COMMONWEALTH OF VIRGINIA COMMISSION ON MENTAL HEALTH LAW REFORM

REPORT OF THE

WORKFORCE DEVELOPMENT COMMITTEE OF THE TASK FORCE ON ACCESS TO SERVICES

MARCH 2010

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PREFACE

The Commonwealth of Virginia Commission on Mental Health Law Reform ("Commission") was appointed by the Chief Justice of the Supreme Court of Virginia, the Honorable Leroy Rountree Hassell, Sr., in October 2006. Commission members include officials from all three branches of state government as well as representatives of many private stakeholder groups. The Commission was directed by the Chief Justice to conduct a comprehensive examination of Virginia's mental health laws and services and to study ways to use the law more effectively to serve the needs and protect the rights of people with mental illness, while respecting the interests of their families and communities. Goals of reform include reducing the need for commitment by improving access to mental health services, avoiding the criminalization of people with mental illness, making the process of involuntary treatment more fair and effective, enabling consumers of mental health services to have greater choice regarding the services they receive, and helping young people with mental health problems and their families before these problems spiral out of control.

During the first phase of its work, the Commission was assisted by five Task Forces charged, respectively, with addressing gaps in access to services, involuntary civil commitment, empowerment and self-determination, special needs of children and adolescents, and intersections between the mental health and criminal justice systems. In addition, the Commission established a Working Group on Health Privacy and the Commitment Process ("Working Group"). Based on its research and the reports of its Task Forces and Working Groups, the Commission issued its *Preliminary Report and Recommendations of the Commonwealth of Virginia Commission on Mental Health Law Reform* ("Preliminary Report") in December, 2007.

After the General Assembly enacted a major overhaul of the commitment process in 2008, the Commission moved into the second phase of its work. Three new Task Forces were established – one on Implementation of the 2008 Reforms, another on Future Commitment Reforms and one on Advance Directives. In addition, the Commission created a separate Working Group on Transportation. Each of these Task Forces and Working Groups presented reports to the Commission, together with recommendations for the Commission's consideration. In December, 2008, the Commission issued a Progress Report reviewing its work in 2008, providing a status report on the progress of mental health law reform, and recommending a second package of legislative actions. During 2009, the Commission focused on implementation and refinement of the reforms adopted during 2008 and 2009 and on several key issues that had been deferred, including the length of the emergency hospitalization period (the "TDO" period) and the possible expansion of mandatory outpatient treatment. The Commission also continued to study ways of enhancing access to services in an integrated services system. It issued another Progress Report in December, 2009, together with a third package of reforms. Reports of the

Commission and its various Task Forces are all available at
http://www.courts.state.va.us/programs/cmh/home.html

From the outset of its work, the Commission has investigated ways to create and sustain the capacity of the services system to provide the safety net of behavioral health and disability services to which the Commonwealth has consistently committed itself. During the past year, under the leadership of then-Inspector General Jim Stewart, a committee of the Task Force on Access to Services has focused specifically on the workforce that will be needed to accomplish this objective. In the accompanying report, the committee has provided a comprehensive and detailed analysis of the currently available workforce, the factors affecting the supply of, and demand for, properly qualified and trained professionals, and the steps that will be required to develop and sustain the leadership and professional capacity needed for an adequate services system during the 21st century.

The accompanying Report represents the views of the members of the Workforce Development Committee. The Committee's recommendations have been reviewed and endorsed by the Commission on Mental Health Law Reform. However, the Report should not be construed as reflecting the opinions or positions of the, the Chief Justice, the individual Justices of the Supreme Court of Virginia, or of the Executive Secretary of the Supreme Court. Any recommendations or proposals embraced by the Court itself will lie exclusively within the judicial sphere.

Richard J. Bonnie, Chair
Commission on Mental Health Law Reform
March 2010

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Supreme Court Commission on Mental Health Law Reform

Report of the
Workforce Development Committee
of the Task Force on Access to Services

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COMMITTEE REPORT

CHAPTER 1. Introduction and Summary of Recommendations

A. Background

Critical to ensuring the soundness of the safety net in Virginia for persons with mental illness, developmental disabilities, and substance abuse issues is having a workforce that is both well trained and accessible in all regions of the Commonwealth ("Safety Net Workforce").[1] What do we mean by the Safety Net Workforce? In this Report we are focused on those individuals and organizations that provide services to individuals with serious mental illness (or children with or at risk of serious emotional disturbance), developmental disabilities and substance abuse issues in community based settings, in hospital emergency rooms, in private hospitals, or in state mental facilities. These individuals include entry-level intake workers at community services boards ("CSBs"),[2] psychiatrists, supervisory personnel, hospital workers and others. And, broadly, this workforce included both those employed in public and private sectors. This Safety Net Workforce must be able not only to interact with the individual in need of services but is often required to coordinate care and services with law enforcement, the courts, and a range of public and private providers. What is required to do this effectively is a good substantive understanding of the health and services needed by these populations but, also, how services are organized and financed in Virginia, how civil commitment law bears on a person who may be in a mental health crises, what ancillary support services might be available including employment support and housing.

Development of the workforce is one of the most critical factors needed to improve access to services in the Virginia mental health, intellectual disability, and substance abuse services system. By "development" we mean putting into place the necessary elements to promote the education and training of persons who want to go into mental health as a career path, developing the training, tools, and oversight to enable them to perform their jobs well, implementing systems to encourage them to develop in their jobs to positions of greater responsibility, and incentives to retain them in their positions.

Given the range of settings in the public and private sectors where behavioral health services are provided as part of the Safety Net, it is challenging to precisely estimate the size of the workforce. However, note the following general indicators of its size:

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[1] The Safety Net Workforce includes individuals with a wide range of responsibilities and educational backgrounds such as psychiatrists, nurses, and social workers. Also included are Emergency Services Counselors, who perform mental status assessments, short term crisis intervention services, makes referrals or coordinates admissions to treatment services, generally require persons with masters degrees; Case Workers, Service Representatives, etc.

[2] Together, the 39 CSBs and one BHA will be referred to as CSBs in this Report.

- Mental Health Facilities. As of June 30, 2008, there were 8,613 employees in the 16 facilities[3] operated by the Department of Behavioral Health & Developmental Services ("DBHDS"). Of this total, 5,854 (68%) provided direct service to those served by the facilities.

- CSBs. The FY08-09 Performance Contract between DBHDS and CSBs reported 11,809 full-time equivalent employees in the 40 CSBs across the state. Of this number, 8,871 employees (75%) provided direct services to individuals and families.

- Total Public Providers. In total, the public providers (state facilities and CSBs) employed over 20,000 individuals.

- Private Providers. In addition, there are currently 512 licensed private providers operating from over 3,000 locations.[4] Information captured by the DBHDS Office of Licensing regarding the private agencies and organizations that are licensed does not include the total number of employees, so a total employee count for the private sector is not available.

For some years now advocates, families and recipients of services have identified the need for greater consistency in services across the Commonwealth. Reviews of CSB and state facility services by the Office of the Inspector General have repeatedly identified the need for greater emphasis on training/development of the existing workforce and improved consistency in practices across the state.[5] Recruitment and retention of qualified staff is consistently identified as a problem for both community and facility services. Rural areas particularly struggle to employ and retain qualified staff.

A better utilization of peer support would also improve access to mental health services. Peer support personnel are direct services employees who have been or are recipients of behavioral health services themselves. There is considerable research that shows they

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[3] Virginia operates 16 facilities: seven behavioral health facilities, five training centers, a psychiatric facility for children and adolescents, a medical center, a psychiatric geriatric hospital and a center for behavioral rehabilitation.

[4] The DBHDS Office of Licensing licenses services pursuant to §37.2-404. DBHDS licenses services providing treatment, training, support and habilitation: to individuals who have mental illness, intellectual disabilities or substance abuse disorders; to individuals receiving services under the Individual and Family Developmental Disabilities Support Waiver; or to individuals receiving services in residential facilities for individuals with brain injuries. Two distinct licenses are available through this office: Children's Residential Services, or All Other Services–Except Children's Residential Services.

[5] See, e.g., *Follow-Up Review Of Mental Health Facilities Operated By Department Of Mental Health, Mental Retardation And Substance Abuse Services*, May – June 2006, Office of The Inspector General For Mental Health, Mental Retardation & Substance Abuse Services, OIG Report #131–06. Available at: http://www.oig.virginia.gov/SystemicReviewsofMentalHealthFacilities.htm. See, also: *Follow-Up Review of Active Findings In The State Operated Mental Health Facilities,* March 31, 2009, Office of the Inspector General for Mental Health, Mental Retardation & Substance Abuse Services, OIG Report #168-08. Available at: http://www.oig.virginia.gov/documents/Syst-Rev-2009FollowupMH-168-08.pdf.

are effective in promoting recovery among individuals with serious mental illness. Although there has been significant progress in creating peer support positions in local CSBs over recent years, peer support personnel continue to be underutilized. On June 30, 2008, the State mental health facilities employed 10 peer support staff (10 out of 8613 total employees or 0.1%). CSBs employed 70.5 peer support (70.5 out of 11,809 is little better, only 0.6%) personnel. Unfortunately, many providers still do not include peer support personnel in their workforce complement. As a result, some programs now in place to train peer support personnel are unable to find positions for their graduates.

The Access to Services Task Force established the Workforce Development Committee to examine ways in which development of the Safety Net Workforce could facilitate greater access to more effective services. Through an initial phase of planning and organizational work, the Workforce Development Committee made a series of observations regarding the current state of the workforce and workforce development in Virginia; identified trends and developments that must be considered in planning for the development of the workforce; and established principles to guide its work. These observations and goals are provided below:

B. Current State of the Workforce and Workforce Development in Virginia

In its review of the current state of the Safety Net Workforce and systems in place to promote workforce development in Virginia, the Workforce Development Committee found, generally, that Virginia's Safety Net Workforce is understaffed, undertrained, and under-resourced. More specifically, the Workforce Development Committee found the following:

- There is significant inconsistency in the skill level among Safety Net providers across the Commonwealth is common.

- Those who have the most contact with Safety Net consumers not only have the least formal education to begin with but, also, receive the least training as part of their employment.

- Non-credentialed workers often lack needed skills to deal with the level of complexities that they face in their work with consumers.

- Linkages to psychiatric and medical personnel are limited. Emergency services workers, by definition, often must address the most acute mental health needs of those they serve but they frequently lack adequate access to consultation from psychiatric and medical personnel.

- Training and professional development opportunities for staff at all direct service levels are inadequate.

- Turnover is high, particularly among entry-level workers. Because of low pay and high caseloads, many entry-level workers move on to other settings after their

initial training after a relatively short period of employment. This high turnover is disruptive and highly inefficient.

- Non-credentialed, direct support staff too often provide more care than they do support to those they serve, resulting in missed opportunities for development and growth on the part of the consumer.

- Promotions of employees into administrative and clinical supervisory positions are often without adequate training to promote the development of essential supervisory skills.

- There are only limited opportunities for career advancement and pay increases in the public mental health sector.

- There is no formal system for developing case managers whose role in the system of care has become more critical, as the emphasis on supporting most individuals in the community vs. the facility has increased.

- Core competencies for direct service positions are not adequately defined.

- Training and development of staff is often the first thing eliminated when budgets are tight.

- New program and service initiatives often fail to dedicate adequate resources to the development of staff skills and changes in organizational culture needed to successfully implement the expected change.

- There are significant inconsistencies in workforce capacity across the state and no guidelines for baseline staffing requirements.

- Most training initiatives in the Commonwealth can best be described as "spray and pray." They consist of one time training events with no follow-up and no accountability related to the implementation of change.

- While DBHDS has articulated a statewide vision and goal for recovery, self-determination and person centered services, only very limited resources and development opportunities have been made available to successfully retool the workforce to actualize this vision. Many staff in the current workforce do not understand recovery and believe that recovery is not possible for those with mental health disorders and addictions.

