NORTH CAROLINA COMMISSION
FOR MENTAL HEALTH,
DEVELOPMENTAL DISABILITIES
AND SUBSTANCE ABUSE SERVICES

and the

NORTH CAROLINA DIVISION OF
MENTAL HEALTH, DEVELOPMENTAL DISABILITIES
AND SUBSTANCE ABUSE SERVICES

THE Workforce Development INITIATIVE

April 15, 2008

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

Pender McElroy, Chairman

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

Michael Moseley, Director

Co-Chairs, Workforce Development Initiative

Marvin Swartz, Chair, the NC Commission for MH/DD/SAS Advisory Committee
Steven Hairston, Chief, Operations Support Section, Division of MH/DD/SAS

Subcommittees of the Workforce Development Initiative

Governance Subcommittee

Advisory Committee Co-Chair: Tom Ryba
Division Co-Chair: Michelle Edelen
Advisory Committee Members: Robin Huffman, John Tote, Martha Macon, Laura Coker, Ann Forbes
Division Staff: Monica T. Jones

Data and Information Subcommittee

Advisory Committee Co-Chair: Clayton Cone
Division Co-Chair: Rebecca Carina
Advisory Committee Members: Carl Shantzis, Laura Coker
Division Staff: Jacqui Harrison, Michael Schwartz

Professional and Direct Support Staff Development Subcommittee

Advisory Committee Co-Chair: Marvin Swartz
Division Co-Chair: Steven Hairston
Advisory Committee Members: Judy Lewis, Karen Stallings
Division Staff: Leesa Galloway, Sheila Bazemore, Markita Keaton

Participants in this subcommittee also included representatives from
The North Carolina Council on Developmental Disabilities: Holly Riddle, Executive Director, Larry Swabe, Jason Laws

Regulatory Subcommittee

Advisory Committee Co-Chair: Dave Richard
Division Co-Chair: Denise Baker
Advisory Committee Members: Emily Moore, Bob Hedrick, Dorothy Crawford, Chris Egan
Division Staff: Marta Hester

Executive Summary

In state fiscal year 2007, the North Carolina Commission for Mental Health, Developmental Disabilities and Substance Abuse Services (the Commission) and the state Division of Mental Health, Developmental Disabilities and Substance Abuse Services (the Division) undertook a joint initiative to assess growing concerns about the workforce situation in North Carolina and make recommendations for action.

Concerns about the workforce had arisen as a result of national trends, the ongoing transformation of the North Carolina public mental health, developmental disabilities and substance abuse services system and the resulting increase in demands for services in communities and changes made in state-operated facilities.

The Commission and the Division formed four subcommittees as defined below to clarify the purpose of the initiative and to examine the current status of the workforce serving the consumers of public mental health, developmental disabilities and substance abuse services.[1] The Commission and the Division invited the North Carolina Council on Developmental Disabilities (the DD Council) to participate in the Professional and Direct Support Staff Development Subcommittee. Consultants from the Annapolis Coalition, the Research and Training Center on Community Living of the University of Minnesota, and the Paraprofessional Healthcare Institute provided national perspectives to the effort.

Subcommittee	**Activities**
Governance Subcommittee	Defined the purpose, mission and vision of the workforce development initiative.
Data and Information Subcommittee	Researched labor market information, current and projected population and demands for services.
Professional and Direct Support Staff Development Subcommittee	Identified workforce development partners, held focus groups with stakeholders and identified strategies for recruitment, retention and training.
Ad Hoc Subcommittee on Regulatory Matters	Reviewed the effects of current statutes, rules and policies and recommended needed changes.

Definitions and Language

For purposes of this initiative, the term "workforce" includes individuals in training or currently employed to manage or provide health promotion, prevention, and treatment services and supports for persons with mental health conditions, or substance abuse or substance abuse

[1] Membership of the subcommittees is shown inside the front cover.

disorders, or developmental disabilities, or co-occurring disorders. Individuals in the workforce may have graduate training, associate's or bachelor's degrees, high school diplomas or less formal education. In addition, consumers of services and their family members are recognized as having critical roles in caring for themselves and each other, whether informally or more formally through organized peer- and family-support services.

