NC's Struggle to Maintain an Effective Mental Health Workforce

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The Nation's Behavioral Health Workforce Crisis

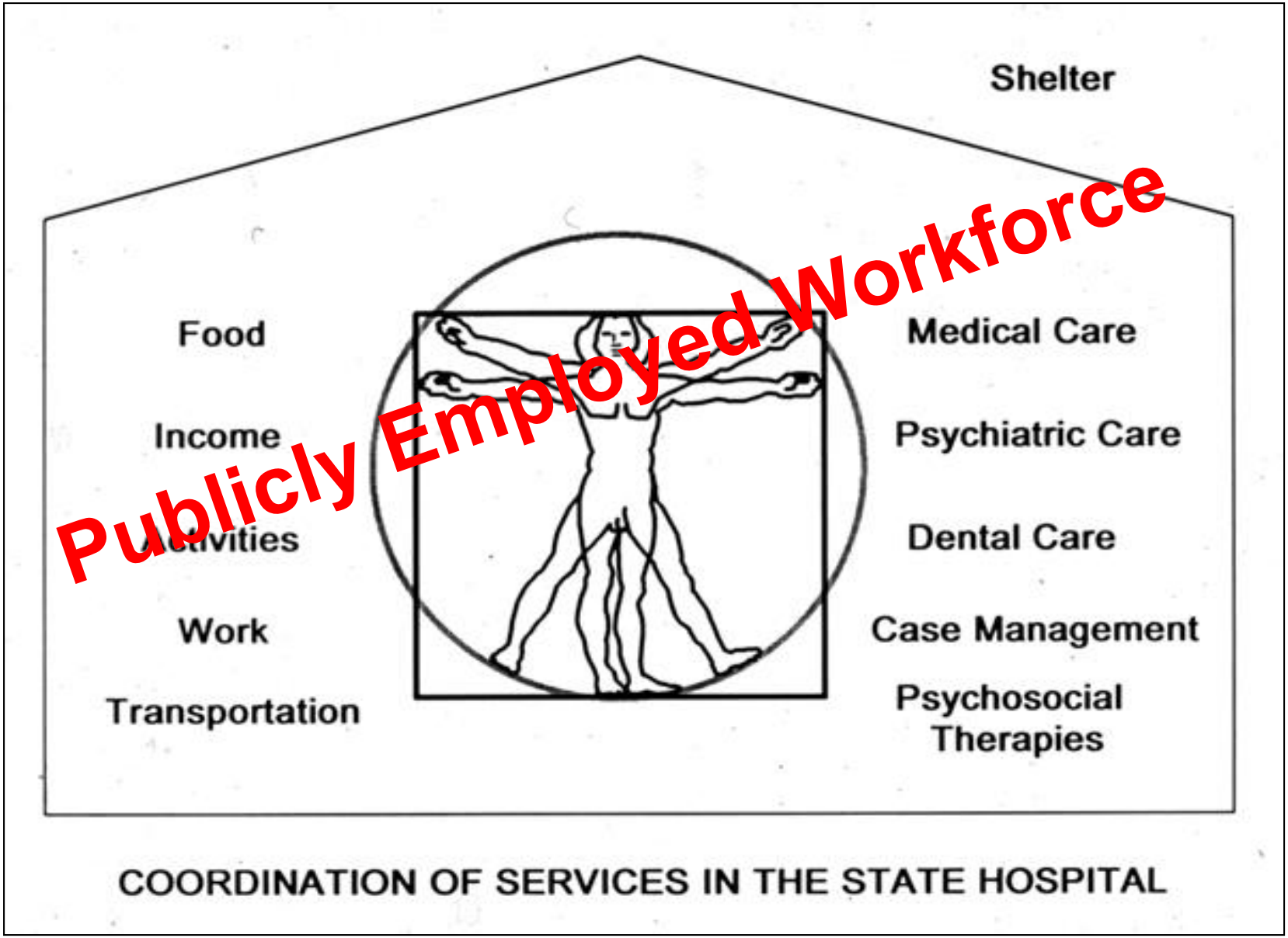
- **"Across the nation there is a high degree of concern about the state of the behavioral health workforce and pessimism about its future.**
- **Workforce problems have an impact on almost every aspect of prevention and treatment across all sectors of the diverse behavioral health field.**
- **There 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