- There is inadequate training or development opportunities to promote the integration of mental health services and supports. In many practice settings service programs and professional disciplines do not operate in a fashion that assures maximum integration for the benefit of the consumer.

- There is no entity or body within the Commonwealth or at regional levels that takes primary responsibility for establishing a vision for the development of the mental health, intellectual disability and substance abuse workforce and provides leadership in establishing the plans and developing the resources to realize this vision.

C. Trends and Developments Affecting the Safety Net Workforce That Must Be Considered

The Workforce Development Committee identified the following trends and developments nationally and in Virginia that must be considered in planning for development of the workforce:

- Those who seek publicly supported services present with increasingly more complex issues, often with co-occurring disabilities and medical fragility.

- The trend away from the provision of services in large institutions and isolated residential settings in favor of community-based care continues.

- In 2006, DBHDS adopted the following goals in its Integrated Strategic Plan[6] to guide the service delivery system:

  - *Fully implement self-determination, empowerment, recovery, resilience, and person-centered core values at all levels of the system through policy and practices that reflect the unique circumstances of each population group.*
  - *Incorporate the principles of inclusion, participation, and partnerships into daily operations at all levels.*
  - *Expand services and supports options needed to support individual and family choice, community integration, and independent living.*

- There is increased competition for workers, particularly at the direct service level.

- A significant portion of the current Virginia behavioral health workforce, particularly in more senior service delivery, managerial and executive level positions, is expected to retire over the next five to ten years. Many of these more experienced individuals have left the workforce in the past three to five years. The result of the aging workforce will be loss of significant knowledge, experience and perspective on the Virginia system of behavioral health services.

- Peer support is growing in credibility and acceptance but is underutilized in Virginia.

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[6] Department of Mental Health, Mental Retardation and Substance Abuse Services, *Envision the Possibilities: An Integrated Strategic Plan for Virginia's Mental Health, Mental Retardation and Substance Abuse Services*, January 2006. Available at: http://www.dmhmrsas.virginia.gov/documents/reports/OPD-IntegratedStrategicPlan.pdf.

Over the past decade and a half, practice-oriented research has enabled the identification of a number of evidence-based practices. Many of these practices are currently in use by one or more providers in Virginia; however, they are not uniformly available and information about these practices is not readily available across the state.

- Advances in technology have, and will continue to provide, the opportunity to deliver services in new ways that increase effectiveness and efficiency.

- The proportion of the service population that is over 62 years of age will increase dramatically over the next two decades posing challenges for the Safety Net Workforce.

- The number of veterans and their families in need of services is increasing rapidly. These individuals have unique needs for which much of the current behavioral health provider workforce has not received training.

- It is broadly recognized that early intervention with children and adolescents can prevent more complex and longer-term mental health and substance abuse problems. Virginia's system of services for children, adolescents and their families is quite limited and varies tremendously across the state.[7]

- Family and consumer expectations for involvement in decision-making related to their treatment continue to increase.

- Funding sources have become more complex, requiring stricter compliance to both administrative and practice requirements in order to assure reimbursement. Funders now generally require providers to measure the outcome of their treatment interventions, requiring expertise in program assessment, a skill set not historically part of what providers have had to have.

- A tightening economy brings with it the necessity for difficult decision making about the size of the workforce, funding for training and skill development, and other factors that directly affect the delivery of services.

D. Guiding Principles for Workforce Development

The Workforce Development Committee developed the following Guiding Principles for crafting its Recommendations to improve Virginia's Safety Net Workforce:

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[7] See, e.g., *An Integrated Policy and Plan to Provide and Improve Access to Mental Health, Mental Retardation Services for Children, Adolescents and Their Families*, July 1. 2008-June 30. 2009, Department of Behavioral Health and Developmental Services, Report Document No. 160; *Review of Community Services Board Child and Adolescent Services*, 2009, Office of the Inspector General, September 19, 2008, Report # 149-08.

- The workforce must be capable of responding to the constantly changing profile of those who seek services.
- The workforce must be culturally and linguistically competent.
- The workforce must be guided by the principles of self-determination and recovery.
- There must be consistency in workforce capability throughout the Commonwealth and sufficient workforce capacity to meet demand for services.
- The workforce must be provided with opportunities for continual improvement in professional growth.
- Training and development initiatives must be innovative, creative and include the measurement of outcomes to assure effectiveness and identify areas where improvements are needed.
- Initiatives to improve and/or expand services must incorporate appropriate workforce development.
- Organizational leadership at all levels must take responsibility for assuring adequate and effective workforce development efforts and an organizational culture that supports its workers.
- The workforce must be staffed and developed in such a way that scarce professional resources can be used flexibly and be adapted to meet the demand for services. The workforce must be cross-trained in appropriate and related skills.
- The workforce must be capable of delivering services using evidence based (proven to be effective) practices and state of the art technologies. Implementation of these practices and technologies must take into consideration the experience and preferences of those who are served.
- Workforce development efforts must build on current knowledge and experience and include systems for succession management.

Recognizing that the Workforce Development Committee would have to limit the number of issues that could be effectively explored in a reasonable timeframe, it established four focus areas and Subcommittees for each. Each Subcommittee is listed below along with the name of the individual who chaired the subcommittee:

- Subcommittee on Leadership and Supervisory Development – chaired by Kathy Drumwright, Virginia Beach CSB
- Subcommittee on Peer Support Workforce Development – chaired initially by Mary McQuown, Recovery Innovations of Virginia, and then by Becky Sterling, Middle Peninsula-Northern Neck CSB
- Subcommittee on Case Management Training/Certification – chaired by Linda Berardi, Norfolk CSB
- Subcommittee on Recruitment and Retention – chaired by India Sue Ridout, Department of Behavioral Health & Developmental Services

The Workforce Development Committee was chaired by Jim Stewart, Inspector General for Behavioral Health & Developmental Services.

Each Subcommittee conducted extensive research on workforce issues within Virginia and nationally to assure an in-depth understanding of current workforce development practices related to the topical areas that were addressed and inform their Recommendations. This extensive background information on the work of each Subcommittee to support their Recommendations can be found in their reports incorporated and endorsed as part of the Workforce Development Committee's Report to the Commission in Chapters 2 through 5.[8] Chapter 1 provides background to the issue of workforce development as well as brief summaries of the Subcommittee Recommendations discussed more fully in the rest of this Report.

It is the hope of the Workforce Development Committee that its Recommendations and plans that evolve from this work apply to both the public and private provider workforces in order that all who receive mental health, intellectual disability and substance abuse services in Virginia benefit from these efforts.

D. Summary of Recommendations

1. Leadership and Supervision Workforce Development Recommendations

A transition in leadership among Safety Net providers is taking place that could have profound and negative consequences for the Safety Net Workforce and the consumers they serve. Senior leaders in mid-level management and executive positions are leaving their positions in unprecedented numbers and this loss in experienced personnel is expected to continue into the foreseeable future. Unfortunately, the majority of those who move into clinical and administrative supervisory positions for the first time have received no training in supervision and leadership. Furthermore, this workforce transition is occurring at a time when the behavioral health and intellectual disability service system is more complex than ever. For example, complicated and burdensome technical requirements are associated with most of the various funding streams that support the service system. DBHDS and the federal government now expect greater accountability with measurement of performance and the achievement of positive outcomes. Such performance and outcomes measures require specialized training. In addition, those consumers who are served through the Safety Net present more complex conditions than at any point in the past.

There is also a growing effort to provide services for those with even acute mental health and co-occurring conditions to be served in the community instead of in hospitals, requiring the integration of services and collaboration among behavioral health, schools, law enforcement, health, social services and other human service delivery systems in local communities and throughout the various regions of the state. . And finally, all of these stressors on the Safety Net Workforce leadership are taking place in an environment in which resources to support services are tighter than at any point in the recent past. The expectations of those who lead our public and private behavioral health and intellectual disability provider agencies are greater than ever. Unfortunately, in

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[8] These Subcommittee Reports can be found in Chapters 2 through 5 of this Report.

Virginia the needed workforce development initiatives have not been in place to prepare more junior employees to move successfully into supervisory, middle management and executive positions in the behavioral health and intellectual disability service system.

Recommendation 1. Leadership & Supervisory Training. A program of training and development for supervisors, managers and senior executives in Virginia's behavioral health and intellectual disability services system should be established to enhance the knowledge, skills, abilities and effectiveness of those in these roles, so that the systems of care and services provided to the citizens of the Commonwealth are effective, efficient and of high quality.

Based on a comprehensive review of leadership and supervisory development programs and best practices around the country and within the state of Virginia, the Workforce Development Committee recommends that the proposed program of training and development include the following initiatives and components:

- **Core Competencies**. Development of an agreed upon set of core competencies for executive leadership and supervisory development in the fields of behavioral health and intellectual disabilities, being certain to incorporate principles of recovery, self determination and person-centered planning.
- **Leadership Academy**. Establishment of a leadership academy for executive leadership, middle managers and both administrative and clinical supervisors that focuses specifically on the development of the core competencies as they are applied to behavioral health and intellectual disabilities.
- **Action Learning Model**. Implementation of an action learning model that includes training, coaching and follow-up to assure implementation. Development of a preceptorship model for new leaders and/or a mentoring component should be a part of the program.
- **Statewide, Regional, and Local Training Programs**. Delivery of training and programs on a statewide basis and a regional/local basis, providing opportunities for the leaders and supervisors of public and private organizations that work together within a community or region to learn and grow together.
- **Document Clearinghouse**. Development of a clearinghouse of documents, e-learning training courses and other materials specifically relevant to leadership and supervision, research and evaluation and workforce development in behavioral health care and intellectual disabilities.

To facilitate the implementation of this recommendation, DBHDS in collaboration with the Virginia Association of Community Service Boards ("VACSB") should establish a Steering Committee to take the following actions:

- Determine what organizational arrangement will be most appropriate for housing the program – a non-profit corporation, an existing association that represents the interests of behavioral health and intellectual disabilities, an agency of government, etc.

- Determine what type of governance, overseeing board, etc. will be needed and appropriate
- Establish an initial vision and mission for the initiative
- Develop a two to three year budget for the initiative
- Propose funding options that maximize the development of partnerships that will enable the leveraging of resources (for example, corporate or foundation funding of a pilot program, SAMHSA, Robert Wood Johnson, Kennedy Foundation, VHCA, private provider community, state funding, a schedule of fees)
- Secure funding
- Identify and develop the managing Board
- Develop a process to report progress to interested stakeholders

The membership of the Steering Committee should include the Secretary of Health and Human Resources/designee, Commissioner for DBHDS, Inspector General for BHDS, three Community Services Board representatives (two Operating CSB and one Policy/Admin CSB), two state facility representatives (one hospital and one training center), three individuals who have received services, two representatives of private providers, and one representative of Supreme Court Commission on Mental Health Law Reform.

2. Peer Support Workforce Development and Utilization Recommendations

Providing services and supports to individuals with mental illness by persons who have also experienced these conditions and received services (peers) offers a unique and effective method of delivering treatment and rehabilitation. The use of peer support personnel in Virginia's public mental health system began in the mid-to-late 1990's but the growth of this service over the past decade, while steady, has been very slow. With support from public funding, training programs for peer support personnel have been established. However, the limited availability of jobs into which graduates can be hired has prevented the system of care from benefiting fully from the use of peer support personnel. Failure on the part of providers to fully understand the importance of peer support, limited funding to expand services, a decrease in support for the training of peers, and "barrier crime" limitations[9] on employment in state/federal laws have all contributed to the very slow growth of peer support employment in the Commonwealth.

