48
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Staffing Behavioral Health Systems

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Given the increasing demand for cost-effective behavioral health services in the managed care environment, the allocation of human resources within systems of care is one of the most critical issues confronting system designers. Although the preponderance of behavioral health service costs is for personnel, few data are available about what blend of human resources delivering what types of services to which subpopulations of patients results in the best outcomes. Absent these data, systems of care are governed by historic networks of providers, a fledgling effort at the development of clinical guidelines for care, and prevailing market forces. In this chapter I outline considerations for behavioral health systems design related to the appropriate composition, competencies, training, credentialing, and management of our industry's most important asset—human resources. As with previous chapters, an emphasis is placed on the type of work force required to work in managed care environments.

Many forces contribute to the dynamic landscape of human resource management in behavioral health settings. Traditionally, the knowledge base and scientific advances within the mental health field have driven treatment. These advances can have large and unpredictable effects on staffing needs. For example, advances in psychopharmacology and the understanding of brain-based disorders have vastly changed the practice of psychiatry over the past several decades. The wide variety of medication options, with increasing efficacy, has altered the nature of the doctor-patient relationship toward the identification of diagnosable syndromes constituting "purer" disorders with increasingly specific treatments. As such, medication regimens have gained in simplicity and acceptability to a point at which the largest prescribers of psychotropic medications are not behavioral specialists but primary care physicians. While evidence mounts as to the risks and benefits of mental healthcare being provided by these practitioners (Shore 1996; Sturm and Wells 1995; Wells et al. 1994), no one disputes its impact on the site of care for most mental disorders and the attendant shift in medical work force needs. Psychiatry is now commonly considered a tertiary care specialty, and in many systems its providers play a consultative role to primary care systems. In addition, referrals to specialty mental health services are often made via primary care gatekeeping models.

The emphasis on outcomes has pushed the development of briefer and at times more intensive models of care to achieve similar or better outcomes at lower costs. One has only to look at the evolution of briefer cognitive psychotherapy models and the reduction of

insurance-financed insight-oriented psychotherapies to appreciate the shifting training and staffing issues within mental health systems. Short-term, goal-oriented treatment has become the standard; most patients receive a course of treatment in a small number of sessions. Assuming no change in the incidence and prevalence of mental disorders, briefer and more effective treatments should require fewer clinicians.

Instead of the state of science and technology predominantly determining the nature of treatment, our society is now focused on rising healthcare expenditures and is increasingly willing to accept limitations on its application. The era of unlimited resources for both research and clinical services is over, and the management of care is focused on obtaining the biggest bang for the buck. This resource rationing coincides with broad acceptance of the principle of least restrictive alternatives to shape the site, and staffing patterns, of mental health practice. Therefore, the locus of care has increasingly moved from high-cost medical inpatient settings to relatively low-cost community-based systems of care. This has shifted mental health personnel from more medically trained physicians and nurses to community providers with a broad array of biological, psychological, and social skills. Although the policy of deinstitutionalization was borne out of primarily humanitarian concerns for providing care to those with severe mental illnesses in the least restrictive settings, it also served the economic agendas of most states, whose taxpayers poorly accepted burgeoning budgets. One can see the downsizing of the state hospital census, from a high of 585,000 patients in the 1960s to the current level of less than 100,000, juxtaposed with the rapid growth of psychosocial rehabilitation programs over that same period. Since the 1980s, psychosocial rehabilitation services have grown dramatically. Conservative estimates of the psychosocial rehabilitation work force are now 100,000 staff persons working in more than 7,000 agencies (Department of Health and Human Services 1996). Now, as efforts to contain costs mount, and capitation financing strategies grow, the role of psychosocial rehabilitation and ultimately funding support is forcing close monitoring of utilization and outcomes that may shift resources away from these services.