The credentials and qualifications that apply to staff of the system are defined in North Carolina Administrative Code.[2] These include associate professionals, certified substance abuse professionals, directors, licensed professionals, nurses, paraprofessionals, psychiatrists, psychologists, qualified client record managers, qualified professionals and qualified substance abuse prevention professionals. The code allows for the establishment of a competency-based employment system for qualified professionals, associate professionals and paraprofessionals.

The term "community services and supports" refers to all services provided in the community for any of the populations served. "State-operated services" refer to the services provided in the facilities operated by the Division including psychiatric hospitals, alcohol and drug abuse treatment centers, developmental centers, residential programs for children, and neuro-medical treatment centers.

"Clinical services" mean active direct treatment and habilitation, such as counseling, medication management, diagnostic assessment and detoxification. They are primarily provided in an office or clinical setting, including state-operated facilities, by qualified professionals or associate professionals.

"Direct support services" are typically provided in the homes of families and in the community. These services enable consumers, whether adults or children, to live in community settings and to participate within the environment of their family's culture. The workforce of direct support service roles predominantly consists of bachelor's level employees and individuals with high school diplomas or GED diplomas, otherwise identified as paraprofessionals.

The term "direct support workers" has traditionally referred to the workforce providing services and supports for persons with developmental disabilities. Currently, direct support workers play a vital role in the lives of people with developmental disabilities, mental health needs, substance abuse challenges and their families, as well as the aging population. They assist people with a wide range of activities such as help with maintaining a home, finding work, transportation, making important decisions, taking medications, learning new skills, personal care, and connecting with other people and activities.[3]

Direct support services are also compatible with the system of care approach used in the field of children's mental health. The combination of direct support services with traditional clinical services have been found to be the most successful for children with challenging needs as evidenced by Multi-Systemic Therapy, an evidence-based practice, or Intensive In-Home service. Clinicians provide consistent and frequent supervision to ensure that direct support workers are prepared to meet the challenges that are inherent in their jobs from understanding

[2] See appendix D of this document for a copy of this statute 10A NCAC 27G .0104.
[3] See Hewitt, A., et al., Direct Support Professional Work Group Report, October 2007.

basic theories of behavior, to possessing strong listening and communication skills, and other skills as well as support for practical aspects of the job such as scheduling and coverage.

While other health and human service providers, such as primary care providers, emergency room staff, and others have major roles in responding to the needs of consumers of public mental health/developmental disabilities/substance abuse services, those segments of the workforce are not addressed in this initiative.

General findings

National studies indicate that a workforce crisis is occurring across the nation in healthcare and human services. As stated by the Annapolis Coalition on the Behavioral Health Workforce:

> "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. … There is substantial and alarming evidence that the current workforce lacks adequate support to function effectively and is largely unable to deliver care of proven effectiveness in partnership with the people who need services."[4]

These findings are further supported by a recent report of the North Carolina Institute of Medicine that states: "The state is likely to face a severe shortage of physicians, nurse practitioners, physician assistants and certified nurse midwives over the next 20 years".[5] The North Carolina Institute of Medicine identified four primary challenges:

1. Growth in provider supply will not keep pace with the growth in North Carolina's healthcare needs.
2. Many areas of the state are currently experiencing provider shortages.
3. There is a significant mal-distribution among certain specialties across the state.
4. The existing workforce does not reflect the state's diverse population.

To identify the workforce issues currently facing stakeholders of North Carolina's public mental health, developmental disabilities and substance abuse services system, the subcommittees collected available data from professional boards and various state agencies including the North Carolina Employment Security Commission.

Population Growth: Trends in North Carolina's population indicate both the probable future demands for services as well as the probable availability of workers. By 2014, the projected population in North Carolina will be between 9.5 and 10 million people, up from 8.5 million in 2005. The United States Census Bureau has projected that North Carolina will become the

[4] Annapolis Coalition on the Behavioral Health Workforce, An Action Plan for Behavioral Health Workforce Development, A Framework for Discussion, Executive Summary, 2007, pp. 1-2.
[5] North Carolina Institute of Medicine, *Providers in Demand: North Carolina's Primary Care and Specialty Supply*, June 2007, p. 13.

seventh most populous state by 2030, with over 12.2 million residents. Growth is projected in the number of retirees and in both the Asian and Latino populations.