- **"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

- **"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.**



COORDINATION OF SERVICES IN THE STATE HOSPITAL

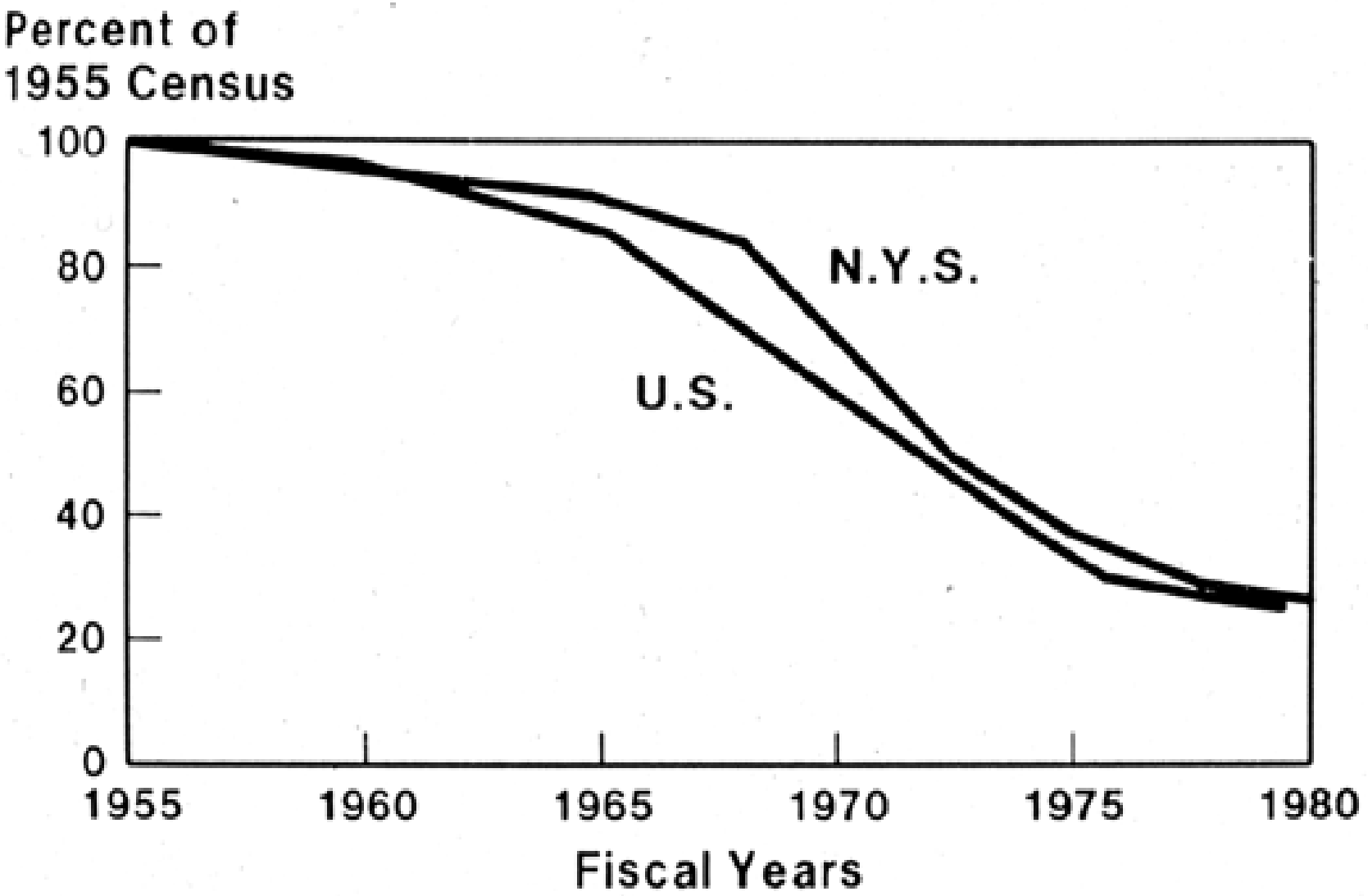
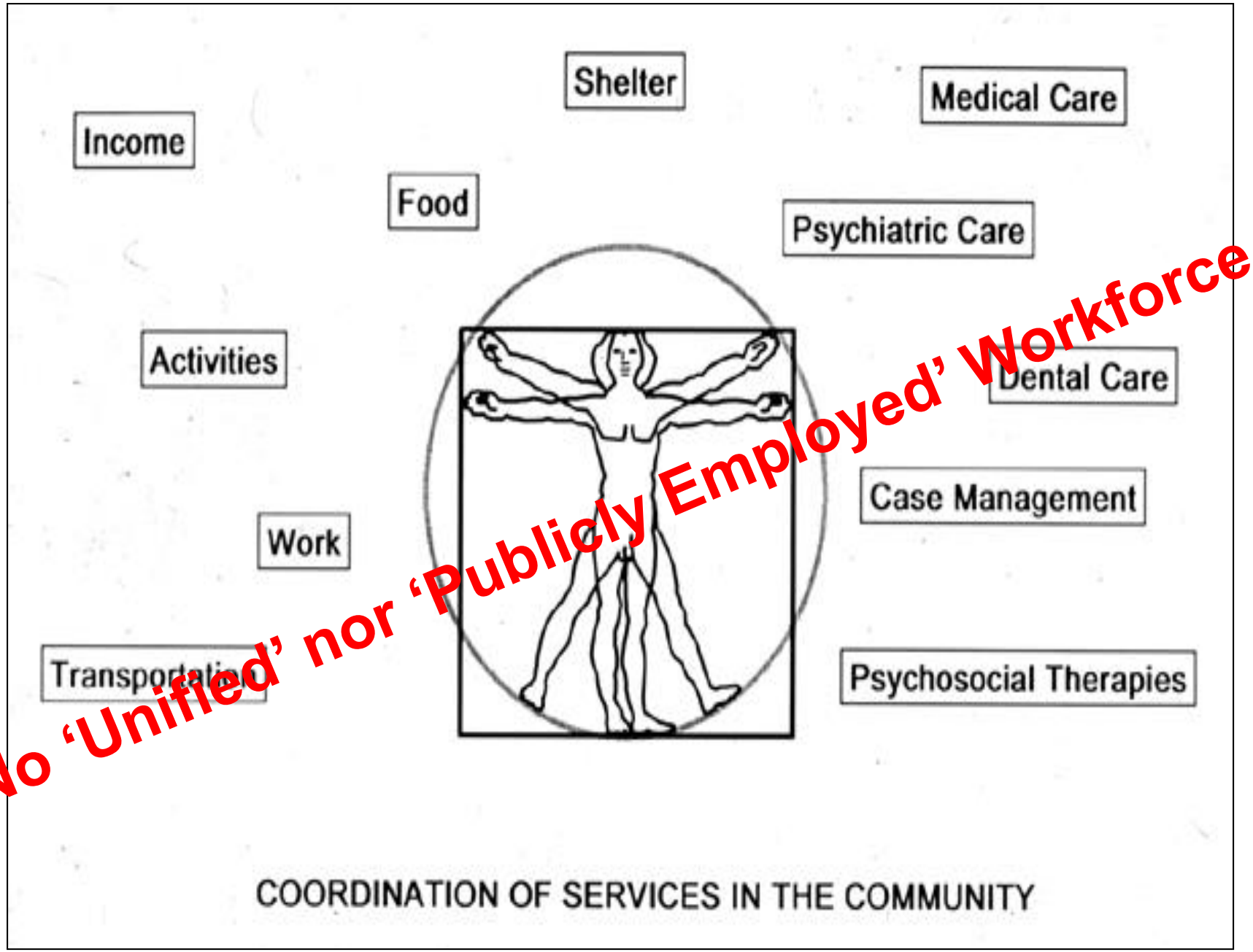
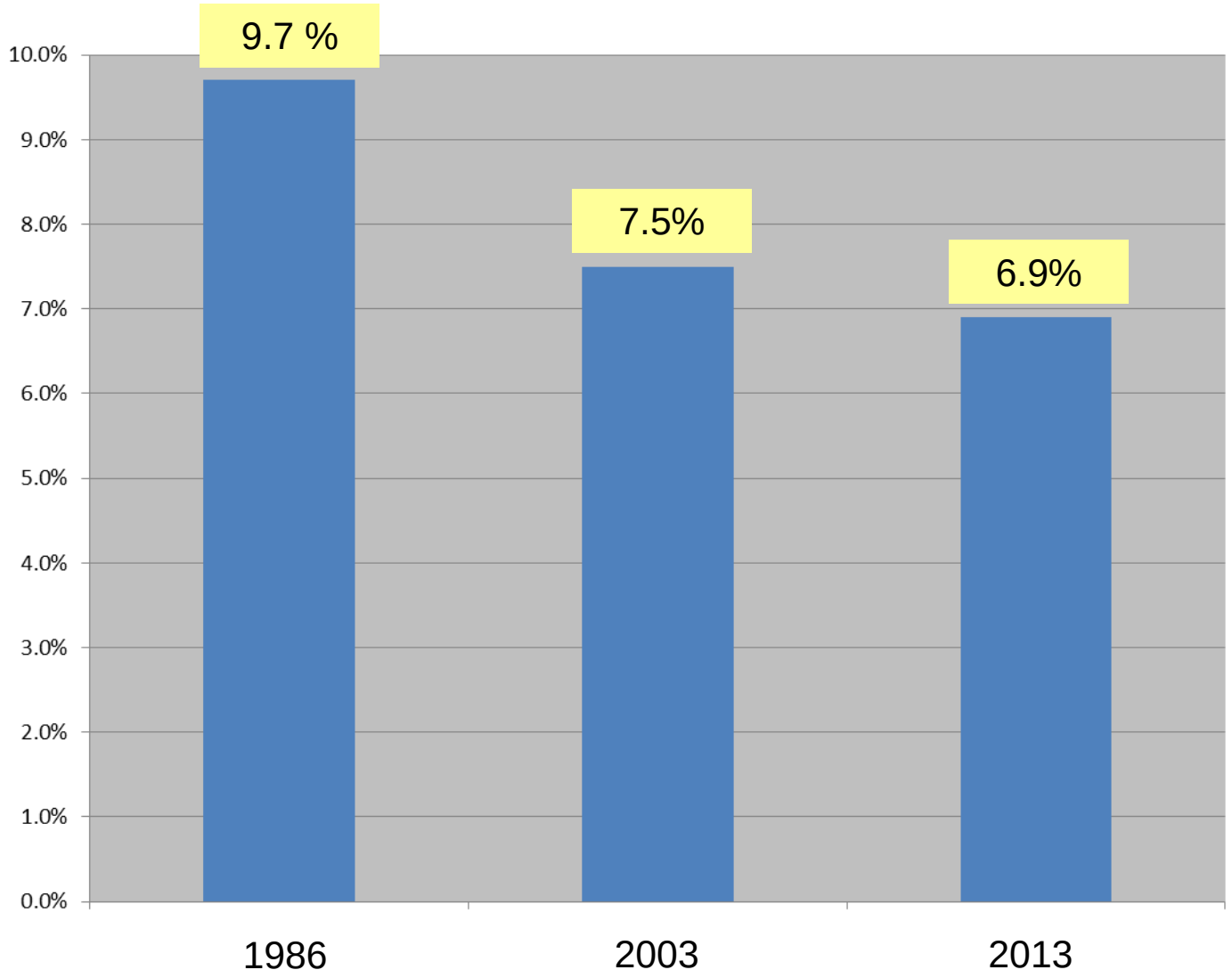


Figure 2. Percent of 1955 census state psychiatric centers in United States and New York. From New York State Office of Mental Health, 1981.