Work Force Assessment

To determine appropriate staffing, a clear articulation of the mission of each provider or service sector is required. The organizational values will have a large effect on the allocation of personnel resources. If training is an important part of the mission, then the need for seasoned personnel with professional backgrounds and supervision experience will be important. If generating knowledge is a central part of the mission, then research backgrounds and the capacity to capture research dollars will be emphasized. Increasingly, the central mission of many agencies, particularly those associated with managed care organizations (MCOs) is to provide effective mental healthcare in the least costly fashion. Market forces create incentives for managers to employ the least costly staff members to deliver any care that the managers have credentialed them for and that the staff members are competent to do. As such, psychiatrists can be seen narrowly as the workers licensed to prescribe medication; the impact of this perception is to reserve physician time for medication evaluations. This role constriction has implications for the recruitment and retention of physician staff. For psychological treatments, including psychotherapy, agencies principally concerned with cost will direct care to lower cost nonphysicians.

With the transformation of healthcare purchasers from patients to benefits managers, the assessment of work force composition has changed dramatically (Table 11–1). In the past, the patient's assessment of his or her mental health needs, and of the provider competencies required to meet those needs, determined the type, length, and, in turn, cost of care. The patients' beliefs, informed or not, that a particular type of provider (often a specialist) was necessary for care was the basis for choosing a provider, making appointments, and ensuring that the bill was paid. Now care managers are assessing need, interpreting medical necessity criteria, monitoring the quality of care, and authorizing continued services. Program administrators must address many questions in determining the appropriate composition of their mental health work force: What services are to be provided, and how will administrators manage the behavioral health benefit? Who will be served, and how will these patients be identified? How will full-time equivalents be defined, and what will the direct care expectancies be? What are consumers' expectations about the professional backgrounds of their providers? What geographic access does any given patient need to the range of mental health professionals in the community?

Hospitals (psychiatric or general), clinics (within mental health settings or outside them), or academic

TABLE 11–1. Factors to consider in work force assessment

What population is targeted for care? How will the population be identified?
What staff competencies are legally required?
What staff competencies are expected by patients/consumers?
What resources are available for personnel?
What geographic access is required?
Is training central to the agency mission?
Is knowledge generation central to the agency mission?

settings will all have different requirements based both on their missions and on standards set by accrediting agencies. Typically, an MCO contracts with a provider network of clinicians, institutions, group practices, and agencies. In return for being included in the network, the provider agrees to practice within the company guidelines. The provider will be responsible for collecting any co-payments from the patient and will be paid by the MCO on either a capitated or a fee-for-service basis. Providers may receive subcapitation contracts from the MCO and go at-risk for the care provided. In the latter arrangement, the providers control the staffing pattern, but they assume the same cost incentives that govern the MCO.

Few data exist to inform decisions about staffing composition and staffing levels. Standardization and generalization of workloads are impossible because of the number of variables affecting patient need (e.g., patient age, level of disability, interpersonal and case management support). These variables similarly affect assumptions regarding the percentage of direct clinical care or average length of stay. This knowledge gap must be addressed by services research.

Work Force Composition

The growing emphasis on coordinated, multidisciplinary treatment delivery has been associated with improved access and quality of mental healthcare. Depending on the patients' needs, following adequate triage activities, nonphysician mental health practitioners work solely or in collaboration with psychiatrists. The value of diverse clinical and theoretical perspectives has been cited as an important feature in delivering care to persons with complex disorders and multiple problems. A secondary effect of multidisciplinary service settings has been the continued blurring of mental health professional boundaries. To outsiders, it is often difficult to understand where medical treatment ends and nonmedical services begin. The nature of these role relationships has a large influence on required staffing patterns. Increasingly, the supervisory relationship defines mental health roles (Benarroche and Astrachan 1983). In this model, one professional has clinical responsibility (both legally and ethically) for another professional's or a nonprofessional's work. State regulations or professional organizations may specify the type and intensity of supervision required for licensure. The supervisory model extends the expertise of professional staff to most patients through the work of mental health workers who have less experience or training. Although professionals have historically valued the educational aspects of supervision, they have raised concerns regarding the liability imparted by these administrative relationships. Federal financing agencies are concerned about the quality of supervision, particularly as it relates to the oversight of psychiatric resident education. Recent Medicare guidelines from the Health Care Financing Administration have sought to delineate the nature of clinical supervision with an insistence on direct observation of trainee services. This policy clarification has a significant impact on the staffing patterns within academic settings.