Economic and Workforce Trends: In 2006, the number of people over 16 years of age in the North Carolina labor force was approximately 4,520,961. Fifty-nine counties in North Carolina had unemployment rates at or below 5 percent in 2006.[6] However, counties that traditionally have emphasized manufacturing and agriculture have experienced higher rates of unemployment due to loss of jobs as industries closed or relocated. Often, problems with substance abuse and depression affect dislocated workers.

A clear assessment of the current public MH/DD/SAS workforce for comparison of local needs with currently available staff and their skills was not possible due to the lack of readily available or easily accessible data.[7] Through focus groups with providers, consumers and LMEs, significant problems were identified, such as a high rate of turnover among staff that provides the majority of direct care and support for MH/DD/SAS consumers, and inconsistent or lack of adequate supervision. As the population grows, the need for a competency-based, well-trained, stable MH/DD/SAS workforce also grows.

Prevalence of MH/DD/SA Consumers: North Carolina has designed its public system to serve those persons who have the highest need for ongoing care and limited access to privately-funded services. Increasing delivery of services to these persons is a nationally accepted measure of system performance. This is measured by comparing the prevalence (percent of the population estimated to have a particular condition in a given year) to the treated prevalence (percent of the population in need who actually receive services for that condition within a year).

Consumers of community-based federal or state funded services SFY 2007[8]

Services	Persons served	Treated prevalence
Adult mental health	128,883	38%
Child mental health	82,363	41%
Adult developmental disabilities	17,879	36%
Child developmental disabilities	9,977	19%
Adult substance abuse	40,588	7%
Child substance abuse	3,152	6%

Other specific concerns affecting programs of the public MH/DD/SAS system include increases in the number of children diagnosed with autism; the number individuals with traumatic brain injury resulting in significant cognitive, behavioral and communicative disabilities and long-term medical complications; the number of veterans with post traumatic stress syndrome, suicides, substance abuse problems, and other responses to the war in Iraq; and in the number of veterans' family members with mental health and substance abuse problems.

[6] Employment Security Commission of NC, October 2006.
[7] Even the attempt to identify this workforce through the Employment Security Commission database was unsuccessful, because providers use various job classifications that do not match the job titles used by LMEs, the Office of State Personnel, or the Employment Security Commission.
[8] DMHDDSAS. Community Systems Progress Indicators. December 3, 2007.

Additionally, the Commission and the Division took action to obtain the perspectives of individuals with disabilities and their families, providers, human resource managers, educators, direct support workers and supervisors through focus groups and listening sessions. The Division partnered with the Behavioral Health Care Resources Program (BHRP) in the School of Social Work of the University of North Carolina at Chapel Hill to administer surveys and conduct focus groups across North Carolina.[9] The DD Council contracted with the Research and Training Center on Community Living, University of Minnesota to hold listening sessions regarding the challenges individuals with disabilities and their families face and ideas about solutions.[10]

Key issues emerged as needing immediate attention:

- There are an inadequate number of supervisors within the system and a strong need for improvement in the quality of both management and clinical supervisory skills.
- There is need for review, clarification, and/or revision of current mental health, developmental disabilities and substance abuse services rules, especially regarding competency-based staff qualifications.
- There are both a shortage of and a mal-distribution of psychiatric and other professional and direct support staff across the state.
    - The differences in urban versus rural areas are significant.
    - There is a high rate of competition for available professionals.
    - There are chronic vacancy rates among nurses, pharmacists, physical therapists, occupational therapists, recreational therapists, healthcare technicians, substance abuse counselors, and mental retardation habilitation coordinators at state operated facilities.
- There is a high rate of turnover among staff that provides the majority of direct care and support for consumers and there is difficulty in filling staff vacancies. Precipitating problems appear to be the effect of part time work, an inadequate living wage, poor or absent supervision, lack of benefits, unreliable schedules, no career ladder and lack of adequate training.
- There is insufficient data about the current public mental health, developmental disabilities and substance abuse services workforce that is needed for adequate planning and monitoring.