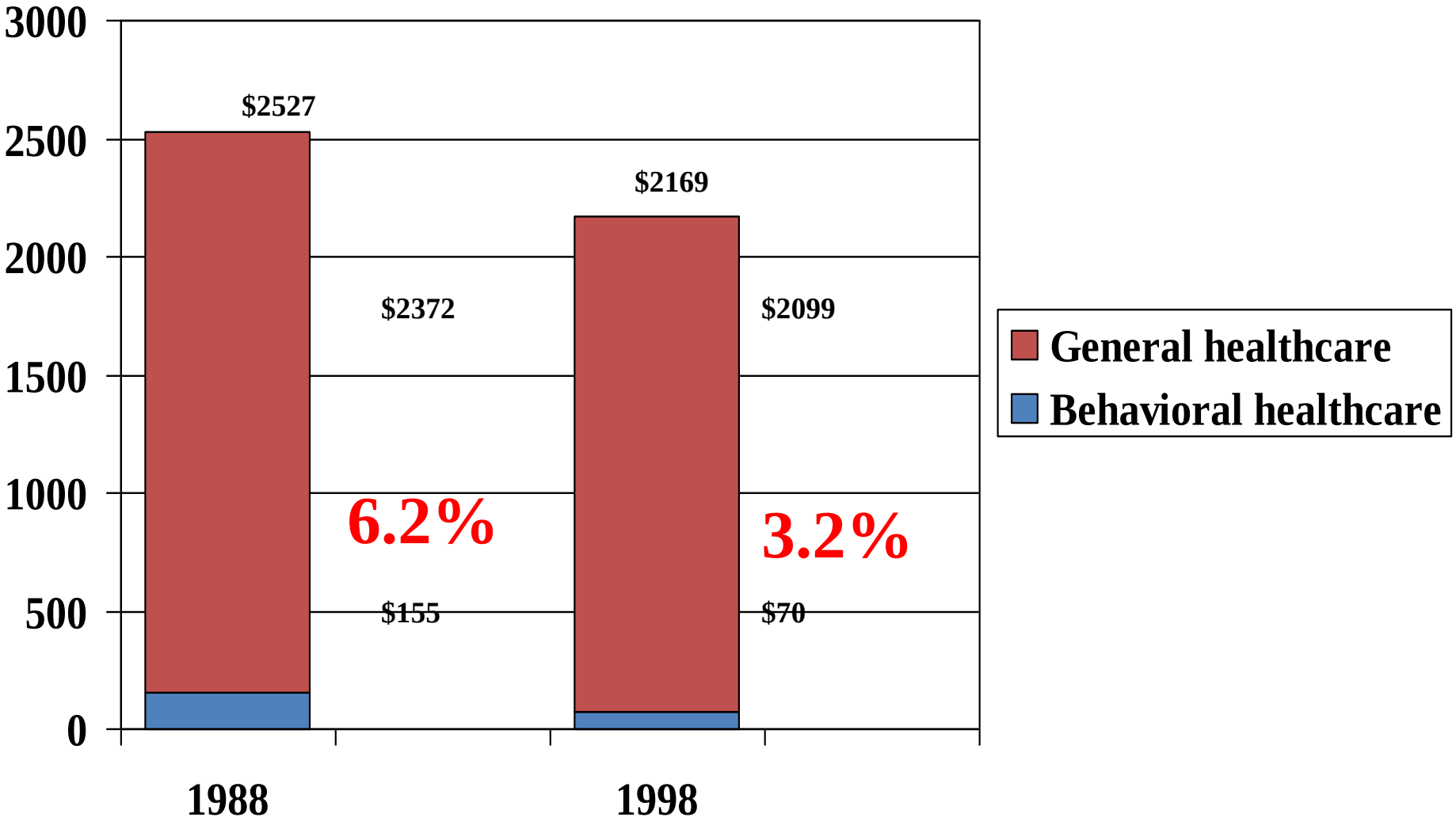

Shelter
Medical Care
Income
Food
Psychiatric Care
Activities
Dental Care
Case Management
Work
Transportation
Psychosocial Therapies
No 'Unified' nor 'Publicly Employed' Workforce
COORDINATION OF SERVICES IN THE COMMUNITY

MHSA Expenditures as a Percent of Total Health Care Expenditures



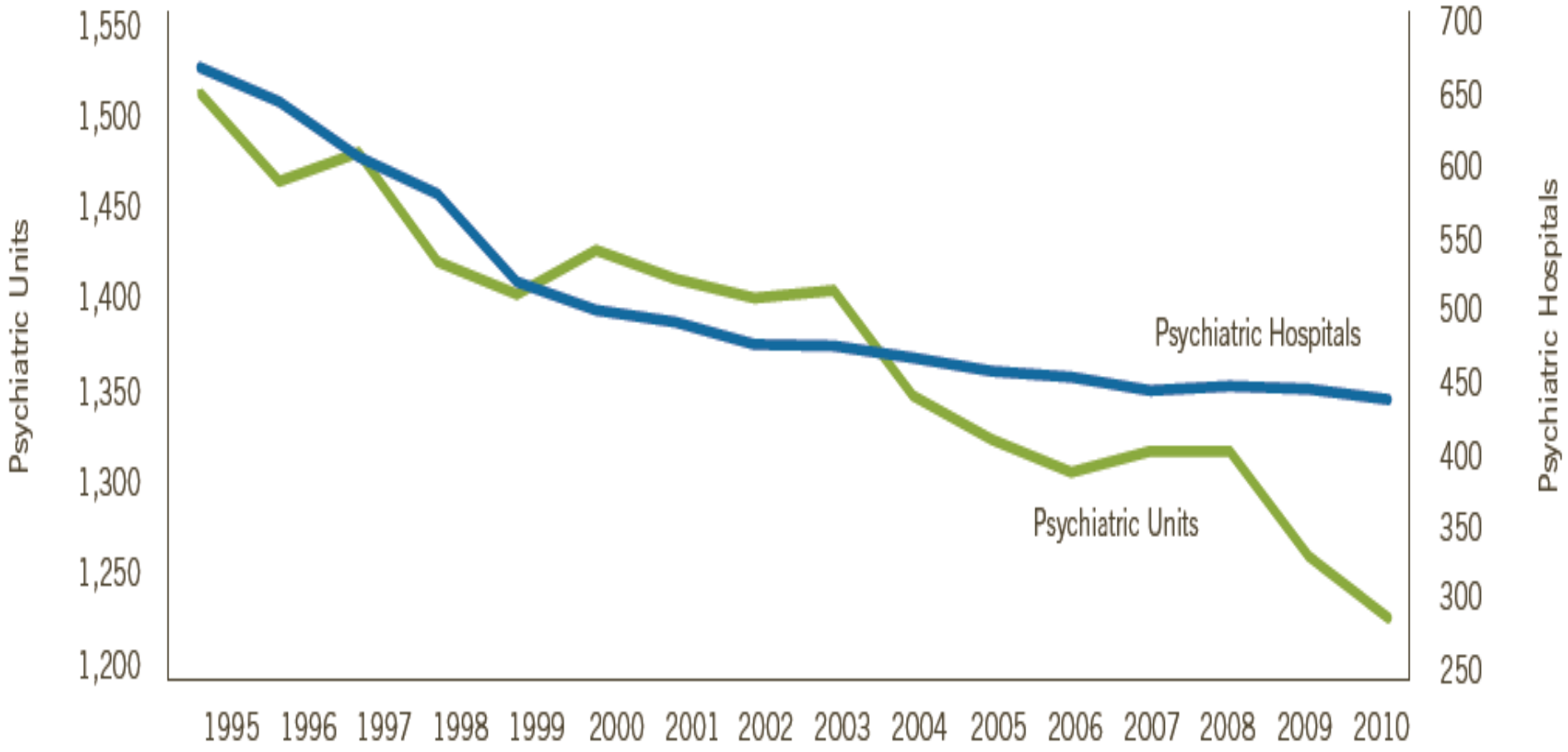
SAMHSA, Projections of National Expenditures for Mental Health Services and Substance Abuse Treatment, 2004– 2014. 2008. Publication No. SMA 08-4326