The Mental Health Work Force: Titles and Roles

Professional Staff

The range of human resources available to provide elements of mental healthcare is broad, and providers' skill sets frequently overlap. Core mental health disciplines include psychiatry, psychology, social work, and psychiatric nursing (Table 11–2). In addition, practitioners of occupational therapy, counseling, and marriage and family therapy provide significant amounts of mental health treatment, psychosocial rehabilitation, and school psychology. Not all of these disciplines are recognized in all states, and licensing and credentialing may not be standardized. Nonetheless, the appropriate ratio of these disciplines in mental health settings is the subject of intense debate.

The role of psychiatrists in mental health systems can be either narrowly defined to reduce direct personnel costs or expanded in recognition of their being the

TABLE 11–2. Roles and responsibilities of professional staff

Staff	Roles and responsibilities
Psychiatrists	Diagnostic evaluation Medication management Psychotherapy Clinical supervision
Psychologists	Diagnostic evaluation Psychotherapy Clinical supervision
Social workers	Psychotherapy Accessing entitlements and income supports Care management Environmental interventions
Psychiatric nurses	Diagnostic evaluation Medication administration Psychotherapy
Professional counselors	Guidance and consulting Psychotherapy Crisis intervention Functional assessment

only mental health professionals grounded in biology and psychology with a medical tradition focused on epidemiology, etiology, and differential diagnosis. With more than 29,000 clinically active psychiatrists (Department of Health and Human Services 1996), the United States has the lowest psychiatrist-patient ratio and the highest absolute number of psychiatrists in the world (Weissman 1994). Depending on one's perspective, there are either too many or too few psychiatrists for the country's mental health needs. Psychologists are involved in every type of mental health setting, and the number of licensed psychologists has risen from 20,000 in 1975 to almost 70,000 in 1995 (Department of Health and Human Services 1996). Their roles encompass all aspects of clinical care, and recent demonstrations have explored their capacity to prescribe psychotropic medication (Cullen and Newman 1997). The issue of prescribing privileges for psychologists is likely to bring together the professional psychological associations with MCOs, where the role expansion and cost-cutting agendas are well aligned.

Nursing generalists and advanced practice psychiatric nurses provide a wide range of mental health services. About 35 states have granted nurse practitioners either complementary authority (requiring physician supervision) or substitute authority (not requiring physician supervision) for prescribing medication. Research is needed to determine the effect of these regulatory approaches on clinical outcomes. Again, MCOs are keenly interested in prescribing roles for nurses.

Social workers have been major providers of mental health services for over a century. Their training emphasizes the blending of individual and environmental interventions. Private group practice and outpatient clinic work are the fastest growing settings for an estimated 180,000 clinically trained social workers in the United States (Department of Health and Human Services 1996). As a group, social workers bring a breadth of skills at a cost typically below other mental health professionals. As such, they are increasingly sought after within behavioral health systems.

Nonprofessional Staff

Increasingly, consumers are being used as staff members in multidisciplinary settings to engage difficult-to-reach patients who have severe mental illnesses. The value of firsthand experience with mental disorders and treatment systems may give an individual the capacity for empathy and improve the development of therapeutic alliances with difficult-to-engage patient populations. The few reported studies suggest that the presence of consumers affords important opportunities yet creates significant challenges related to boundaries and stressors leading to decompensation (Dixon et al. 1994; Mowbray et al. 1996). Self-help groups and consumer-run drop-in centers, while not typically counted in staffing plans, have been cited by some behavioral health organizations as providers of significant adjunctive care. A question arises as to the effectiveness of these nonprofessional services replacing more treatment-oriented programs.

Case management services range from brokered models with primarily a linkage function to integrated treatment teams providing treatment, rehabilitation, and social services. Often nonprofessionally trained case managers provide a critical component of care for patients with severe mental illnesses. These staff members may or may not have bachelor's degrees and spend large portions of their work day in direct clinical contact. They are often the most underpaid and overworked staff members in community mental health systems. Of paramount importance are adequate oversight and supervision of their encounters.