Recommendation 2. Establishment of a Peer Support Workforce Development Commission. DBHDS should establish a Peer Support Workforce Development

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[9] Barrier crime laws prohibit persons convicted of certain statutorily- defined crimes from obtaining employment with certain employers, mostly those employers specializing in the care of vulnerable populations, such as children, the elderly, and those with mental disabilities. Currently, Virginia has barrier crime laws pertaining to such social service and health care employers as: child welfare agencies; foster and adoptive homes; licensed nursing homes; hospital pharmacy employees; home care organizations; licensed hospice; DBHDS employees at state facilities and those that handle state funds; DBHDS employees in direct consumer care positions; Community Service Boards (CSBs); Behavioral Health Authorities (BHAs); child day centers; family day homes; assisted living facilities; and adult day centers. See: http://legis.state.va.us/jchc/9.14.06Barrier.pdf, which is a report prepared by Jaime H. Hoyle, Senior Staff Attorney for the Joint Commission on Health Care.

Commission ("Peer Support Commission") composed of experienced peer support personnel and provider agency representatives. Peer and provider participants should represent both community-based and state facility settings. The purpose of the Peer Support Commission will be to accomplish the following:

- **Core Competencies**. Define the core competencies needed for peer support personnel who work in public and private organizations that provide mental health services.
- **Ethical Guidelines**. Develop ethical guidelines to assist providers and peer support personnel in dealing with the complexities of peer support employees working in the same organization from which they receive mental health, intellectual disability and substance abuse services.
- **Model Career Path**. Develop a model career path program for peer support personnel that can be implemented by provider organizations. This initiative should include the development of model job descriptions and explore avenues for experienced peer support personnel to move into a wider range of employment opportunities over time.
- **Data Initiative**. Define the data and other information that is needed on a statewide basis to validate the effectiveness (outcome and cost) of emerging peer support practices in the delivery of mental health, intellectual disability and substance abuse services. This initiative should include a determination of how an outcome evaluation system can be supported and operated on an ongoing basis.
- **Peer Certification Program**. Explore the value and potential benefits of establishing a certification program for peer support workers. If it is determined that such a program is in the best interest of service recipients, the peer support workforce, and provider organizations, the Commission should define the criteria that must be met by peer support workers to receive certification.
- **Peer Training and Support**. Establish a plan to assure that adequate peer support training and development resources will be available in the Commonwealth in the future. This initiative should include:
  - Development of plans for the provision of comprehensive training for peer support specialists on a statewide and regional basis.
  - Ongoing consultation to community-based and state facility providers and consumers in the transformation of the mental health system to one that embraces a culture of recovery, promotes wellness management, peer support and supported employment.
  - Expansion of training efforts for peers to develop the knowledge and skills needed to facilitate Wellness Recovery Action Plans ("WRAP"). This training is currently being provided through a partnership between DBHDS and VOCAL's Virginia REACH program.

Recommendation 3. Foster an Organizational Culture for Recovery. All public and private entities that provide mental health services should take steps to establish an organizational culture in which the principles of recovery are central to the mission and primary values of the organization, the value of peer support is understood, peer support

personnel are routinely employed in treatment and rehabilitation services, and needed structures to support peer employees are maintained.

Recommendation 4. Establish a Peer Support Website. DBHDS should support the establishment of a Statewide Peer Support Website to provide an avenue for the provision of electronic peer support services; to make information about recovery and peer support practices widely available to recipients of services, peer providers and provider organizations; and to assist those seeking jobs as peer supporters in finding employment.

Recommendation 5. Collaboration to Provide Benefits. DBHDS, Department of Rehabilitative Services ("DRS"), public and private providers should work closely with the Department of Social Services ("DSS"), the Social Security Administration, housing agencies and all other agencies that provide benefits to individuals with mental illness to reduce the complexity of tapered benefit services as a person regains the ability to sustain employment and independence.

Recommendation 6. Change Medicaid Provider Requirements. Virginia's Department of Medical Assistance Services ("DMAS") should take the following actions related to Medicaid:

- Change the requirements for paraprofessionals to allow life experience as a qualification or add peer support provider as a reimbursable provider
- Request funding in the state budget process to add paraprofessionals and peer support providers as allowed providers for Mental Health Crisis Intervention and Mental Health Crisis Stabilization
- Disseminate information to provider organizations that clarifies which Medicaid services allow reimbursement for peer support providers

Recommendation 7. Reduce Barriers to Employment. The following actions should be taken related to the impact of barrier crimes statutes on the employability of persons with mental illness and substance abuse disorders:

a. The General Assembly should amend § 37.2-416 (Code of Virginia) to reduce the amount of time that applicants who have been convicted of barrier crimes listed in § 37.2-314 and excluding those listed in § 37.2-506 C are required to have been free of parole or probation prior to being considered for employment in a mental health or substance abuse service operated by a provider licensed by the Department of Behavioral Health and Developmental Services that is not a community services board or a behavioral health authority:

> D. The hiring provider and a screening contractor designated by the Department shall screen applicants who meet the criteria set forth in subsection C to assess whether the applicants have been rehabilitated successfully and are not a risk to consumers based on their criminal history backgrounds and substance abuse or mental illness histories. To be eligible for such screening, the applicant shall have completed all prison or

jail terms, shall not be under probation or parole supervision, shall have no pending charges in any locality, shall have paid all fines, restitution, and court costs for any prior convictions, and shall have been free of parole or probation for at least ~~five~~ three years for all convictions. In addition to any supplementary information the provider or screening contractor may require or the applicant may wish to present, the applicant shall provide to the screening contractor a statement from his most recent probation or parole officer, if any, outlining his period of supervision and a copy of any pre-sentencing or post-sentencing report in connection with the felony conviction. The cost of this screening shall be paid by the applicant, unless the licensed provider decides to pay the cost.

b. The General Assembly should amend § 37.2-416 (Code of Virginia) to reduce the amount of time that must have lapsed after the applicant has been convicted of not more than one misdemeanor offense under § 18.2-57 or 18.2-57.2 from 10 to five years before the applicant can be considered for employment in a mental health or substance abuse service for adults operated by a private provider licensed by the Department of Behavioral Health and Developmental Services that is not a community services board or a behavioral health authority:

> E. Notwithstanding the provisions of subsection B, a provider may hire for compensated employment persons who have been convicted of not more than one misdemeanor offense under § 18.2-57 or 18.2-57.2, if ~~10~~ five years have elapsed following the conviction, unless the person committed the offense while employed in a direct consumer care position.

c. The General Assembly should amend § 37.2-506 (Code of Virginia) to reduce the amount of time that applicants who have been convicted of barrier crimes listed in § 37.2-314 and excluding those listed in § 37.2-506 C are required to have been free of parole or probation prior to being considered for employment in a mental health or substance abuse service for adults operated directly by a community services board or behavioral health authority:

> D. The community services board and a screening contractor designated by the Department shall screen applicants who meet the criteria set forth in subsection C to assess whether the applicants have been rehabilitated successfully and are not a risk to consumers based on their criminal history backgrounds and substance abuse or mental illness histories. To be eligible for such screening, the applicant shall have completed all prison or jail terms, shall not be under probation or parole supervision, shall have no pending charges in any locality, shall have paid all fines, restitution, and court costs for any prior convictions, and shall have been free of parole or probation for at least ~~five~~ three years for all convictions. In addition to any supplementary information the community services board or screening contractor may require or the applicant may wish to present, the applicant shall provide to the screening contractor a statement from his most recent

probation or parole officer, if any, outlining his period of supervision and a copy of any pre-sentencing or post-sentencing report in connection with the felony conviction. The cost of this screening shall be paid by the applicant, unless the board decides to pay the cost.

d. The General Assembly should amend § 37.2-506.E (Code of Virginia) to reduce the amount of time that must have lapsed after the applicant has been convicted of not more than one misdemeanor offense under § 18.2-57 or 18.2-57.2 from 10 to five years before the applicant can be considered for employment in a mental health or substance abuse service for adults operated by a community services board or behavioral health authority:

> E. Notwithstanding the provisions of subsection B, a community services board may hire for compensated employment persons who have been convicted of not more than one misdemeanor offense under § 18.2-57 or 18.2-57.2, if 10 seven years have elapsed following the conviction, unless the person committed the offense while employed in a direct consumer care position.

e. DBHDS should take the following actions related to the Department's responsibility established in § 37.2-506.C & D and § 37.2-416.C & D (Code of Virginia) to designate screening contractors to screen applicants to determine that the criminal behavior was substantially related to the applicant's substance abuse or mental illness and that the person has been successfully rehabilitated and is not a risk to consumers based on his criminal history background and his substance abuse or mental illness history.

   o Establish criteria for those who are to be engaged as screening contractors that are relevant to both mental illness and substance use.
   o Take steps to increase the number and regional availability of screening contractors.
   o More clearly define the payment structure for screening contractors.
   o Publicize the screening process and contact information for screening contractors in ways that will make this information available to potential applicants and providers.

f. The Peer Support Workforce Development Commission to be established by DBHDS per Recommendation 2 herein should develop a methodology for the collection and analysis of data on recidivism rates of those with mental illness and substance use disorders who have been found guilty of a barrier crime and who have been employed by providers of mental health and substance use providers.

3. Case Management Workforce Development Recommendations

The role of the case manager in the behavioral health and intellectual disability service systems has become significantly more complex and is now central to the achievement of

positive outcomes for consumers who experience more serious psychiatric, developmental and behavioral conditions in Virginia. As the goal of serving the vast majority of individuals in community settings has increasingly been realized, the work of the case manager has become more critical and now requires a broader set of knowledge, skills and abilities. Today the case manager is expected by state regulation to have knowledge of the nature of serious mental illness, intellectual disabilities and/or substance abuse populations; different types of assessments and their uses in service planning; treatment modalities and intervention techniques including behavior management, counseling and crisis intervention; service planning; the use of medications in treatment; not only mental health, intellectual disability and/or substance abuse services, but also support and primary health care services; and all applicable federal, state and local laws, regulations and ordinances. The case manager is expected to work independently.

Further, because more seriously disabled individuals are being served in the community and the use of inpatient services has been drastically decreased, case managers must provide supportive counseling to more seriously disabled individuals, spend more of their time providing crisis intervention, coordinate more complex plans of care, and spend more time monitoring the effectiveness of the entire range services to prevent the need for more intensive and expensive interventions. The case manager is often the sole continuing therapeutic support person for not only the consumer but also the family. In addition, the case manager is expected to be the consumer's consultant and advocate in helping him retain an adequate array of appropriate health, financial and social services.

In spite of the complex demands on case mangers, Virginia has no specialized training for case managers or a system for assuring that case managers have the knowledge and skills needed to be effective. Most case managers who come to the job with formal education at the bachelor and masters degree levels have not had the specialized coursework to prepare them for their role. The primary method of developing case managers is on-the-job coaching by supervisors who may or may not have case management experience. As a result, the level and quality of case management services varies widely from community to community. Because there are no real career supports to assist case managers in their professional development and advancement, it is often not a role that young behavioral health professionals aspire to, turnover is high, and tenure in the job is short. The impact of high turnover rates is that this most important relationship between the consumer and case manager is interrupted too often and continuity of care is disrupted.

Recommendation 8. Training for Case Management. A program of training and development for case managers in Virginia's behavioral health and intellectual disability services system should be established. This program should include the following initiatives:

- Development of an agreed upon set of core competencies for case managers, being certain to incorporate principles of recovery, self-determination and person-

centered planning. The Human Resources Committee of the VACSB has already begun work on this task.
- Establishment of a core curriculum that will provide case managers with the foundational knowledge that is needed to fulfill their role.
- Delivery of training programs on not only a statewide, but also regional/local basis.
- Development of a clearinghouse of documents, e-learning training courses and other materials specifically relevant to the provision of case management for behavioral health care and intellectual disabilities.

DBHDS should establish a Planning Committee composed of representatives of DBHDS, the CSBs, former and current recipients of services, and DMAS to take the following actions:

- Determine what organizational arrangement will be most appropriate for housing the program.
- Establish an initial vision and mission for the initiative.
- Develop a two to three year budget for the initiative.
- Propose funding options and develop a plan to secure funding.
- Develop a process to report progress to interested stakeholders.