Long-term issues include:

- Along with projections of a growing and aging population, and thus increased demands for services, there is a corresponding projection that the number of providers and the workforce are not growing at an adequate rate.
- An aging and growing population with longer life expectancies is driving the projections of 700,000 new jobs in North Carolina by 2014 with a majority in healthcare support; healthcare practitioners and technicians; and education, training and library leading to competition for a workforce that is not growing at the same rate as the population to be served.[11]

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[9] See appendix F for a report by the Behavioral Health Care Resources Program.
[10] See Hewitt, A., et al., Direct Support Professional Work Group Report, October 2007.
[11] See the Employment Security Commission of North Carolina News Release dated February 26, 2007 at http://www.ncesc.com

In summary, the Commission and the Division found that North Carolina's public mental health, developmental disabilities and substance abuse services workforce does face significant challenges consistent with the deepening national health and human services workforce crisis.

Conclusions and Recommendations

Clearly, a decision point is at hand and now is the time to take action while these issues are receiving national, state and local attention. Recognizing this is a large and complex issue, the Commission and the Division are in agreement with the North Carolina Institute of Medicine and many other professional and trade associations in North Carolina that prompt action is needed to build a workforce that is adequate in both numbers and quality to meet the needs of the populations we serve.

Building a viable, adequate and quality workforce requires (1) a collaborative effort among state agencies, universities, community colleges, other educational institutions, professional organizations, LMEs, providers, consumers and their families, and their advocates; and (2) effective methods to operate and carry out strategies to retain, recruit and train people who make up the workforce in community-based services and supports and in state-operated facilities. As stated by the Annapolis Coalition in its Executive Summary:

> "If the behavioral health field is to address the workforce crisis seriously, a number of key elements will be required: a clear vision; a practical blueprint; a structure for implementation; methods for monitoring progress; collaboration across the various sectors in the field and careful attention to the levers of change." (page 24)

Therefore, the Commission and the Division identified 12 recommendations as shown in table 1. Each recommendation is discussed in detail in the final chapter of this report.

The Commission and the Division recognize that implementation of these recommendations requires additional funding. Funding is needed for:

- Support of the workforce development initiative.
- Marketing and raising public awareness and promotion of the careers.
- Educational institutions in securing relevant clinical and management curricula using a variety of training media.
- Ongoing training for management, clinical and direct support staffs.
- Collecting and analyzing data for monitoring the needs for a current and future workforce in communities and in state operated facilities.
- A variety of recruitment and retention strategies such as loan repayment programs and state-wide benefits for workers.

Table 1. Recommendations for the Development of North Carolina's Mental Health, Developmental Disabilities and Substance Abuse Workforce

STRUCTURES TO SUPPORT THE WORKFORCE
***Recommendation 1**: Develop a detailed plan of action for implementation of these recommendations under the oversight and involvement of the Commission and the Division.*
***Recommendation 2**: Create a consistent means to identify data and other information about the status of the North Carolina public mental health, developmental disabilities and substance abuse services workforce as a quality improvement function and report annually to policy makers.*
***Recommendation 3**: Employ within the Division a Workforce Development Specialist who has expertise in the assessment of workforce issues and development of solutions and who will serve as the project manager for carrying out the plan of action for implementing the recommendations identified in this report and other workforce initiatives of the Division.*
BROADENING THE CONCEPT OF WORKFORCE
***Recommendation 4**: Create new service options for consumer directed services for all individuals with disabilities and, as appropriate, for their families.*
***Recommendation 5:** Create a workforce marketing and public awareness campaign for all types of staff positions in the public mental health, developmental disabilities and substance abuse services system.*
STRENGTHENING THE WORKFORCE
***Recommendation 6**: 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 7**: Create selection tools to assist providers in reducing early turnover of workers.*
***Recommendation 8**: Improve access to psychiatric, other medical and non-medical care for individuals served by the public mental health, developmental disabilities and substance abuse service system.*
***Recommendation 9**: Create coordinated competency-based curricula and certification plans for professional and direct support workers.*
***Recommendation 10**: Provide systematic training, technical assistance and incentives to all providers statewide on effective recruitment, retention and training practices.*
***Recommendation 11**: Foster, encourage and support system wide training to frontline supervisors and managers on effective supervision.*
***Recommendation 12**: In order to create positive work environments, provide opportunities to empower professional and direct support workers serving consumers of publicly funded mental health, developmental disabilities and substance abuse services.*