The increased emphasis on utilization review and quality management has created the need for a new

cadre of behavioral health staff with primarily nonclinical responsibilities. The need for management information systems capable of generating reports and documentation for multiple applications has increased a reliance on information specialists to help the clinical enterprise. Increasing demands for documentation and review have also shifted staff resources from clinical to administrative activity. This remains a hidden cost of quality management operations and presumably is offset by the cost savings realized from the elimination of so-called unnecessary services. Table 11–3 summarizes the roles and responsibilities of nonprofessional staff.

TABLE 11–3. Roles and responsibilities of nonprofessional staff

Staff	Roles and responsibilities
Case managers (bachelor's prepared or less)	Engagement of patient Linkage to essential services and supports Monitoring of social and health status
Consumer employees	Engagement of patients/consumers Liaison to professional staff Counseling on community integration
Management information specialists	Data collection and analysis Documentation and billing Technology support

Specialists Versus Generalists

The tenets of primary care and the need to reduce health expenditures have challenged the healthcare professions to provide gatekeeping and screening functions inherent in managed care approaches. Thus, the generalist brings a breadth and flexibility that are welcome in most settings. Also, the compartmentalization of behavioral disorders has been seen as a mismatch with the complex problems that patients typically bring when seeking care from mental health professionals. Indeed, calls are surfacing for the integration of health services to provide comprehensive, holistic, and effective service. We can see a clear example of this in responding to the needs of persons with comorbid mental and addictive disorders. Epidemiologic data (Kessler et al. 1996) have shown that the prevalence of dual diagnoses is high and that in some settings the modal patient is likely to have dual disorders. Staff members whom we have trained exclusively within the mental health system with few skills in working with addictive disorders often feel uncomfortable and may be ill prepared to effectively address both disorders in an integrated manner. Cross-trained individuals with broad skills enhance both the clinical outcomes and the system efficiency.

Licensing, Credentialing, and Provider Profiling

The Institute of Medicine defines quality of care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Institute of Medicine 1990, p. 21). Yet, how is one to know which blend of staffing will work in which setting? With which population? To achieve what outcomes? Licensing and credentialing of practitioners can be only one dimension of staffing a mental health system, and even in this dimension, a correlation may not exist between desirable outcomes and an individual's training. Nonetheless, licensure of practitioners plays a critical role in consumer protection.

MCOs typically have a system for credentialing professionals as providers. This system generally starts with professional licensing and may include a variety of inclusion criteria (e.g., certification) and exclusion criteria (e.g., history of malpractice litigation). With varying emphases, MCOs may also have a mechanism in which training, licensing, and quality of care are validated.

Missing from this process is an assessment of whether the licensing and credentialing on which staffing decisions are made reflect best practices from the perspective of system planners. Although the methods and emphases in delivering mental healthcare have changed dramatically, the licensing and credentialing criteria have not. Small and isolated efforts have been made to expose trainees to managed care practices and principles, but professional associations and schools have not developed focused agendas in these areas, and state licensing boards tend to follow the lead of these associations.

With the absence of defined practice standards in managed care, an internal system for rating providers has evolved, based on practice patterns and outcomes. Increasingly, attention is being focused on the use of provider profiles in determining the cost and effective-

ness of care. Elements of these profiles include the number of visits by provider per episode of treatment, the cost of care by provider per episode of treatment, client satisfaction data, and client outcomes data. These data can be used as corrective feedback to providers within the network and to influence referral patterns. They can also be used to select a network of providers with a demonstrated capacity to manage utilization successfully. This method of provider profiling is often not shared externally and may have a significant impact on referral to providers and the composition of the provider network. Providers who are the subject of frequent consumer complaints or who practice outside of the MCO guidelines may be subject to adverse referral patterns.