Value of Private Behavioral Health Benefits, 1988-1998 (NAPHS/Hays Group)



The health care system's capacity to deliver mental health services has been shrinking.

Chart 5: Total Number of Psychiatric Units[1] in U.S. Hospitals and Total Number of Freestanding Psychiatric Hospitals[2] in U.S., 1995-2010



Note: Includes all registered and non-registered hospitals in the U.S.

(1) Hospitals with a psychiatric unit are registered community hospitals that reported having a hospital-based inpatient psychiatric care unit for that year.

(2) Freestanding psychiatric hospitals also include children's psychiatric hospitals and alcoholism/chemical dependency hospitals.

Source: Health Forum, AHA Annual Survey of Hospitals, 1995-2010.

State Beds/Population

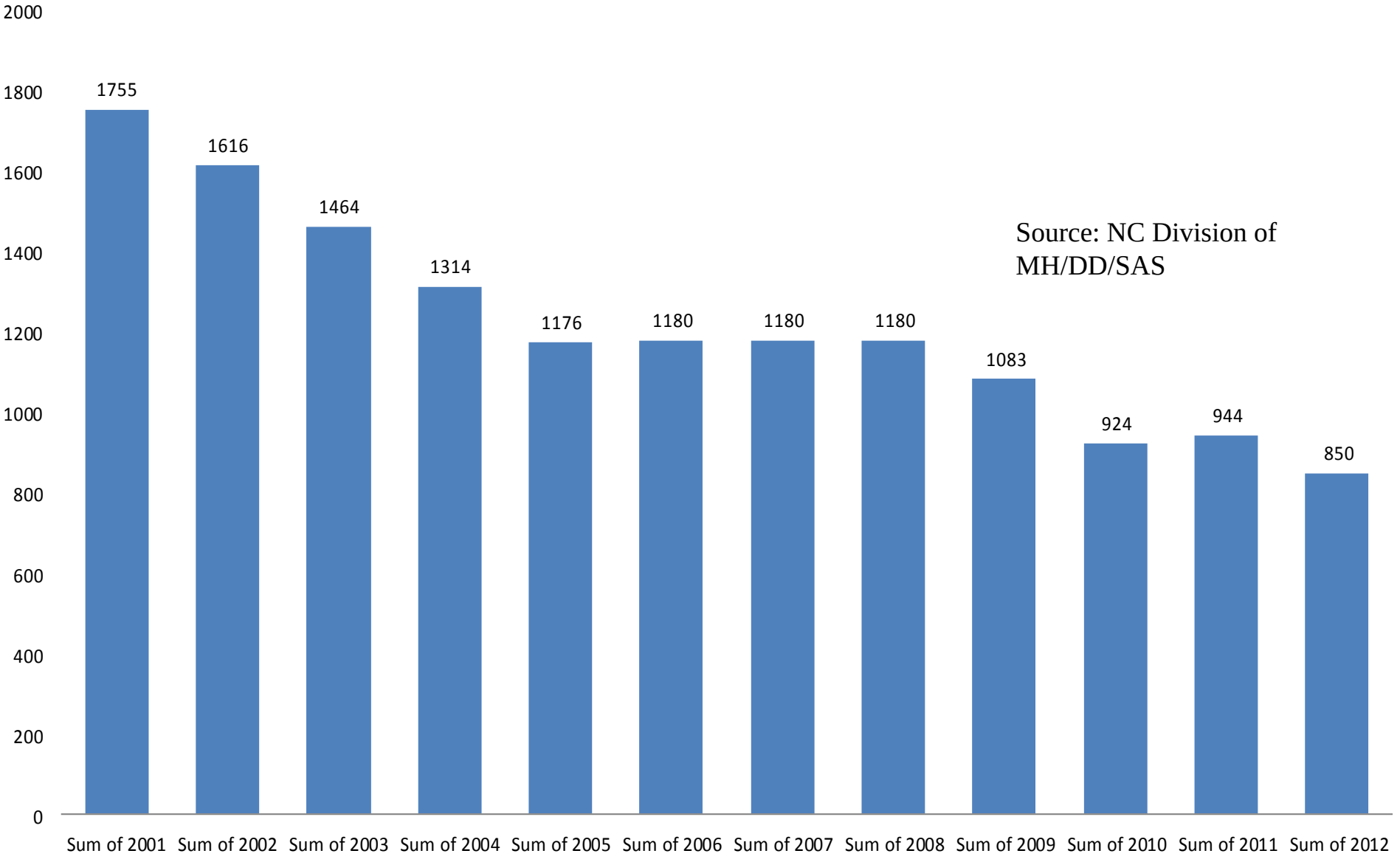
Per Treatment Advocacy Center Data

- 1955 340/100,000
- 2005 17/100,000
- Proposed standard 50/100,000
- National Bed Shortage 95,000

