

## **ACMHA ARM CHAIR REFLECTIONS**

### **Tomorrow's Success Depends on our Greatest Asset: Our Workers**

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Here is the dilemma: health care, predominantly a service industry, today takes up 16 percent (Organization for Economic Co-operation and Development, 2010) of our GDP and we can't really expand that percentage much without hurting our international competitiveness — or so we are told and believe. We are, therefore, in a conundrum.

In behavioral care today, only about 20 percent of those needing care receive it. As parity and healthcare reform advance, we will likely increase the opportunity for more Americans to access specialty behavioral care by both improving access overall and earlier recognition of problems that are then prevented from reaching specialty or acute care. The dilemma: increased specialty access coupled with earlier recognition and increased prevention, but no significant increase in health care spending or costs. How can we do this?

Over the past months, many exceptionally qualified individuals have reflected on this in earlier *Arm Chair Reflections*. Again and again, experienced practitioners and leaders all point to one common element that will make or break everything as we move forward – the skills and competencies of our workers, peer through highest-degreed professional.

In May 2009, Dr. Richard Beinecke underscored the need for developing leaders and leadership competencies if behavioral health is to meet the new day (Beinecke, 2009). In January of that same year, Dr. Leighton Huey, a colleague on the Annapolis Coalition, described the trained and educated worker as "ground zero" of reform (Huey, 2009). He also pronounced something we all need to hear again, "Reforming the system and how its workforce functions clearly involves complex challenges that will take decades to achieve."

Those of us who practice in the substance use and mental health field know that "health care reform" cannot be so rapid that we lose the specialty understanding and clinical skills gained—at times very painfully—over the years. Indeed, according to SAMHSA, all specialty providers should be co-occurring capable (Center for Substance Abuse Treatment, 2005) and that is clearly not the case today. Additionally, we must insure that the earlier interventions and the care provided by non-specialty providers, (e.g. medical homes, federally qualified health centers, community health centers, etc.) truly do understand SPMI care and/or the nature of addiction. Recently, at a presentation at a prestigious conference on drug dependency, a group of PCPs challenged this author by publicly asking, "You behaviorists all torture your patients."

Why not just give them the medication and let them go home?" My presentation was on risk management in methadone treatment. Study after study confirms similar perceptions in primary care of recurrent depression, anxiety, OCD, ADHD, and many other illnesses. What we need here is "a parity in understanding" of behavioral healthcare and medical care, lest the solution—laudable as it may be—becomes part of the next problem.

Our safest and best solution to the apparent conundrum is our worker, our workforce.

The longstanding deterioration of our behavioral health workforce has been well documented, including the Institute of Medicine (2001, 2003, 2006), Abt Associates (2006), Annapolis Coalition (2007), Addiction Technology Transfer Center National Office (Murphy and Hubbard, 2009) and, most recently, SAMHSA's *Description of a Modern Addictions and Mental Health Service System* (2010) and SAMHSA's Strategic Plan for 2011-2014 (October, 2010 [draft]). As the deterioration continues, there is a simultaneous expansion in the complexity of the knowledge base and practice environment. Proven evidence-based practices; new medications; electronic records; case or care management coordination and the need to link and engage individuals, families, and communities in care; de-institutionalization with new models and less structure; recovery linkages and supports...the list is virtually never-ending. Even our understanding of certain illnesses is radically changing. For example, addictions are increasingly accepted as being more chronic than acute in nature, more often needing continuing care. We now know that trauma trumps all else if we are to abate the growing suicide problem in America, not to mention what we are learning about the role of trauma in criminal justice populations and the increased awareness of the impact of extended deployments on military members and their families, in many cases complicated by new understandings of the previously undetected effects of head injury.

A corollary to the scientific and practice changes is the impact of changing reimbursement strategies. New payment methodologies are being studied that can support attaining and maintaining recovery and wellness and not just address sustaining treatment of the pathology. Prevention is now a respected first priority in the clinical continuum with solid science and hard-earned community support.

Who, pray tell, can do all this but competent, skilled professional workers—peer through professional—whatever their discipline or practice concentration?

In its draft strategic plan for 2011-2014, SAMHSA writes that workforce development is important enough to be "cross-cutting" and embedded in all other priorities. Attaining this stature can be viewed as a long-awaited victory for advocates or as an unspoken surrender to the size of the problem with no suggestion for what we, as a nation, can really do about it in an organized way. Too big to address openly or tackle head-on? Perhaps.

Remember that GDP? While politicians, editorialists, and, candidly, most of us, clamor about the need for jobs in the country, we too often ignore a universe of potential workers who could be knocking at the door seeking careers and ways that they can help. There are many, many capable individuals in our country who may lack educational credentials, but have earned knowledge and skills in the course of life experience, especially in their own recoveries from substance use and/or mental illness. They have traversed paths that others can learn to follow. Or they are confronted with a changing world of work and could be enlisted to bring other skills

to the services and supports that are so desperately needed by many with behavioral health problems. Beyond these new kinds of workers, the enhanced workforce and the jobs potentially created to address new demands, we continue to need more workers in all of the traditional behavioral health disciplines to address illnesses and offer an opportunity for measured recovery or wellness (World Health Organization Quality Of Life, 1998; White, 2008). It would amount to a tragic misstep if we fund acute models of care over and over again while neglecting person-centered care (IOM 2001, 2006) and individual responsibility in that care to attain and sustain wellness. Sometimes a set of solutions cannot be seen because they are too big or maybe too scary.

By honestly, earnestly chipping away at the task of developing a competent workforce for all levels or services for behavioral health and general medical care, we can achieve breakthroughs. In recent years we have learned a lot. We have more sophisticated, sharper and stronger tools and technology to bring to the daunting task of breaking through to our goal: a competent, motivated, skilled, and engaged workforce that can deliver efficient, state of the art care.

In testimony on the October draft of SAMHSA's strategic plan, the Annapolis Coalition (AC) revisited the seven goals that emerged from the AC national planning process as first steps to address workforce development. We think they're as relevant today as they were three years ago:

1. Significantly expand the role of individuals in recovery and their families, when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others; and educate the workforce.
2. Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness.
3. Implement systematic recruitment and retention strategies at the federal, state, and local levels.
4. Increase the relevance, effectiveness, and accessibility of training and education.
5. Actively foster leadership development among all segments of the workforce.
6. Enhance the infrastructure available to support and coordinate workforce development efforts.
7. Implement a national research and evaluation agenda on behavioral health workforce development.

In September, the National Council for Community Behavioral Healthcare won a \$26.2 million cooperative agreement from the US Department of Health and Human Service to establish the first National Training and Technical Assistance Center for Primary and Behavioral Healthcare Integration. Workforce development is one of six core areas of focus. This center can create new tools that we can use in this work.

We must focus on all areas where individuals with behavioral health needs may appear or in any setting in which we can impact the prevention of illnesses and the promotion of wellness. And yes, we must recall our conundrum and the advice that this work may take decades to achieve as we work step-by-step to achieve it. Dramatic change, while exciting, is exceedingly rare and less likely to be sustainable. More often what is needed is steady, hard work on the part of many committed individuals and leaders, planning and working together at the common goal of having our best technology—competent workers—at all levels. We remain grateful to ACMHA for its role in both recognizing the challenge of workforce and for taking the first critical steps against this challenging but critical national dilemma.

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