Staff Competencies: Training and Retraining

In traditional independent practice, clinicians were free to design interventions with little outside clinical review. The emphasis was frequently on patient insight, and the responsibility for payment was typically the patient's concern. This frequently resulted in long-term open-ended therapies; as such, training was geared toward this approach. With the arrival of managed care, requirements for goal-specific, well-documented interventions have become the norm, and medical necessity criteria govern the length of care. A third party, the managed behavioral healthcare organization, now brokers the decision to begin or end care—previously the province of the clinician and the patient—with an incentive for reducing expenditures. This fundamental shift has brought with it a new list of competencies and skill sets for today's practitioners. They must be familiar with management information systems and quality management criteria and procedures and must have the capacity to juggle quality and cost-of-care issues. Table 11–4 highlights staff competencies relevant to changing behavioral healthcare delivery systems.

TABLE 11–4. Types of staff competencies required in managed care systems

Clinical
Cultural
Economic
Ethical

Clinical Competencies

Much has been written about the clinical competencies required of the mental health work force in the twenty-first century. Increasing emphasis will be placed on the development of problem-oriented, goal-directed treatment; the use of group and alternative low-cost treatments; knowledge of appropriate community alternatives to higher cost inpatient and residential care; and the principles of quality management. Authorization procedures will limit time for extensive evaluations, and treatment plans will likely be less precise. Clinicians will need to be aware of and practice cost-effective treatments supported by services research data.

Cultural Competencies

Racial and ethnic minorities frequently lack access to behavioral healthcare, let alone care that is culturally appropriate. One of the more difficult staffing issues in the development of networks of providers is preservation of the capacity to serve these minority populations. To create smaller and more efficiently staffed organizations, the retention of a culturally diverse staff is critical. Often the excuse for not having a culturally diverse staff is that research has not proven the effectiveness of these culturally defined interventions. This lack of data should not weaken attention to this critical staffing dimension (Institute of Medicine 1997). Related to the issue of cultural diversity is an organization's capacity to serve persons with disabilities such as deafness or blindness. Bringing in the personnel and skill sets necessary to serve these special populations can be labor intensive but is no less important in ensuring access to appropriate care.

Economic Competencies

For managed care principles to be implemented effectively, the organization's staff must be aware of and share the organization's values. The value that all services provided are necessary and medically appropriate is central to the mission and performance of MCOs. It is equally important that the staff share the value that the goal of care is to increase the patient's independence and to reduce reliance on treatment settings and providers. For persons with severe and persistent mental illnesses, this goal becomes the achievement of the highest functional capacity with the lowest utilization of mental health services. These philosophic values are the cornerstones of economic performance and must be embraced by the network of providers in a sharing

of the business and clinical objectives of the system of care. Providers must have the capacity to view simultaneously their contributions to both the patients seeking their care and the system they represent.

Ethical Competencies

In staffing a behavioral health system, the clinical and economic incentives must be aligned in a way that does not create clinician discomfort nor violate ethical standards of health care. In past fee-for-service financing arrangements, concerns were primarily related to the overprovision of services and the attendant costs. In today's managed care environments, particularly those using capitated financing, the danger is the underprovision of services as a way of staying within budget or increasing one's profit margin. There should be no prohibition of or contractual limitations on practitioners' discussing clinically appropriate treatment with their patients and families. It is important that staff be aware of strategies for maintaining confidentiality while meeting the needs of practitioners to coordinate care and move patients between levels of care.

It is for these reasons that attention to medical ethics is critical. To help staff negotiate these ethical dilemmas, McFarland et al. (1997) offered two general strategies: 1) the development of clear guidelines to guide service utilization throughout the service continuum, including level-of-care criteria and practice standards, and 2) the training of staff in required utilization management skills in level-of-care determinations, treatment planning, and relating to utilization reviewers.

Conclusion

In these times of accelerated changes within behavioral health services delivery systems, organizational staffing is the most important consideration. The type of personnel employed will determine success in both attaining organizational objectives and remaining cost effective. Achieving a balance between the economic and clinical goals of a system is critical. Since available data to guide personnel decisions are lacking, a clear and pressing need for research exists.

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