- NC Beds 8/100,00

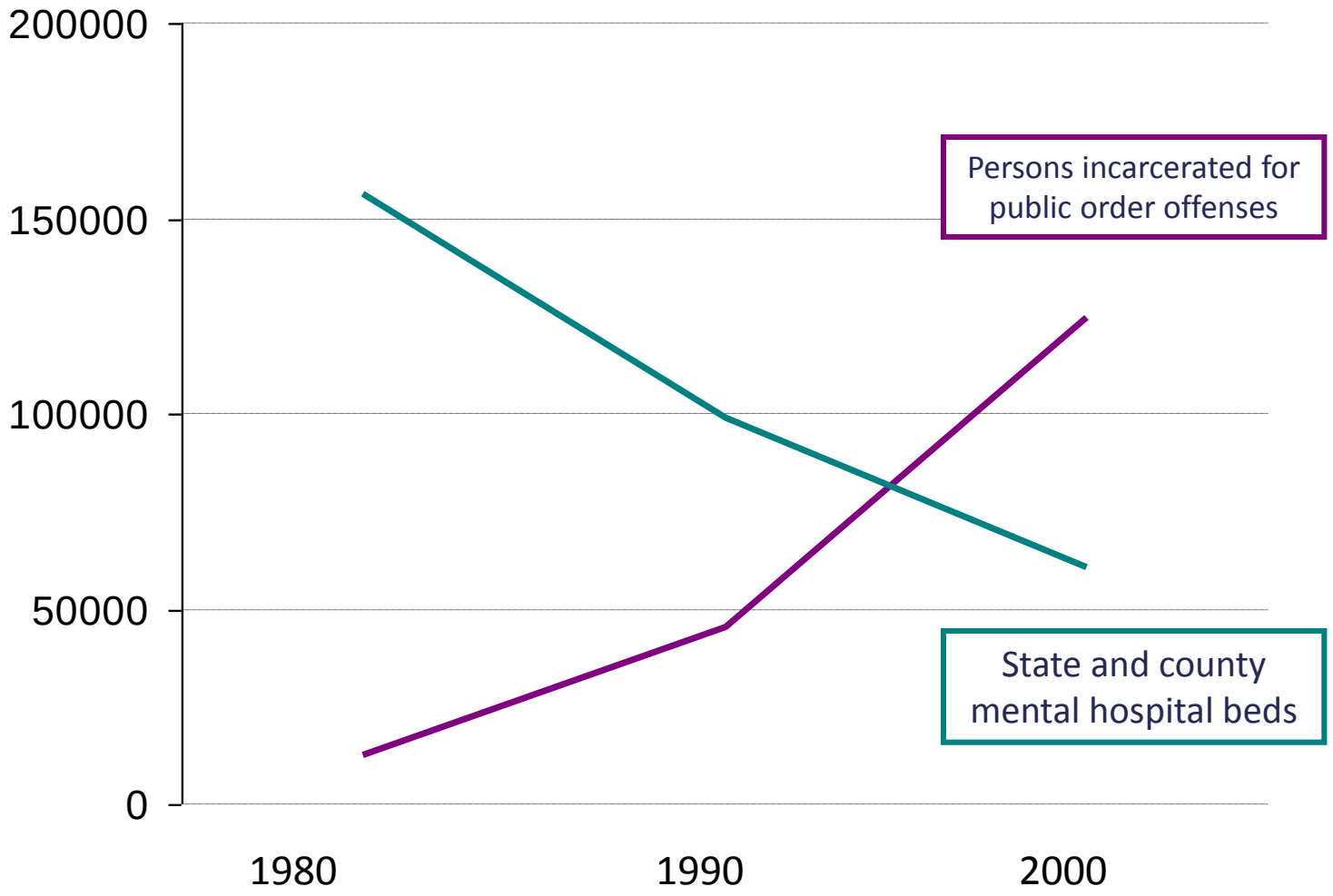
Source: Treatment Advocacy Center:
http://www.treatmentadvocacycenter.org/storage/documents/the_shortage_of_publichospital_beds.pdf

Total Operating State Hospital Beds



Source: NC Division of MH/DD/SAS

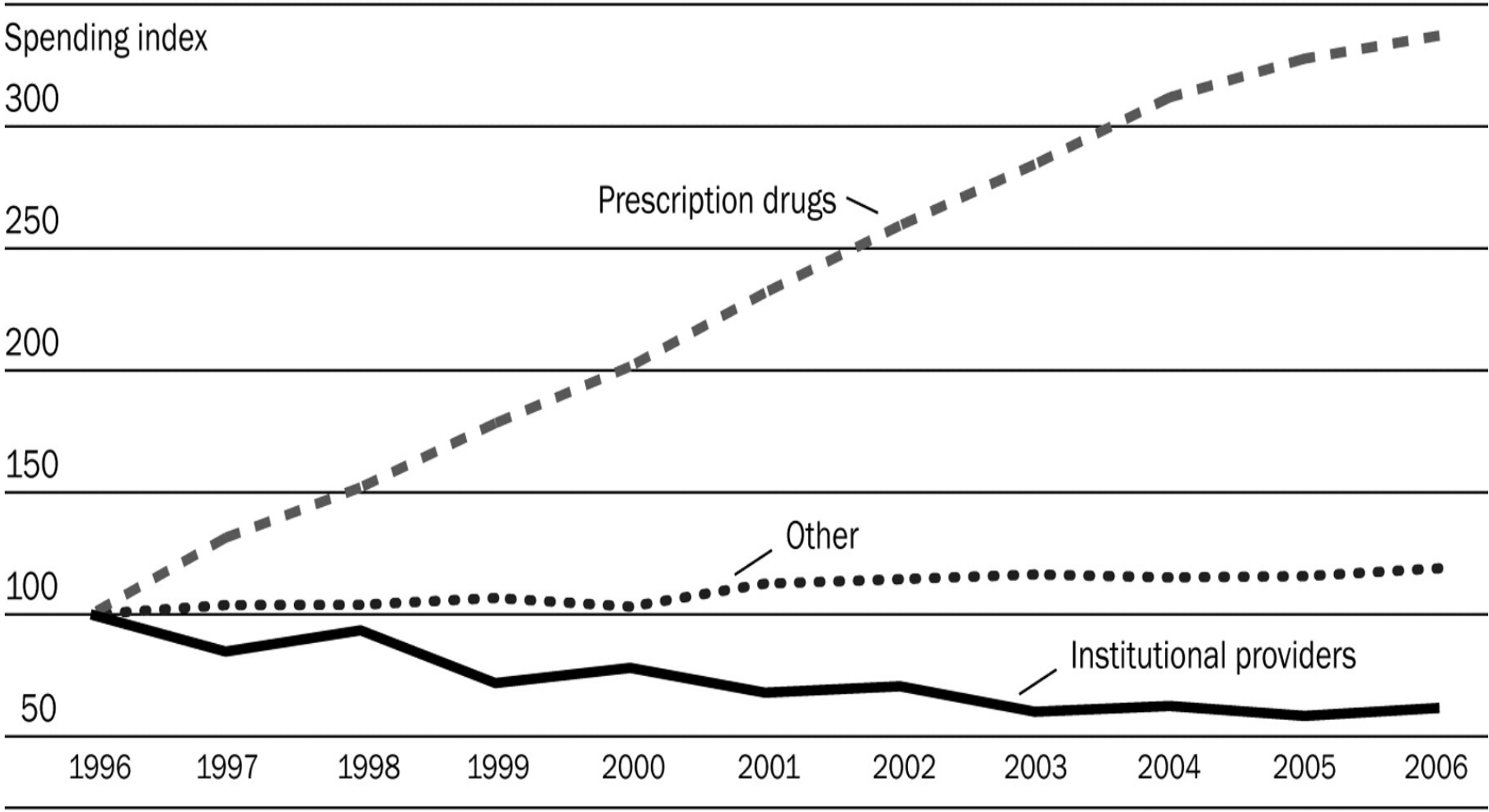
Coincidental trends?



Source: Bureau of Justice Statistics & SAMHSA

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.

Medicaid And Mental Health: Be Careful What You Ask For

Growth in Medicaid mental health spending has ironically resulted in less money for the mental health care safety net.

by Richard G. Frank, Howard H. Goldman, and Michael Hogan

ABSTRACT: Medicaid has had an enormous impact on the shape and impact of public mental health care. Medicaid mental health policy has expanded access, fostered consumerism, and created incentives for expansion of community-based providers. It also has dramatically changed the economic rules governing public mental health care, leading state governments to alter their behavior. The result has been a tilting of public mental health care toward Medicaid-covered people and services.