Recommendation 9. Certification of Case Managers. The General Assembly should establish a certification requirement for case managers who provide case management services called for in §37.2-500 (Code of Virginia).

> Amend §37.2-500 Purpose; community services board; services to be provided. – Second Paragraph:
>
> > The core of services provided by community services boards within the cities and counties that they serve shall include emergency services and, subject to the availability of funds appropriated for them, case management, provided by employees of the community services board who have completed a certification program approved by the Department.

4. Recruitment and Retention Recommendations

Recruiting and retaining competent health care professionals for the network of Virginia behavioral health and intellectual disability providers is an ongoing challenge. The inability of provider organizations to maintain a full complement of qualified personnel compromises the quality of services delivered and decreases the capacity of the system. The following five critical roles in both public and private organizations continue to be most difficult positions to fill. Turnover is also quite high with these positions.

- Physicians/Psychiatrists,
- Registered Nurses,
- Licensed Clinical Social Workers,

- Case Managers (QMHP & QMRP), and
- Direct Support Professionals

Recommendation 10. Continue and Expand a Physician Loan Repayment Program.
The General Assembly should reinstate and expand the Physician Loan Repayment
Program, which has helped to recruit and retain physicians to rural state facilities as soon
as funding permits. This program was recently eliminated as a result of budget
reductions. This program has been offered through the Bureau of Health Professions
("BHPr"), Division of State, Community and Public Health & the Virginia State Loan
Repayment Program (VA SLRP) a loan repayment program for medically underserved
areas of the state, especially for psychiatrists. The cost of these programs is $25,000 and
$35,000 per year for a maximum of two years per physician. The biennial cost for ten
physicians ranges from $500,000 to $700,000.

Recommendation 11. Establish Psychiatric Fellowships. DBHDS should establish
psychiatric fellowships through a partnership between DBHDS and medical schools
located in Virginia. Each one-year fellowship costs approximately $60,000. The biennial
cost of 10 fellowships is approximately $1.2 million.

Recommendation 12. Expand Direct Support Pathway Program. It is recommended
that the Direct Support Pathway Program be expanded to create a new level of direct
service position, entitled Direct Support Professional, in Virginia for state facilities, CSBs
and private providers. The Direct Support Pathway Program provides for an increase in
compensation for direct support employees who develop additional competencies. The
Direct Support Pathway Program is provided through a collaborative partnership
involving DBHDS, the College of Direct Support and the Virginia Community College
System. The anticipated biennial cost of this program would be approximately $1.5
million dollars.

**Recommendation 13. Loan Repayment Program for Nurses and Clinical Social
Workers.** DBHDS should establish a statewide task force to study the potential value
and cost of creating a Loan Repayment Program for nurses and clinical social workers in
Virginia.

**Recommendation 14. Examine Tax Credit Changes for Nurses and Clinical Social
Workers.** DBHDS should propose changes in the Code of Virginia that would enable
expansion of the Tax Credit Program that currently allows certain tax credits for
physicians who work in rural and underprivileged communities to also be available to
nurses and clinical social workers.

Recommendation 15. Develop a Model On-Boarding Program. DBHDS should
establish a statewide taskforce to develop a model On-Boarding Program that can be
utilized by public and private providers of behavioral health and intellectual disability
provider organizations across the state.

On-boarding is the process of integrating employees into their new work environment. It is the last stage of the recruitment process and the first step toward retention. These programs continue well past the traditional new employee orientation and can last from 3 months to 2 years, depending on the position and the employee.

Recommendation 16. Expand Workforce Development Website. DBHDS should expand its Website on Workforce Development and Innovation ("WDI") to include resources, best practices and compensation toolboxes for critical health care professionals. This will enable the sharing of resources and reduction of duplicative efforts in provider organizations. It will also lead to the implementation of more effective recruitment and retention practices statewide.

CHAPTER 2. Background Report on Leadership and Supervisory Development

A. Introduction and Background

In Virginia, a period of transition has begun in the behavioral healthcare workforce in which experienced leaders in middle and senior management positions are leaving the workforce to move into retirement. Turnover in the more senior positions at state facilities and CSBs is expected to continue into the foreseeable future. As a result, community and facility providers, both public and private, are struggling to capture the institutional knowledge of those leaving while preparing the current workforce to take on these critical leadership roles. A significant portion of the current Virginia workforce in service delivery, managerial and executive level positions is expected to retire over the next 5-10 years. The result of these changes will be the loss of significant knowledge, experience and perspective on the Virginia system of services.

Historically, in Virginia as elsewhere in the country, many of those who have filled first line and clinical supervisory positions have been promoted from within the organization. Most often those who have been promoted or hired into administrative and clinical supervisory positions have not received the benefit of specialized training focused on the knowledge and skills needed to effectively supervise and develop other less experienced employees. Similarly, large numbers of those who have moved into mid-level management positions and senior executive roles have not received specialized managerial and leadership development training.

In recent years, the Commonwealth of Virginia has developed a number of training programs for managers and supervisors. Some of the larger localities have also established supervisor and management development programs. While state employees and those who work at some of the larger, more urban CSBs have the opportunity to participate in these programs, the majority of the CSB workforce and those in the licensed private sector do not. Training and professional development opportunities for administrative supervisors, clinical supervisors, managers and executives in the Virginia behavioral healthcare system are quite limited and most of the training that is available does not focus specifically on the unique challenges associated with the provision of behavioral health and developmental/intellectual disability services.

There is no body or entity within the Commonwealth or at the regional level that takes primary responsibility for establishing a vision, developing plans, or developing resources to assure adequate development of the behavioral healthcare intellectual disability workforce. This has traditionally not been seen as a primary responsibility of DBHDS. Targeted funding for training provided through DBHDS has always been extremely limited and has been focused on specific program initiatives and the skills needed by those who provide direct services. Resources to provide for the development of supervisors, managers and executives have not been available. At the provider level, the allotment of resources for training has always been limited and these funds are normally the first to be eliminated when budgets must be reduced. As a result:

- Skill levels among providers is inconsistent across Virginia
- Training and professional development for staff at all levels is inadequate
- Supervisory employees are often promoted without adequate effort on the part of the employer to develop their supervisory skills, whether administrative or clinical, or both
- Core competencies for leadership and supervisory positions are not adequately defined
- Few supervisors are prepared to provide effective supervision for the peer support employees

Organizational leadership at all levels must take responsibility for assuring adequate and effective workforce development efforts, including systems for succession management. A formal system of leadership training is needed for individuals who transition from direct service to clinical and administrative supervisory positions and for those who take on middle management and senior executive roles. The skills and core competencies needed to be successful in these roles must be defined.

The Subcommittee on Leadership and Supervisory Development conducted extensive research to identify existing workforce development efforts available within Virginia and around the nation. Detailed information about these programs is provided in the following section of this Report.

It is the vision of the Subcommittee on Leadership and Supervisory Development that:

> *Current and future leaders in the Virginia behavioral health and developmental disabilities services system will be well prepared to supervise, manage and lead the employees and organizations that provide these services through the identification of core competencies, the development of training curricula and provision of development programs that enhance the skills needed for executive leadership, clinical and administrative supervision, and the development and supervision of peer workers.*

B. Summary of Research and Data Collection

The Subcommittee on Leadership and Supervisory Development conducted research both within Virginia and across the nation to identify currently available training and development programs for supervisors, managers and senior leaders. A sampling of successful programs that could be adapted to Virginia is described briefly below.

1. Leadership and Supervisory Development Training Models in Virginia

The Subcommittee on Leadership and Supervisory Development identified development programs available through Virginia state government, the University of Virginia Weldon Cooper Center for Public Service, the Federal Office of Personnel Management, and a variety of training opportunities available through local governments or local CSBs.

Managing Virginia Program

The *Managing Virginia Program ("MVP")* is an initiative by the Commonwealth to provide comprehensive, basic management and leadership training to all state supervisors and managers.[10] The program provides a standard curriculum and philosophy that is to be consistent throughout state government. The *MVP*, unlike other programs, is of no direct cost to state agencies and is available to all state supervisors and managers.

The program is intended to give the Commonwealth the ability to establish and maintain a baseline of skills and management practices geared toward the uniqueness of state government. While the current focus of the *MVP* is today's supervisors and managers, it also gives all agencies a valuable workforce planning/succession planning tool, putting in place curriculum for those individuals who will hold these same positions tomorrow.

These courses were designed to provide baseline skills for supervisors and managers to increase retention and productivity of staff, increase exposure to leadership skills, and to promote consistent application of Human Resource policies. While the target audience is Commonwealth of Virginia first-line supervisors and managers, it is open to all state employees.

The MVP core curriculum is structured around these identified areas:

- Technical and Functional Expertise
- Understand the Business
- Achieve Results
- Serve the Customer
- Teamwork
- Interpersonal and Communications Skills
- Leadership and Personal Effectiveness

The MVP was developed by a committee comprised of Human Resources and Training Development personnel from across the state. This committee used several different selection techniques to identify the courses for the program:

- Existing Management and Leadership programs in state agencies
- Current courses being taught and offered to management personnel and
- Solicitation of input from supervisors and managers

MVP courses can be delivered through the Commonwealth's Knowledge Center, a web based training system. Courses can also be taken in an instructor-led format. For each course, there is a pre-test to evaluate the participant's knowledge of the subject matter. These questions are fact-based, but also assess the participant's ability to apply the basic principles of the courses. If a supervisor has taken a similar course in the past and can

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[10] Information available at: http://www.dhrm.virginia.gov/training/mvpoverview.html.

answer the skill assessment questions correctly, he/she will not have to take the MVP course on the particular subject.

Under development now are the selection, development, evaluation, and implementation of Elective Courses in a Web-Based & Instructor-Led format. This format will focus on identifying and providing MVP participants with a quality selection of elective courses, seminars, networking opportunities, and workshops that will aide in continuing their management development.

There are nine basic leadership courses offered through the MVP which include:

Communication Skills
     Course 1: Frankly Speaking
     Course 2: The Art of Listening

Conflict Management
     Course 1: Conflict Management Concepts
     Course 2: Practical Application

Customer Service
     Course 1: Customer Service: Basic Skills
     Course 2: Managing Customer Service

Enhancing Employee Performance
     Course 1: Coaching
     Course 2: Delegating
     Course 3: Introduction to Supervision
     Course 4: Managing the Work Process
     Course 5: Motivating for Improved Performance

Ethical Decision Making

Human Resource Policy & Law

Leadership Styles & Essentials
     Course 1: Influencing Others & Building Trust
     Course 2: Leadership Competencies
     Course 3: Leadership Styles

Self Management
     Course 1: Emotional Intelligence
     Course 2: Stress Management
     Course 3: Time Management

Valuing Differences: Cultural & Generational Diversity

Virginia Certified Public Manager Program

The Virginia Certified Public Manager Program ("VaCPM") is a broad-based management development program, providing public professionals with training to maximize the effectiveness of government organizations. It is offered through the Virginia Department of Human Resources Management. As a part of a national consortium, this certificate program offers practitioner-oriented course work that builds upon management training programs offered through agencies, colleges, and universities. This curriculum uses the foundation of theory and applies it to practical problems facing the participants, their agency/department and the Commonwealth. At the completion of each program level, participants have developed practical applications relevant to advancing the mission and objectives of their organizations. Those who complete the program will earn the national designation of Certified Public Manager.

VaCPM is very rigorous in scope and not considered to be "entry level." This program offers public leaders an opportunity to enhance their leadership capabilities. The 300-hour program consists of sequential levels of instruction in management theory and practice. The coursework is highly interactive and is delivered primarily through classroom training, distance learning, and on-line instruction. Additional program hours include project completion, self-study, and electives.

The VaCPM program is for all state, federal, and local employees who manage or supervise people, projects, and/or programs or aspire to such a position. Participants must have completed their probationary period.

