORCE

- **Recommendation 5:** Optimize wages and benefits for professional and direct support workers serving consumers of the public mental health, developmental disabilities and substance abuse service system.
- **Recommendation 6:** Create selection tools to assist providers in reducing early turnover of workers.
- **Recommendation 7:** Improve access to psychiatric and other medical care for populations served by the public mental health, developmental disabilities and substance abuse service system.

STRENGTHENING THE WORKFORCE

- **Recommendation 8:** Create coordinated curricula and certification plans for professional and direct support workers.
- **Recommendation 9:** Provide systematic training, technical assistance and incentives to all providers statewide on effective recruitment, retention and training practices.
- **Recommendation 10:** Foster, encourage and support system wide training to frontline supervisors and managers on effective supervision.
- **Recommendation 11:** Provide opportunities to empower professional and direct support workers serving consumers of publicly funded mental health, developmental disabilities and substance abuse services.

Parity Legislation; Background

- The *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA)* was enacted on 10/3/2008
- “Equal rights in health insurance” – end discrimination
- Predecessor - the Mental Health Parity Act of 1996
 - Eliminated differential annual or lifetime limits
 - Covered large group market but not small groups or self insured plans
 - Specifically excluded substance use disorders
 - Did not include prescription drug benefits

MHPAEA Features

- Continues existing law protections (annual/lifetime limits)
- Applies to large group market and its insurers
 - Covers some 140 million employed Americans
 - 446,400 ERISA groups - 111 M
 - 20,000+ State/Local Govt. - 29 M
 - Also applies to Medicaid managed care organizations (34 M)
- Adds substance use disorders to the disorders entitled to protection
- Adds special rule for prescription drug benefits
- Does not cover everybody, however
 - Plans under 50 employees, Individual Market (& Medicare)

Other MHPAEA Features

- Does not mandate mental health benefit coverage
 - If MH is covered, however, must comply parity basis
- Note “opt out” for state & local (non Federal) government self insured employers
- Generally effective for plan years beginning after July 1, 2010 (realistically, begins Jan 1, 2011)
- However, in the interim, health plans must make a “good faith” effort to comply with the reasonable interpretation of the law.

Key MHPAEA Protections

If plan has mental health/substance use disorder benefits:

- Financial requirements (deductibles/co-pays) and treatment limits (# visits/days of coverage) can be no more restrictive than predominant requirements/limits for substantially all M/S
- No separate cost sharing or TX limits for MH/SUD only
- IF plan offers out-of-network M/S benefits, then must do same for MH/SUD
- Standards for medical necessity determinations and reasons for any denial must be disclosed upon request
- Must use “generally recognized standards” for MH and SUD
- No preemption of stronger state law coverage

Thanks!