Medicaid=Privatization=No One 'Owns' the MHDDSAS Workforce

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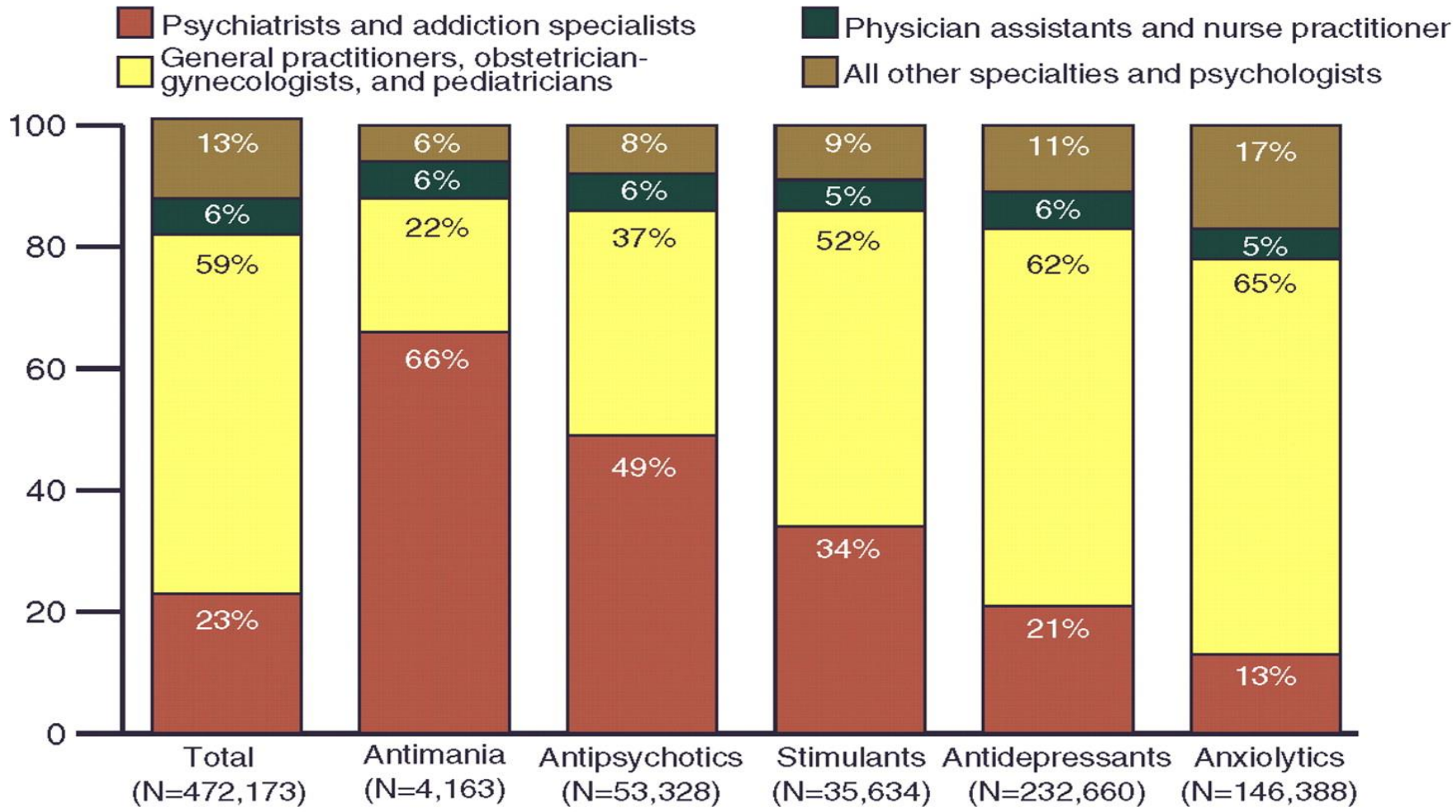
Figure 1

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

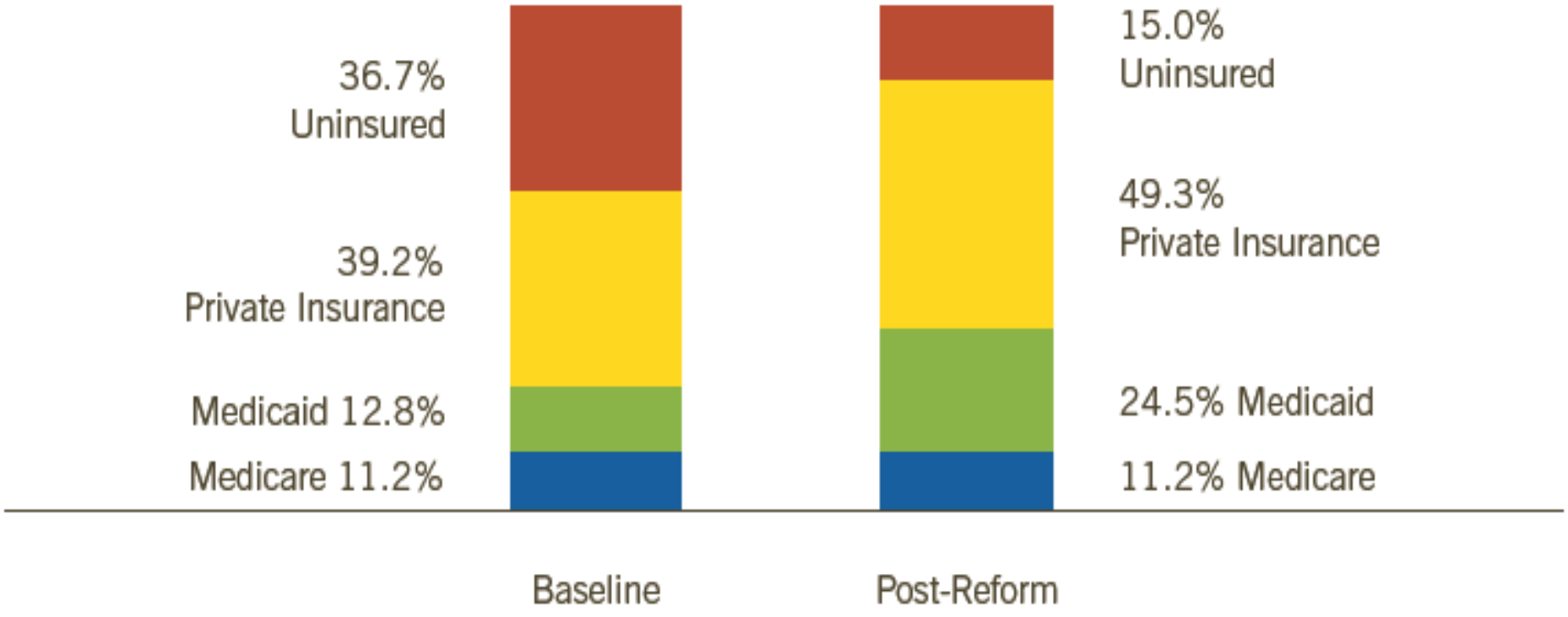
Federal Parity, Insurance Expansion and Health Care Reform

WELLSTONE AND DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)(2008)& ACA(2010):

POTENTIAL EFFECTS ON REFORM EFFORTS

A substantial number of uninsured adults with mental health needs will gain coverage under health reform.