The objectives of this program are the following:

- Assess and practice fundamental management theories, tools, and techniques in an increasingly challenging work environment
- Discover new approaches to leading teams and serving as a model to other leaders
- Receive 360° feedback and other forms of evaluation for individual assessment
- Develop practical applications of up to date management theory and philosophy to assist in meeting the objectives of their organizations

The Core Competencies that have been identified for VaCPM are as follows:

Personal and Organizational Integrity
- Increasing awareness, building skills and modeling behaviors related to identifying potential ethical problems and conflicts of interest; appropriate workplace behavior; and legal and policy compliance. Subset: Ethics and Values.

Managing Work
- Meeting organizational goals through effective planning, prioritizing, organizing and aligning human, financial, material and information resources. Empowering others by delegating clear job expectations; providing meaningful feedback and coaching; creating a motivational environment and measuring performance.

Monitoring workloads and documenting performance. Dealing effectively with performance problems. Subset: resource management, visioning and planning, coaching/mentoring, information management.

Leading People
- Inspiring others to positive action through a clear vision; promotes a diverse workforce. Encouraging and facilitating cooperation, pride, trust, and group identity; fostering commitment and team spirit. Articulating a vision, ideas and facts in a clear and organized way; effectively managing emotions and impulses. Subset: people management, visioning and planning, communication.

Developing Self
- Demonstrating commitment to continuous learning, self-awareness and individual performance planning through feedback, study and analysis.

Systemic Integration
- Approaching planning, decision-making and implementation from an enterprise perspective; understanding internal and external relationships that impact the organization. Subset: organizational awareness.

Public Service Focus
- Delivering superior services to the public and internal and external recipients; including customer/client identification, expectations, needs and developing and implementing paradigms, processes and procedures that stimulate positive spirit and climate; demonstrating agency and personal commitment to quality service. Subset: proactive business management.

Change Leadership
- Acting as a change agent; initiating and supporting change within the organization by implementing strategies to help others adapt to changes in the work environment, including personal reactions to change; emphasizing and fostering creativity and innovation; being proactive. Subset: critical thinking.

Senior Executive Institute and Leading, Educating and Developing – Weldon Cooper Center for Public Services at the University of Virginia IT Infrastructure Partnership

Senior Executive Institute

The Senior Executive Institute ("SEI") offers two weeks of intensive, interactive learning for senior local government managers focused on the leadership world of local government. The curriculum is designed by the faculty of the UVA Weldon Cooper Center for Public Service. Participants explore leadership from both organizational and personal perspectives with an emphasis on the culture and structure of the Council/Manager form of local government. Participants and instructors compare and discuss differences between entrenched bureaucratic structures and organizational

systems based on democratic values and other factors. The aim of the SEI is to send participants back to their communities with the tools to help craft a healthy, flexible government and to be prepared to interact effectively and collaboratively with citizens. In this program participants develop skills and test strategies that are needed to build a high performance government. They also have the opportunity to discover more about their leadership style through team exercises, feedback from peers, and time for introspection. This program challenges participants to grow and learn professionally, personally, and interpersonally.

The curriculum for the SEI includes the following topical areas:

First Week:
- Essence of Public Service
- Emotional Intelligence
- High Performance Government
- Team Development
- Getting Leadership Right in High Performance Government
- Role of Power
- Dialogue on Leadership
- Creativity

Second Week:
- Governing Bodies and Understanding the Political Arena
- Innovation
- Conflict Resolution and Positive Growth
- Manager's Evolving Role
- Linking to the Elected Agenda
- Outdoor Team Experiential Learning

Leading, Educating and Developing

Leadership, Educating and Developing ("LEAD") is a one-week program that is generally attended by middle managers and senior managers and is designed in much the same fashion as SEI. The curriculum for LEAD includes the following topical areas:

- Essence of Public Service
- Emotional Intelligence
- High Performance Government
- Getting Leadership Right in High Performance Government
- Conflict Resolution and Positive Growth
- Linking to the Elected Agenda
- Role of Power

The SEI and LEAD experiences reflect the environment and culture that the programs endorse. The underlying philosophy stresses interactive learning: everyone teaches,

everyone learns. In the team setting, participants integrate the separate segments of the program and address individual concerns and strategies. The critical components of these programs include clear action plans, the experiences of others in the profession, and ongoing advice from seasoned practitioners. A senior local government manager attends both programs, resides with participants, and serves as a valuable resource and advisor. Both programs take place at the University of Virginia.

Federal Office of Personnel Management's Leadership Education and Development Certificate Program

LEAD is a leadership development curriculum designed for current and aspiring government leaders. It is offered by the Federal Executive Institute and the Management Development Centers. The LEAD program is designed to recognize the developmental efforts of government employees by providing official recognition of achievement at a given level of leadership. Each leadership level requires the participant to complete five courses within three years. There are four leadership levels: Project/Team Lead, Supervisor, Manager, and Executive.

Project/Team Lead training is for high-performing career specialists, team leaders and emerging supervisors who have one year or less supervisory experience. Competencies emphasized include:

- Influencing/Negotiating
- Interpersonal Skills
- Oral Communication
- Public Service Motivation
- Team Building

Supervisor training is for supervisors and managers with at least one year of supervisory experience who want a clearer picture of their leadership strengths and areas for development. Competencies emphasized include:

- Human Capital Management
- Accountability
- Decisiveness
- Interpersonal Skills
- Creativity/Innovation
- Influencing/Negotiating
- Accountability
- Political Savvy

Manager training is for supervisors and managers with at least one year of supervisory experience who want a clearer picture of their leadership strengths and areas for development. Competencies emphasized include:

- External Awareness

- Conflict Management
- Problem Solving
- Accountability
- Resilience

Executive training is for experienced managers and executives who want to develop essential leadership skills for upper-level management. Competencies emphasized include:

- External Awareness
- Strategic Thinking
- Political Savvy
- Oral Communication
- Interpersonal Skills
- Leading Change
- Leading People
- Results Driven
- Business Acumen
- Building Coalitions/Communication

Local and CSB Leadership and Supervisory Training Courses

In March 2009, the Subcommittee on Leadership and Supervisory Development submitted a brief survey to the 40 CSBs in Virginia, state facilities, and the Virginia Network of Private Providers asking for the following information ("Virginia Training Survey":

1. Does your locality/facility currently provide training in leadership and/or supervisory development?
2. If yes, list coursework.
3. Is the training geared towards human services/behavioral health/intellectual disabilities?
4. List gaps between what is currently provided and what is needed.
5. Would you participate in regional/statewide training in leadership and supervisory development?

Following is an abbreviated listing of areas in which the respondents to the Virginia Training Survey indicated leadership and supervisory training and development is needed:

- Transitioning from clinical supervisor to administration, clinician to supervisor, peer to supervisor
- Becoming a good clinical supervisor
- Strategic planning related to behavioral health
- Leadership techniques in behavioral health settings

- Conflict resolution
- Understanding behavioral health agency management/how to maintain the business
- Balancing administrative demands and political realities
- Developing skill sets that cross disciplines- MH/SA/ID
- Advanced supervision skills for co-occurring disorders
- Employee relations, budget management- competencies in the behavioral health arena
- Formalized mentoring/coaching to build on competency development
- Working with cross-functional teams
- Transitioning managers of day-to-day operations to contemporary leadership and management theories and practice
- Supervisory and leadership development for high performing front line staff with potential for executive leadership

There were 31 respondents to the Virginia Training Survey, including 17 CSBs. The information provided varied widely in terms of the availability of training and coursework. The common theme across respondents was that nearly all would be interested in either regional or statewide training/coursework related to leadership, management and supervision. There was general consensus that there was a lack of training preparation for clinicians to become supervisors in both administrative and clinical capacities and there was no specific executive leadership training geared to behavioral health. Norfolk, Arlington, Alexandria, Fairfax, Chesterfield, and Virginia Beach CSBs all provide training courses that are relevant to human services. Some of the training available across Virginia includes the following:

- Leadership and Management in Behavioral Healthcare- Norfolk CSB
- Becoming a Supervisor of Choice- Norfolk CSB
- Leadership for Managers- City of Virginia Beach
- Training for Leaders- City of Virginia Beach
- Foundations for New Supervisors- City of Virginia Beach
- Peer Today, Boss Tomorrow- City of Virginia Beach
- Situation Leadership- City of Virginia Beach
- First line Supervisory Training- City of Arlington
- Supervision, Coaching, Dealing with Conflict- Arlington
- Leadership Development and Team Building- Alexandria
- Planning Effective Meetings- Alexandria

It should be noted that the most significant gaps in training identified through the Virginia Training Survey were in the areas of clinical supervision, the transition from clinician to supervisor, and supervision and development of the peer workforce.

2. Leadership and Supervisory Development Training Models for Behavioral Healthcare Outside of Virginia

The need to provide substantive leadership and supervisory experiences for professionals in mental health is well documented both nationally and in Virginia. Fortunately, Virginia need not re-invent the wheel. There are a number of "best practices" from around the country and the world that have been researched and offer promising replication possibilities for use in Virginia. One of the major efforts in workforce development that involved stakeholders from around the country was a report prepared for the Federal Substance Abuse and Mental Health Services Administration ("SAMHSA") by the Annapolis Coalition on the Behavioral Health Workforce. In addition, several states offer a variety of leadership development training and curricula designed for behavioral health.   A sampling of the various training and development programs available outside the Commonwealth is provided below.

The Annapolis Coalition

In 2005, the SAMHSA commissioned the Annapolis Coalition on the Behavioral Health Workforce ("Annapolis Coalition") to develop an action plan to address major concerns about the behavioral health workforce. The result of the multiyear process was the report, *An Action Plan for Behavioral Health Workforce - A Framework for Discussion* ("Action Plan").[11]   The Action Plan encompasses workforce issues pertaining to recovery, mental illness, substance use, co-occurring disorders throughout the life span. The Annapolis Coalition developed a strategic plan for stakeholders to use or revise in their own areas to address workforce development. Over 5,000 individuals participated in the planning process from across the country, making up expert panels and workgroups on consumer populations from children to adults, financing, cultural competency, information technology, etc. The general findings of the Annapolis Coalition were summarized through the development of seven strategic goals:

1. Expand the role of individuals in recovery
2. Expand the role and capacity of communities to effectively identify their needs
3. Implement systematic recruitment and retention strategies at the federal, state, and local level
4. Increase relevance, effectiveness, and accessibility of training and education
5. Actively foster leadership development among all segments of the workforce
6. Enhance infrastructure available to support and coordinate workforce development efforts
7. Implement national research and evaluation agenda on behavioral health workforce development.

For the purpose of the Subcommittee on Leadership and Supervisory Development, Goal 5 above was explored in further detail. There is recognition that "most leaders in the behavioral health field are part of the 'graying' workforce" and many will be lost to retirement in the coming years. To address this looming leadership loss and achieve the

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[11] The Annapolis Coalition is a not-for-profit organization focused on improving the recruitment, retention, training, and performance of the prevention and treatment workforce in the mental health and addictions sectors of the behavioral health field. Its report as well as other information about the Annapolis Coalition can be found online at: http://www.annapoliscoalition.org/pages/.

goal of fostering leadership development across all segments of the workforce, it is necessary to identify the competencies that are necessary for leadership. It is also important for core competencies to be developed for supervisors. The Annapolis Coalition concluded that leaders are in a unique position to impact systems and the workforce simultaneously and that leadership offers promising potential in behavioral healthcare transformation. The specific objectives, as identified by the Annapolis Coalition for Goal 5 (Actively foster leadership among all segments of the workforce) are as follows:

1. Identify leadership competencies tailored to the unique challenges of behavioral health care
2. Identify effective leadership curricula and programs and develop new training resources to address existing gaps
3. Increase support for formal, continuous leadership development with current and emerging leaders in all segments of the workforce
4. Formally evaluate leadership development programs based on defined criteria and revise based on outcome

Dr. Michael Hoge, Commissioner of Mental Health in New York, was a key leader in the Annapolis Coalition study. In a presentation to Rutgers University's John J. Heldrich Center for Workforce Development in May, 2008, he described the top ten most commonly cited leadership attributes:

1. Having passion, being committed, having a strong belief in the cause, and approaching it with tenacity
2. Possessing good interpersonal and collaboration skills, having the ability to move groups to consensus, creating win-win situations, understanding different ideologies, and being culturally aware
3. Having a vision for the field and for one's role within that by seeing the big picture and focusing on key goals and ideas
4. Having solid experience and expertise such as: learning through longevity in the field, having the ability to evolve over time, having a solid knowledge-base, and having interdisciplinary training
5. Being politically savvy, knowing how to garner support of key decision-makers, being at the right tables for the right reasons and knowing what to do, and understanding when to negotiate for what
6. Having integrity, being honest and trustworthy, and maintaining credibility over time
7. Having curiosity and drive, and being motivational for others
8. Remaining flexible and having patience
9. Being able to communicate ideas and positions clearly and effectively, having the ability to translate complex notions and scientific findings in commonly understood language, and listening.
10. Taking risks, learning from experience, and translating one's learning into action.

New York

New York has training programs for different categories of the behavioral workforce including those designed for executive leadership, mid-level management, and front line workers.

Executive Leadership
The Health Care Association of New York State ("HANYS") has partnered with the Johnson School of Management at Cornell University to present executive leadership programs geared to the health care profession. The HANYS program is modeled similarly to the Ohio program described below. Cornell is a member of UNICON, the International University Consortium for Executive Education, which is a non-profit organization of leading business schools with a commitment to management, executive education and development.[12] UNICON, and its member universities, are committed to advance the field of university-sponsored executive education, and are important resources that can be tapped to enhance programs for health care professionals. The University of Virginia's business school is a member of UNICON.

Mid-Level Management Program
At the Westchester Institute for Human Development, clinical and administrative professionals have the opportunity to build leadership skills and capacity through the LEND program (Leadership Education in Neuro-developmental and related Disabilities Training Program).

Frontline Leadership Program for Service Coordination Supervisors
The state of New York requires all line supervisors for service coordinators to attend a 15 hour training segment that covers responsibilities in supporting service coordinators and assuring quality services to consumers.

Ohio

Ohio was one of the first states to develop a leadership program geared specifically to behavioral healthcare. The L2000+ Leadership Academy, developed at Ohio State University and administered by the John Glenn Institute for Public Policy, resulted from a comprehensive four-month assessment study of the mental health workforce needs.[13] The certification program is described as:

- Offering innovative, individualized and diverse learning opportunities
- Creating an ongoing learning community and growth across professional boundaries

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[12] UNICON's website is: http://www.uniconexed.org/.
[13] The L2000+ Leadership Academy is a certificate program of the John Glenn Institute for current and emerging leaders in mental health and addiction services agencies. For additional information on L2000+ Leadership Academy, see the John Glenn Institute website http://www.glenninstitute.org/glenn/training_L2000_index.asp. For additional information on the Center for Innovative Practice, contact Director Patrick J. Kanary at patrick@cipohio.org

- Developing the skills needed to meet and exceed the needs and expectation of customers, and
- Building capacity to improve quality, cost effectiveness and access[14]

Ohio's program is operated as an ongoing learning and professional development forum, with subject matter experts in the field of behavioral healthcare at the state and national levels.

Colorado

Dr. Randy Stith, Executive Director of Aurora Mental Health Center, in Aurora, Colorado, developed the LEAD (Leadership, Entrepreneurship, and Development) program in 2001 as a response to high staff turnover at community mental health centers LEAD is offered through an application process to all levels of employees and consists of curricula and an action learning component. Groups of students are required to implement a "capstone project" to enhance a service, improve effectiveness of ongoing services, or evaluate the effectiveness of ongoing services. An article in *Behavioral Healthcare,* in April 2008, outlines the program's components and highlights the outcome of substantially reduced turnover attributable to the positive work culture that the program imparts.[15] The Annapolis Coalition, which studied workforce development programs nationally, praised Colorado's program noting, "The Aurora Mental Health Center's LEAD program excelled in all areas and truly sets a new standard for our profession." The LEAD program starts with a three-day retreat dedicated to team building, and then, during the next five months, the team learns through twice monthly meetings to identify challenges, solve problems and collaborate across service lines.

California

The California Institute of Mental Health ("CIMH") has developed a mental health directors' Leadership Institute for leaders of public mental health services in the state of California. The program is administered by the State Capital Center of the University of Southern California School of Policy, Planning, and Development in conjunction with CIMH. Each training class is limited to 35 current leaders in the public mental health system. The Leadership Institute is designed to help good leaders become great leaders and addresses the many challenges facing leaders of public systems and services. The content of the training is based upon input from directors and others about the knowledge, skills and abilities ("KSA"s) needed to lead complex behavioral health organizations. It is a goal of the institute to develop a network among the participants as well as to support ongoing efforts. The curriculum includes the following:

- Leadership effectiveness

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[14] The full curriculum is available by contacting Cindy Holodnak, the Program Coordinator, at Email: holodnak.1@osu.edu.

[15] Stith, Randy. "Taking the LEAD: a CMHC empowers staff to take interest in their agency and the larger community." Behavioral Healthcare, April 2008. Available at: http://www.highbeam.com/doc/1G1-178797660.html.

- Leading through influence, facilitating and negotiating
- Responding to crises
- Consumer and family centered leadership
- Cultural diversity and competency
- Legislative processes
- Policy and Management in a public program
- County and state processes and politics
- Lessons learned in mental health funding and administration
- Working with the media
- Mental health networks
- Evaluating organizational networks
- Managing organizational change
- Organizational culture
- Organizational core processes

The training faculty members are primarily from California, although others come from across the country. The training is specifically for current California County Mental Health Directors, Deputy Directors, and those in management or leadership positions, or those who are executive directors or preparing for executive director roles in community-based non-profit public mental health agencies. The initial three-day residential session and three two-day follow-up modules cost approximately $4,000 per person, exclusive of room accommodations and meals.

The Sacramento School of Policy, Planning, and Development of the University of Southern California provides the Leadership Program for nonprofit and healthcare executives from the twenty-seven northern California counties in the Sierra Health Foundation. Curriculum topics include negotiation, situational leadership, creating and managing effective boards, financial decision-making, organizational culture, communication from within and outside the organization, and team development. Class size is small and participants are selected from an application process. Coursework includes classroom activity and participatory sessions, as well as team projects and peer assistance to address real world issues.

Open Minds

Open Minds is a research and consulting firm specializing in providing training to the behavioral health and social services field in the areas of executive education, covering five key areas: Financial Management, Strategic Planning and Management, Leadership and Governance, Marketing and Development, and Technology and Information Systems. Under Leadership and Governance, the following trainings are available:

- The Executive Leadership Institute
- Best Practice Management: Planning for the Next Generation of Behavioral Health and Social Services
- Assessing and Developing Leadership Competencies

- Using Data Driven Management to Improve Organizational Performance
- Improving the Effectiveness of Your Non-Profit Board
- Leading Through Constant Change: The Mandate for Today's Successful Executive
- Building Your Team's Management Competencies: Skill Building and Succession Planning
- Risk Management for Psychiatric Medical Directors and Administrative Psychiatrists
- The Role of Medical Directors and Clinical Directors in Measuring and Improving Clinical Performance
- Understanding and Enhancing the Role of Your Organization's Medical Director: Making Your Investment in a Medical Director a Value-Added Proposition
- Understanding Your Leadership Style and Building Your Skills
- Unique Challenges of Evolving From Clinical Professional to Clinical Manager.

The above training events can be provided live and on-line, and localities can volunteer to host events that are not already scheduled. Joseph Naughton-Travers, Senior Consultant from Open Minds, has identified a set of five competencies that are key to success in behavioral health organizations. They include:

- Leadership and planning: The ability to develop, effectively communicate, and lead organizational strategy
- Financial Management Competencies: The ability to understand financial processes and metrics -- and to use that information in improving the organization's efficiency and effectiveness
- Marketing and development competencies: Ability to link the organization to its customer base in a manner that balances mission with revenue and margin requirements
- Information technology competencies: Ability to understand and use computer technologies and resulting data for management purposes and to effectively plan and deploy technological solutions to help achieve organizational objectives
- Strategic management competencies: Ability to effectively manage, develop, and deploy the organization's human resources using strategic performance tools to continuously improve the organization's effectiveness

Training for Supervisors

The Subcommittee on Leadership and Supervisory Development located the following programs that specifically target the development of behavioral health supervisors:

Connecticut - SAMHSA awarded a 5-year Mental Health Transformation Grant to Connecticut in 2005. Workforce development was one of the priorities of the transformation effort. The Center for Workforce Development at the Yale School of Medicine issued a Request for Qualifications (RFQ) in January 2009, in connection with the Transformation Grant, to look at supervisor competency development. The initiative developed by the Center for Workforce Development was designed to strengthen the

KSAs of supervisors in selected mental health and rehabilitation agencies. Supervisors were identified as a key segment of the workforce due to the amount of influence they exert over the care provided. There was recognition that most supervisors do not or have not received any formal training on how to be supervisors. The ultimate objective of enhancing the training and development of the supervisors was to improve the capacity of supervisors to supervise, train and mentor their employees in the workplace. The anticipated ancillary result of this supervisor training was an improvement in the competencies of direct care staff and in their ability to partner with consumers and their families to implement person-centered and recovery oriented practice. The training methodology was developed to reduce the use of didactic in-service training and increase the use of workplace-based learning guided by the supervisor and enhanced by access to web-based learning modules.

While training for *supervisors* remains the central focus of the Connecticut workforce initiative, there is also recognition that creating and sustaining change in an organization requires understanding, participation, and support at all levels. As a result, training was also provided to clinical directors, direct care supervisors, and direct care staff. The agency executive directors, prior to the start of the project, also participated in a meeting to discuss how the training would be incorporated into an agency-wide sustainability plan. The core competencies taught include:

- Educating supervisors about "contracting" with supervisees
- Identifying a supervisee's learning needs
- Supporting an individualized educational plan for supervisees
- Working with "supervision resistant" supervisees

All training that is provided through the Connecticut initiative embraces a recovery framework and a person-centered planning perspective.

Arizona - The Arizona Department of Health/Division of Behavioral Health Services (ADHS/DBHS) has researched and published several best practices documents the Clinical and Recovery Practice Protocols, to assist behavioral health providers. One of these Practice Protocols is on Clinical Supervision. This protocol became effective in November of 2008 and was designed to increase the practitioner's ability to provide consistent quality care from the first point of contact by:

- Enhancing the supervisee's personal and professional development
- Providing regular supervision grounded in best practices
- Assessing and evaluating competence and effectiveness on a regular basis
- Adhering to licensing, accreditation and agency requirements
- Monitoring legal, ethical, and cultural issues
- Ensuring staff retention and overall welfare

The Practice Protocol states that even though clinical supervision is a distinct professional competency, most clinicians have not had formal training in clinical supervision. Therefore, it should not be assumed that a good clinician would make a

good clinical supervisor. Also, most supervisors are confronted with the compromise of clinical supervision due to the administrative, regulatory and financial demands on service programs. These demands create a tension that adversely impacts the quality of clinical supervision and often leads to low staff morale and high turnover. This lack of supervision can also affect the amount of direct care provided.

The Mid-Atlantic Addiction Technology and Treatment Center offers coursework in Clinical Supervision for Substance Abuse Treatment Practitioners and also distinguishes between clinical and administrative supervision. Course One is Theories of Clinical Supervision, which is designed to provide substance abuse counselors with an overview of the models and theories of supervision, and it also emphasizes the practical applications of these models. Course Two is Advanced Issues in Clinical Supervision. This course covers supervisor development, and legal, ethical, professional and clinical issues for supervisors with more experience. Course Three is Evidence Based Practices for Supervisors, which incorporates the blended model of supervision with technology transfer to assist the workforce in increasing their knowledge and skills around providing supervision and administration of evidence-based practices.