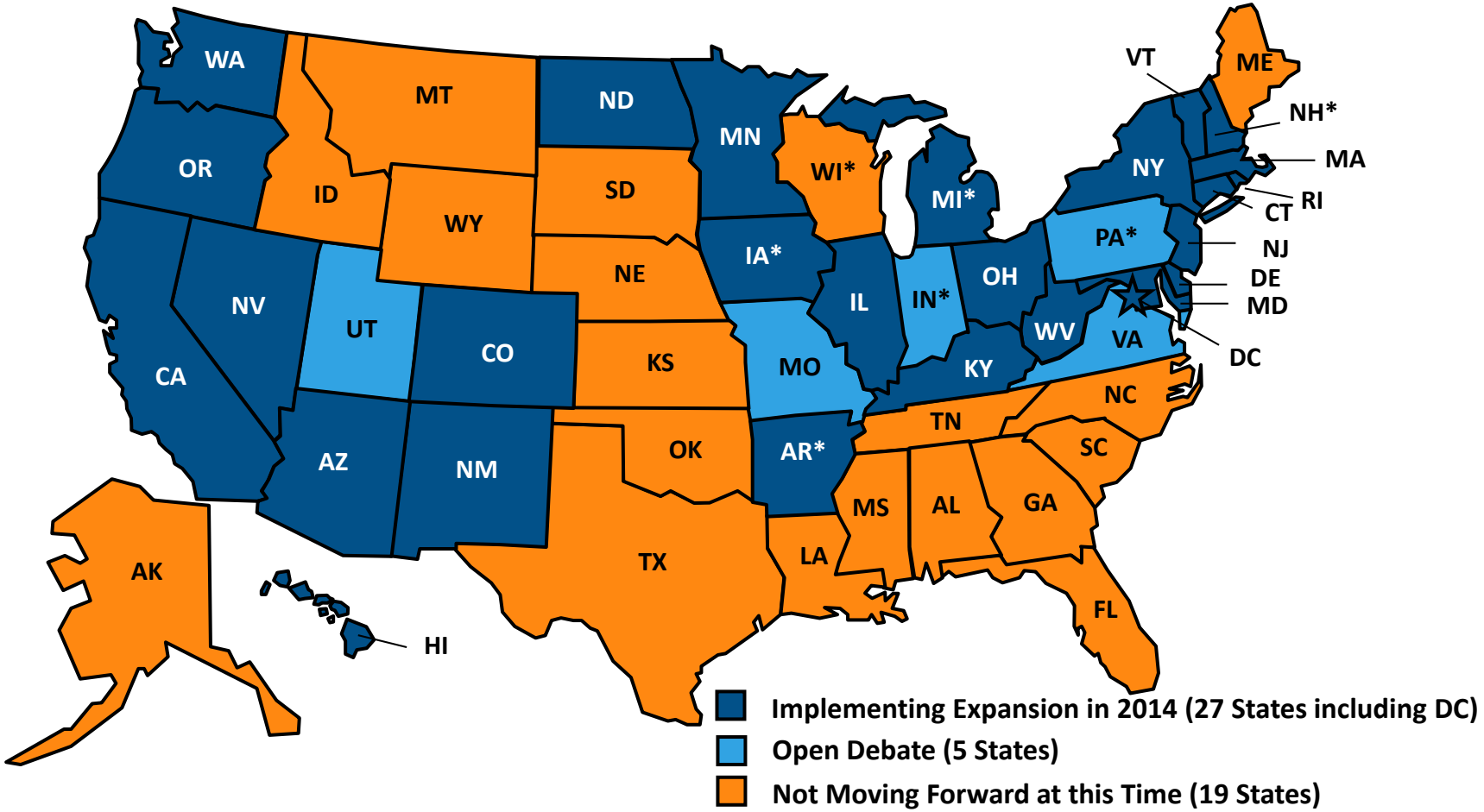
Chart 10: Simulated Change in Coverage After Reform Among Adults with Probable Depression or Serious Psychological Distress



Note: Based on data for adults ages 18-64 in the 2004-2006 Medical Expenditure Panel Surveys.

Source: Garfield, R., et al. (2011). The Impact of National Health Care Reform on Adults With Severe Mental Disorders. *American Journal of Psychiatry*, 168(5): 486-494.

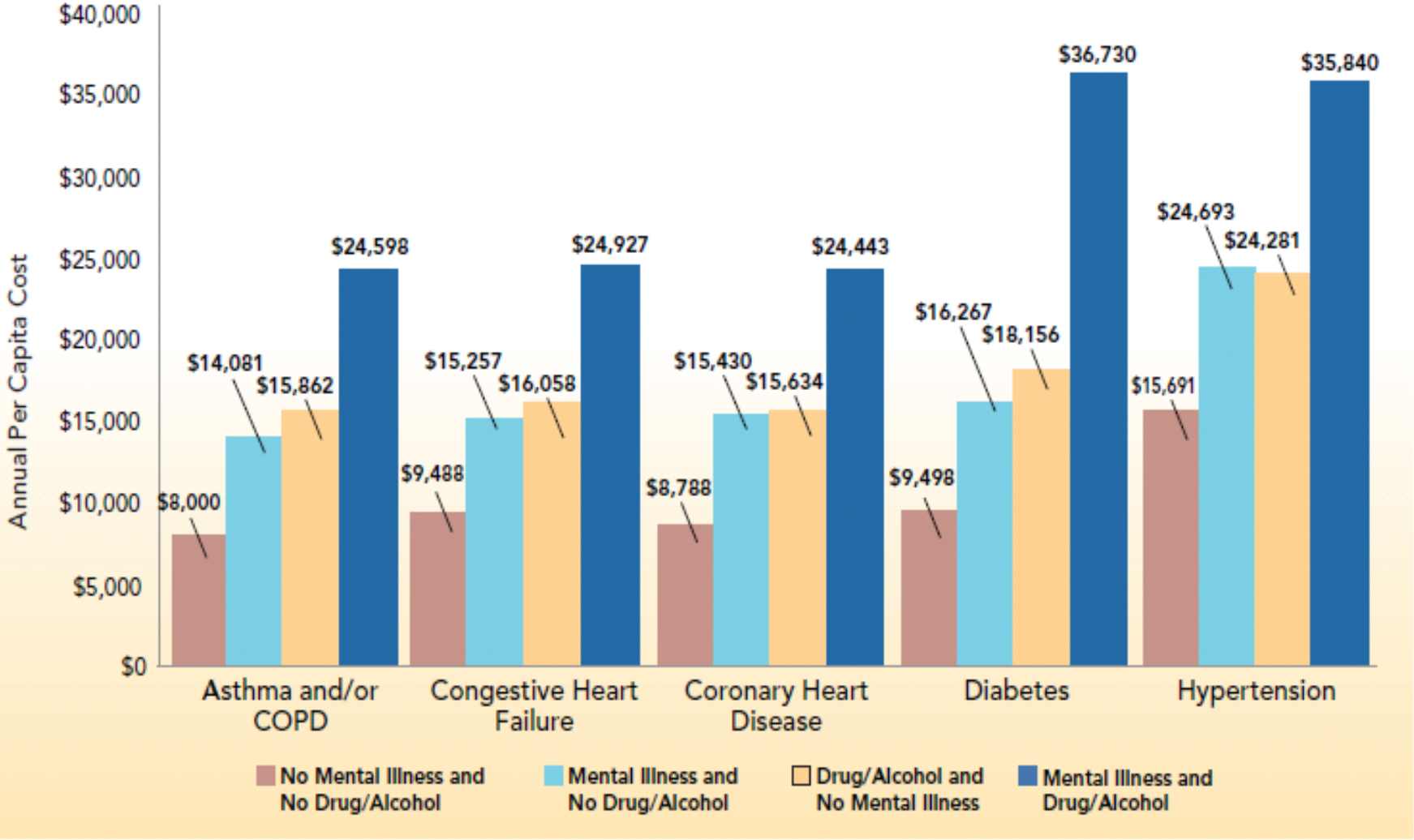
Current Status of State Medicaid Expansion Decisions, 2014



NOTES: Data are as of March 26, 2014. *AR and IA have approved waivers for Medicaid expansion. MI has an approved waiver for expansion and plans to implement in Apr. 2014. IN and PA have pending waivers for alternative Medicaid expansions. WI amended its Medicaid state plan and existing waiver to cover adults up to 100% FPL, but did not adopt the expansion. NH has passed legislation approving the Medicaid expansion in Mar. 2014; the legislation calls for the expansion to begin July 2014.

SOURCES: States implementing in 2014 and not moving forward at this time are based on data from CMS here. States noted as "Open Debate" are based on KCMU analysis of State of the State Addresses, recent public statements made by the Governor, issuance of waiver proposals or passage of a Medicaid expansion bill in at least one chamber of the legislature.

Figure 3 | Impact of Behavioral Health Comorbidities on Per Capita Costs among Medicaid-Only Beneficiaries with Disabilities



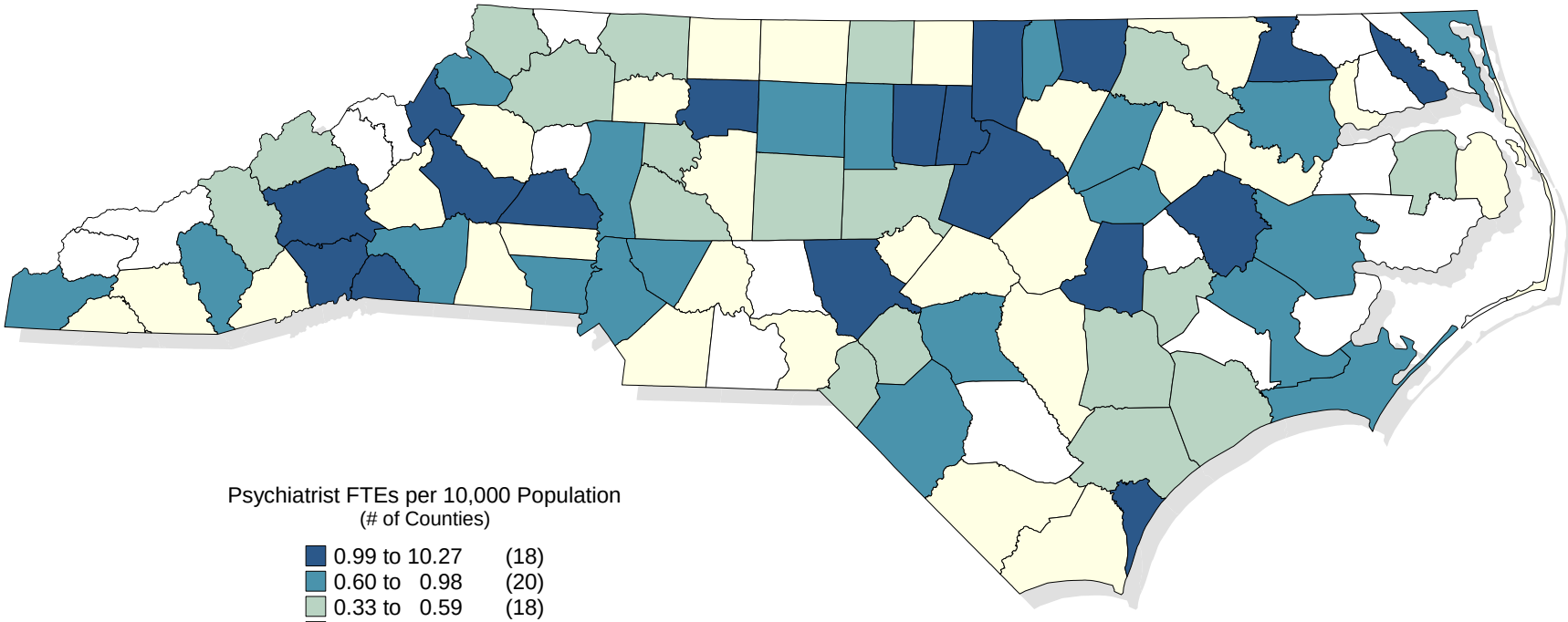
Boyd et al: Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations Center for Health Care Strategies, December, 2010.

Will the MH/SA Workforce be Adequate to Benefit and Enrollment Expansion?

"IT IS DIFFICULT TO OVERSTATE THE MAGNITUDE OF THE WORKFORCE CRISIS IN BEHAVIORAL HEALTH."

--SAMHSA /ANNAPOLIS COALITION

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



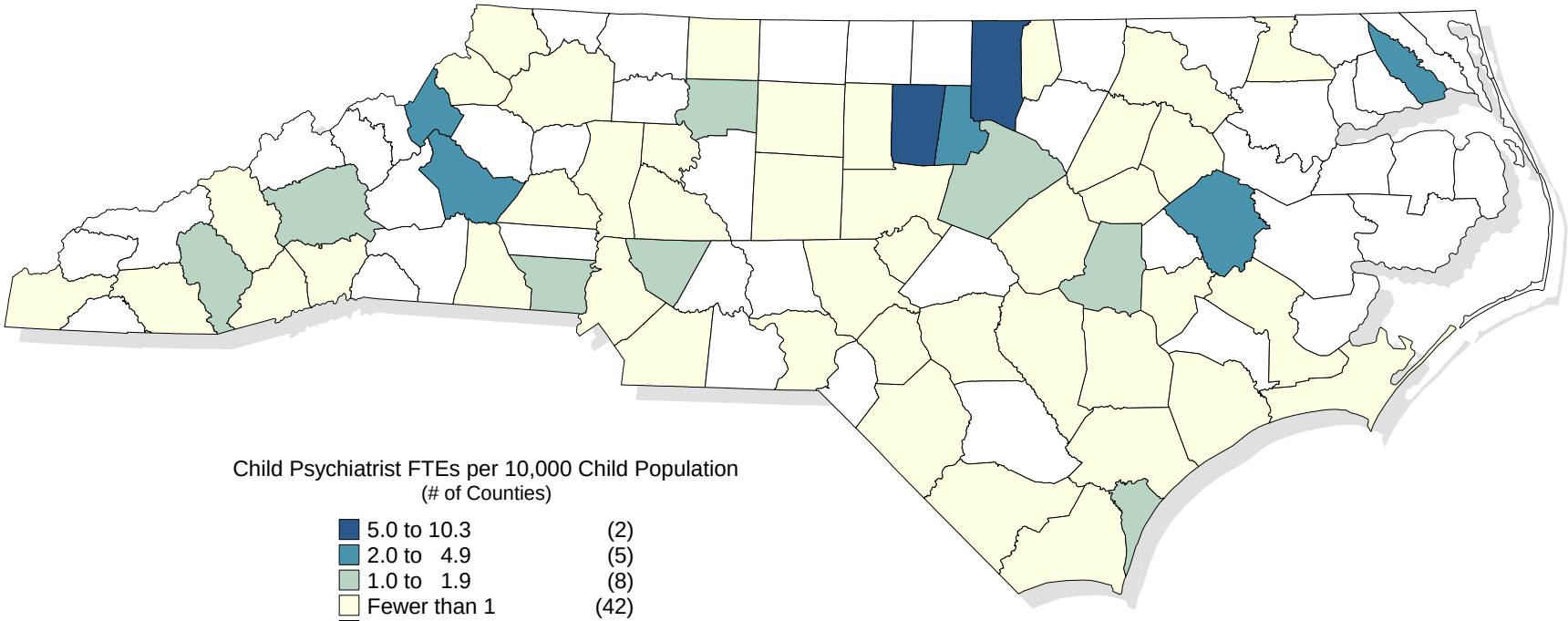
Total Psychiatrists = 1,061

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), instate, nonfederal, non-resident-in-training physicians who indicate a primary or secondary specialty of child psychiatry. Child population includes children 18 and under.

Provider Shortages, Care Re-design and Psychiatry

- In almost every health care reform scenario there is a shortage and/or maldistribution of psychiatrists
- Given~we can not grow our way out of psychiatry manpower shortages instate (and only import MDs)—what remedies are there?
- Public health models (e.g., task-sharing)
- Other team-based models
- What is our strategy for primary care (e.g., collaborative care models)?
- Specialty mental health care?
- Telemedicine

STAY TUNED!

THANKS!