The Zur Institute provides a 6 CEU Credits- Online Course on the Foundations of Clinical Supervision that fulfills the California six hour supervision requirements for psychologists. It is an intermediate course that reviews the currently accepted models for conducting supervision, requirements of licensing bodies, skills and qualities of supervisor and supervisees.

Supervision and Leadership of Peer Support

In addition to supervising professional staff, supervisors in behavioral health often must oversee peer support personnel, which have unique needs. The Subcommittee on Leadership and Supervisory Development located the following programs that include the development of supervisors to support and supervise peer support personnel:

Recovery Innovations of Phoenix, Arizona provides training in leading and coaching peer support staff and has produced a manual that is available to those who participate in the training. They provide a detailed guide for coaching supervisors that emphasizes communication and evaluating performance.

The Ministry of Health in New Zealand has developed a framework entitled "Let's Get Real," the purpose of which is to build a workforce that supports recovery, is person-centered, is culturally capable, and delivers an ongoing commitment to improve the quality of services for those in need. Each of the skills defined sets performance indicators in three areas: essential, practitioner and leader. Performance indicators in each of the three areas focus on working with service users, working with families, working in mental health and substance use treatment settings, working within communities, challenging stigma and discrimination, law, policy and practice, professional and personal development. "Let's Get Real" is intended to complement those professional competencies while embedding the work of recovery throughout.

C. Leadership and Supervision Workforce Development Recommendations

Recommendation 1: Leadership & Supervisory Training.   A program of training and development for supervisors, managers and senior executives in Virginia's behavioral health and intellectual disability services system should be established to enhance the knowledge, skills, abilities and effectiveness of those in these roles, so that the systems of care and services provided to the citizens of the Commonwealth are effective, efficient and of high quality.

Based on a comprehensive review of leadership and supervisory development programs and best practices around the country and within the state of Virginia, the Subcommittee on Leadership and Supervisory Development recommends that the proposed program of training and development include the following initiatives and components:

- Development of an agreed upon set of core competencies for executive leadership and supervisory development in the fields of behavioral health and intellectual disabilities, being certain to incorporate principles of recovery, self determination and person-centered planning
- Establishment of a leadership academy for executive leadership, middle managers and both administrative and clinical supervisors that focuses specifically on the development of the core competencies as they are applied to behavioral health and intellectual disabilities
- Implementation of an action learning model that includes training, coaching and follow-up to assure implementation. Development of a preceptorship model for new leaders and/or a mentoring component should be a part of the program.
- Delivery of training and programs on a statewide basis and a regional/local basis, providing opportunities for the leaders and supervisors of public and private organizations that work together within a community or region to learn and grow together
- Development of a clearinghouse of documents, e-learning training courses and other materials specifically relevant to leadership and supervision, research and evaluation and workforce development in behavioral health care and intellectual disabilities

To facilitate the implementation of this recommendation DBHDS in collaboration with the VACSB should establish a Steering Committee to take the following actions:

- Determine what organizational arrangement will be most appropriate for housing the program – a non-profit corporation, an existing association that represents the interests of behavioral health and intellectual disabilities, an agency of government, etc.
- Determine what type of governance, overseeing board, etc. will be needed and appropriate
- Establish an initial vision and mission for the initiative
- Develop a two to three year budget for the initiative

- Propose funding options that maximize the development of partnerships that will enable the leveraging of resources. For example, corporate or foundation funding of a pilot program, SAMHSA, Robert Wood Johnson, Kennedy Foundation, VHCA, private provider community, state funding, a schedule of fees.
- Secure funding
- Identify and develop the managing Board
- Develop a process to report progress to interested stakeholders

This Subcommittee recommends that the membership of the Steering Committee include the Secretary of Health and Human Resources/designee, Commissioner for DBHDS, Inspector General for BHDS, three Community Services Board representatives (two Operating CSB and one Policy/Admin CSB), two state facility representatives (one hospital and one training center), three individuals who have received services, two representatives of private providers, and one representative of Supreme Court Commission on Mental Health Law Reform.

CHAPTER 3. Background Report on Peer Support Workforce Development and Utilization

A. Introduction and Background

The Americans with Disabilities Act,[16] the Surgeon General's Report on Mental Health,[17] and the President's New Freedom Commission on Mental Health[18] firmly planted the notion that consumers have a valued role in the provision of mental health support. More recently, the Centers for Medicare & Medicaid Services ("CMS") released a guidance letter to Medicaid directors regarding peer support services. The President's New Freedom Commission on Mental Health identified two principles to guide transformation of mental health services:

- Services and treatments must be consumer and family centered
- Care must focus on increasing consumers' ability to successfully cope with life's challenges, on facilitating recovery, and on building resilience, not just on managing symptoms

A peer support workforce meets both these expectations. A person in recovery providing services to his/her peers effectively enhances the mutuality of developing self-management skills. Peers help each other bring forth valuable care responses by providers. Peer-to-peer interactions also increase an individual's ability to participate in work or other social roles. Peer Specialists are trained to work one on one with individuals to create an environment in which people develop an attitude of well being, while demonstrating the positive results of regular self-monitoring of symptoms. They themselves have grown self-management skills and resilience and model how individuals can be active partners in their own care. Peer Support provides the opportunity to restore health, and independence in people who have not previously found a way to recover their lives.

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[16] The Americans with Disabilities Acts, 1990, prohibits discrimination and ensures equal opportunity for persons with disabilities in employment, State and local government services, public accommodations, commercial facilities, and transportation.

[17] *Mental Health: A Report of the Surgeon General*, Surgeon General, U.S. Public Health Service, 1999. This was the first national report on mental health and it asserted that mental health was a major public health issue.   Available at: http://www.surgeongeneral.gov/library/mentalhealth/home.html.

[18] The President's New Freedom Commission on Mental Health was established by Executive Order on June 18, 2001 and was the first major study of public and private mental health services in 25 years. It supported community-based services and programs for individuals with disabilities and directed key federal agencies to work together and with states to ensure full compliance with the Supreme Court's ruling in the Olmstead case (1999) and the Americans with Disabilities Act of 1990. The New Freedom Commission issued its final report, *Achieving the Promise: Transforming Mental Health Care in America*, was issued in July 2003. It is available at:
http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/downloads.html.

What is a Peer Support?

Some of the common terms for peer positions may include Peer Counselor, Peer Advocate, Peer Specialist, Peer Case Manager, Client Liaison, Recovery Specialist, Consumer Coordinator or Director. People who self-identify as having had a challenging mental health experience are serving in a variety of helping roles across the Commonwealth.[19] . Some have advanced degrees at the Masters and Doctorial levels. Others have minimal skills or education beyond their mental health experiences, and have come into a position at the bottom rung of the workforce ladder. There is an alarming tendency to stereotype the role as being one of only minimal education and maximum experience. Mental Health crisis that appreciably causes suffering to a significant life altering degree can happen to anyone, regardless of education, economic status, or any other areas of diversity in the human experience.

While we acknowledge that on a basic human level we are all 'peers" it is necessary to narrow the definition for the purposes of defining an essential work force. Several concepts should be analyzed in their effective use in defining a Peer Supporter. Individuals who by virtue of their own statement of having personally experienced some form of suffering, regardless of whether they were consumers, could act as "peers" who assisted another in his/her recovery journey. A point of consideration is to what degree a consumer needs to either be committed to and/or actively engaged in "recovery" in order to be hired as a Peer Supporter. Some believe that anyone who is a present or former recipient of mental health services is also a "peer" and should be considered for hire. Some have expressed that a significant personal experience with Recovery in some form was a necessary part of being a Peer Supporter. Peer Supporters are individuals who have experienced mental health issues, and are also able to give, focusing on needs other than their own. Peer Specialists provide knowledge, through their personal relationship to recovery, which traditional training cannot duplicate. They are capable of being essential team members who provide individualized, integrated treatment, rehabilitation, and community self-help activities while also providing essential consultation to the entire team to promote a culture of recovery.

Sherry Meade, noted author and researcher, defines Peer Support in this way:

> *Intentional Peer Support* (IPS) *is a way of thinking about purposeful relationships. It is a process where both people (and a group of people) use the relationship to look at things from new angles, develop greater awareness of personal and relational patterns, and to support and challenge each other as we try new things. IPS has been used in crisis respite (alternatives to psychiatric hospitalization), by peers, mental health professionals, families, friends and community-based organizations. IPS is different from traditional service relationships because:*

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[19] For a description of Peer Support roles nationally, see Schwenk, E.B., Brusilovskiy, E., & Salzer, M.S. (2009). *Results from a National Survey of Certified Peer Specialist Job Titles and Job Descriptions: Evidence of a Versatile Behavioral Health Workforce.* The University of Pennsylvania Collaborative on Community Integration: Philadelphia, PA

- *It doesn't start with the assumption of "a problem." Instead people are taught to listen for how and why each of us has learned to make sense of our experiences, and then use the relationship to create new ways of seeing, thinking, and doing.*
- *IPS promotes a 'trauma-informed' way of relating- instead of asking 'what's wrong' we think about 'what happened'?*
- *IPS looks beyond the notion of individuals needing to change and examines our lives in the context of our relationships and communities.*
- *Peer Support relationships are viewed as partnerships that enable both parties to learn and grow- rather than as one person needing to 'help' another.*
- *Instead of a focus on what we need to stop or avoid doing, we are encouraged to move towards what and where we want to be.*

The Effect of Not Having Peer Supporters

The mental health care delivery system will be destined to remain ineffective and inefficient if stigmas, prejudices and misconceptions bar the emergence of an effective peer support workforce. The peer workforce faces barriers that include staff attitudes, hiring and supervision practices, concerns regarding confidentiality, role confusion, and funding.

Despite the progress many mental health agencies have made, there is still significant stigma that recovery is not possible and that peer support workers should be engaged with great caution. Sometimes professionals feel that they may lose their familiar roles as the concept of Peer Supporter grows. It can be a challenge to shift from a work view that placed a person in a position of interpersonal power to a position of shared authority. It is hard to shift from treating someone who you have perceived as weak, and needing your valuable skills, to someone who has strengths and can be the person driving the outcomes.

Without a peer support workforce both consumers and potential peer support workers will miss out on an opportunity to increase the quality of their lives. The lack of a recovery based peer workforce will weaken our neighborhoods and communities. We know that creative, consistent, healthy manpower keeps our communities thriving. There is a cycle of equitable jobs, equitable pay, and equitable contributions that the peer workforce will contribute to.

Virginia has the opportunity to foster and embrace healthy outcomes for a significant number of its citizens through the dynamic reinforcement of the principles grounded in the Mental Health Peer Support Recovery movement. The total wellness of the Commonwealth and its citizens will grow in direct proportion to the funding, implementation and support of the development of a peer support workforce.

Evidence that Peer Support is Effective

Research on Peer Support Programs shows that involvement in these services gives way to improvement in psychiatric experience, decreased hospitalization, larger community support systems and improved sense of worth and human interactions, as well as shorter less frequent hospital stays, and lower services costs overall.[20]

In 2004, a SAMHSA-funded 5 year random assignment, controlled study showed greater improvement in well-being of adults with serious mental illness who participated in peer to peer support. The peer-to-peer recipients showed improvement over the course of the study than participants randomly assigned to only traditional mental health services. "Well being" was a composite construct reflecting recovery, social inclusion, empowerment, quality of life, meaning of life, and hope.[21]

The employment of people with direct experience is rapidly creating an evidence-based phenomenon that demonstratively changes people's lives. Early pioneers are taking their work abroad to Australia, Ireland, New Zealand Germany, Jamaica, and the list goes on. Three years ago Virginia was one of just a few states who were acknowledging the advantages of a Peer to Peer workforce. Now the movement exists from coast to coast.

Our neighbors in Canada are saving $20,000 per person, while establishing a healthier citizen base, just by making use of this emerging workforce. In one study the mean number of days in hospital for the participants dropped from 48.36 to 4.29. Another study showed that Canada saved more than $12 million in reduced hospital stays for three hospitals over the course of one year. People who were partnered with a peer mentor used an average of $20,300 less per person in hospital and emergency room services in the year after discharge.[22]

New Mexico is developing peer and family specialists. Vermont is home to Mary Ellen Copeland, whose WRAP peer to peer recovery program has become a household name in Virginia as well as nationally and internationally. Wisconsin, Michigan, Georgia, New

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[20] Galanter, M. (1988*)"* Research on Social Supports and Mental Illness," American Medical Journal of Psychiarty 1900:145; 1270-1272)*;* Rappaport, Julian and Seidman, Edward, eds*., Handbook of Community Psychology*, (1992) ISBN 0-306-46160-9; Markowitz, F., DeMasi, M., Knight, E. and L. Solka, (1996), "The role of self-help in the recovery process." Paper presented at the 6th Annual Conference on State Mental Health Agency Research and Program Evaluation, Arlington, VA: Dumont, J., and Jones K. (2002). "Findings from a consumer/survivor defined alternative to psychiatric hospitalization," Outlook, Evaluation Center@HSRI and NASMHPD Research Institute, Spring 2002: 4-6.

[21] *Campbell, Jean, COSP Preliminary Findings May 7, 2004. Available at: http://www.power2u.org/downloads/COSPVAREPORT.pdf;* Geoffrey Nelson and Jonathan Lomotey, "Quantity and quality of participation and outcomes of participation in mental health consumer-run organizations," Journal of Mental Health 2006,Vol5, No.1 pp63-74.

[22] *The Consumer/Survivor Initiatives (CSI): Impact, Outcomes and Effectiveness Report,* Consumer Operated Services Program (COSP) Multisite Research Initiative Overview and Preliminary Findings: Dr. Jean Campbell May 7, 2004 Missouri Institute of Mental Health Program in Consumer Studies and Training 5400 Arsenal Street St. Louis Mo. 63139

Hampshire , North Carolina, Maine Pennsylvania, Florida, Hawaii, Oregon, California, Nebraska, all have unique state strategies for advancing the Peer workforce.

A review of the research literature confirmed that when provided in addition to other mental health services, peer support helps participants improve psychological outcomes and reduce hospitalization. A majority of studies suggest recipients of Peer Support perform as well as or better than Non-Peer Support when peer-delivered services are an alternative to traditional mental health services. Peer-delivered services can be useful options for people who might otherwise choose to not engage with traditional supports.

The Virginia peer-to-peer workforce is significantly under-developed. The well intentioned but drastically inadequate attempts to fund this emerging workforce has resulted in a scattered jigsaw puzzle of mismatched efforts by provider agencies to change their organizational culture toward one that embraces Peer Support as an advantageous addition to their current workforce.

B. Summary of Research and Data Collection

1. Brief History of Mental Health Peer Support In Virginia

Although the use of peer support personnel in Virginia's public mental health system began in the mid to late 1990's, the growth of this service over the past decade, while steady, has been very slow. With support from public funding, training programs for peer support personnel have been established. However, the limited availability of jobs for peer support graduates limits their opportunities. Failure on the part of providers to fully understand the importance of peer support, limited funding to expand services, a decrease in support for the training of peers, and "barrier crime" limitations on employment in state/federal laws have all contributed to the very slow growth of peer support employment in the Commonwealth. The following outlines some of the history of mental health peer support in Virginia:

1997   State funding was provided to support a Program of Assertive Community Treatment ("PACT") demonstration program, which was conducted by District 19 CSB and included a Peer Specialist on the PACT Team.

2001 The Virginia Human Services Training ("VHST") program was established in FY 2001 with start-up funding from DBHDS. The VHST consumer-provider training program is modeled after a program that began in 1986 in Denver, Colorado, and promoted within Virginia by a partnership of consumers and staff at Highlands CSB and Region Ten CSB. It is designed to meet and exceed the DMAS training requirements for billable paraprofessional providers.

2002 PACT was expanded to 12 CSBs and related DBHDS licensing regulations were issued. Regulation 12 VAC 35-105-1370 required a Peer Specialist to be part of the PACT Team staffing. This regulation, for the first time in Virginia, made the peer's lived mental health experience a "Bona Fide Occupational Qualification."

2004 DBHDS was awarded a grant from the Center for Medicare and Medicaid (CMS) entitled "Mental Health System Transformation: Real Choice Systems Change." Among a number of efforts to advance recovery-oriented practices through this project, Peer Specialist Training programs were evaluated and introduced to Virginia. The project issued a white paper in 2005 entitled, *"Implementing Illness and Recovery Management in Virginia's Mental Health Service System: A Report of the Steering Committee of the Mental Health System Transformation Real Choice Systems Change Grant."* In response, DBHDS, DMAS, and DRS agreed to "collaborate with consumers, peer providers and community mental health services staff to design and implement peer specialist/provider training programs to expand the number and type of trained, reimbursable peer providers within Virginia's mental health services system. "

2004 REACH, a division of VOCAL Virginia, began its first WRAP Facilitator training while MHA-V held its first CELT classes. WRAP and CELT trainings were the foundations upon which many consumers began their recovery journeys in the State of Virginia. VOCAL and MHA-VA were the two foundational consumer empowerment organizations that were instrumental in initiating the grass roots movement out of which Peer Support in Virginia has grown.[23]

2006 *The Planning Conference on Peer Support and Peer Specialist Training* was held in Charlottesville to provide speakers, consumers and providers with opportunities to discuss (a) Peer Support Services--what they are, what they can be and how to go about providing them; and (b) options for Peer Specialist training programs in Virginia.

2008 The Mental Health System Transformation project subsequently increased the number of mental health consumers who participate in and have leadership roles in the state's mental health system through training and technical assistance. The Mental Health Association of Southeastern Pennsylvania ("MHASP") was awarded a contract to provide four Peer Specialist training events in Virginia. A total of 79 consumers have been trained and awarded the Certified Peer Specialist designation from the MHASP Institute for Community Integration and Recovery.

2008 The Department of Medical Assistance Services ("DMAS") clarified its policy on the qualifications for paraprofessional providers to recognize the MHASP Institute on Recovery and Community Integration's Peer Specialist curriculum. DMAS paraprofessional qualifications include completing a minimum of 90 hours of classroom training and 12 weeks of experience under the direct personal supervision of a QMHP. In addition, at least one year of experience (including the 12 weeks of supervised experience) is required. DMAS will review and approve, as appropriate, curricula for the classroom training program. The MHASP Institute on Recovery and Community

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[23] REACH = Recovery Education and Creative Healing
 VOCAL = Virginia Organization of Consumers Asserting Leadership
 WRAP = Wellness Recovery Action Plan
 MHA-Va = Mental Health America-Virginia
 CELT = Consumer Empowerment Leadership Training

Integration's Peer Specialist curriculum is approved by DMAS. DMAS clarified its policy on the training qualifications for paraprofessional providers to recognize the MHASP Institute on Recovery and Community Integration's Peer Specialist curriculum, as well as the curricula for "META" and Georgia programs described below.

2009 18 PACT Teams plus three locally-funded ICT Teams (the smaller size team) operate in Virginia with Peer Specialists as valued staff members. In addition there are now approximately 124 Peer Specialists, and an estimated 95 (77%) are employed in community mental health settings.

2. Peer Support Today

Community Peer Work Force

Federal, State, and private funding is being used to support venues that enhance the use of a peer workforce. Consumer operated, consumer run, and consumer/professional hybrids are developing throughout the Commonwealth and peers are serving as practitioners in therapeutic settings.

Consumer-Operated service programs are administratively controlled and operated by mental health consumers. They are independent and autonomous from traditional mental health agencies. They operate as alternative helping organizations appealing to people for whom traditional methods have been ineffective.

Peer providers are also being employed as peer practitioners in traditional staff positions within clinical mental health and psychosocial rehabilitation programs that are not necessarily governed or operated by consumers. These individuals are part of a staff team.

A hybrid of these two models also exists where a consumer-operated program is embedded as a separate but interactive program within a CSB.

Mental Health Facilities Peer Work Force

In 2009, the Office of the Inspector General conducted surveys of Recovery Activities at Mental Health Facilities.[24] The findings are bulleted below:

- 722 persons received WRAP training (or similar wellness self help planning and skill building activities) and had an opportunity to develop their own WRAP plans or similar personal recovery plans – up from 141 in 2007. 534 of these persons were engaged with Peer Support staff (consumers) who are certified WRAP trainers.

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[24] Office of the Inspector General, *Review of the Recovery Experience of individuals Served at Mental Health Facilities Operated by DMHMRSAS Follow Up: FY2009. Available at: http://www.oig.virginia.gov/documents/Syst-Rev-2009-Recovery.pdf.*

- All hospitals have at least some paid or volunteer consumers from the community who work with residents (total: 30 in 2009, up from 18 in 2007).
- 6 of 8 hospitals offered some form of paid employment to some residents, with a total of 252 persons employed at the time of the survey (slightly more than in 2007).
- All hospitals offered at least some residents a form of volunteer opportunity.
- All of these activities were improvements over 2007 levels.
- All findings remain active.

State Psychiatric Hospitals are involving consumers in peer to peer opportunities through the use of Peer Supporters. Eastern State Hospital responded to the growing need by developing Peer Support training programs. Many public health agencies are developing Consumer Advisory Councils. CSB and BHA are looking for ways to involve consumers in the workforce. DBHDS has encouraged CSB to conduct recovery-oriented satisfaction surveys. Each Hospital offers satisfaction surveys.

Grass Roots Work Force Development

A successful grass roots effort to provide mutual support to the existing Peer Support workforce exists in the form of The Virginia Peer Support Coalition ('VPSC"). VPSC was formed to promote the success, and encourage the growth of Peer Support in Virginia. VPSC does this by using advocacy, resource development, training opportunities, and networking to build a strong support system for those providing Peer Support. VPSC was born out of a Peer Specialist Coalition Building Conference in September 2008 facilitated by Pat Shank with CMS Transformation Grant funding. Now VPSC is comprised of members who work in both paid and unpaid capacities, in "traditional" Mental Health services and Consumer-Run organizations. Additionally it is available as a resource and advocates for Peer Support in Virginia. VPSC operates a networking website where members can create their own professional profile; discuss common issues and ideas, post events to a calendar, and post and view files, and job opportunities. VPSC also conducts Gatherings around the State, and has sponsored a workshop on employment in Peer Support at the 2009 VOCAL Network Conference.

Medicaid Reimbursed Peer Support Services

Currently, peers may qualify to provide certain Medicaid reimbursed mental health and substance abuse services. Peers who meet the qualifications for paraprofessionals (as outlined in Chapter II of the Medicaid Community Mental Health Rehabilitative Services Manual) may render services under supervision as required by the specific service.

The services that may be provided by paraprofessionals are:

- Mental Health Day Treatment for Children and Adolescents
- Day Treatment/Partial Hospitalization
- Psychosocial Rehabilitation
- Intensive Community Treatment

- Mental Health Supports
- Substance Abuse Crisis Intervention
- Substance Abuse Intensive Outpatient Treatment
- Substance Abuse Day Treatment
- Substance Abuse Opioid Treatment

Mental Health Crisis Intervention and Crisis Stabilization do not currently allow paraprofessionals to render reimbursable services. An appropriation from the General Assembly would be required for Virginia's Medicaid program to add additional providers to provide these services.

Peer Support Work Force and WRAP

No discussion about what is happening statewide could be complete with out discussing the relationship between peer support and the Wellness Recovery Action Plan^{TM} ("WRAP") experience. WRAP facilitation and peer support are two distinct skill sets that although they complement each other nicely should not be substituted for each other in an over generalization of a peer workforce. The combination of WRAP and peer support can be incredibly powerful in helping individuals and systems grow and challenge each other beyond what we thought we were capable of. Virginia, through grass roots consumer input elected to support the Mary Ellen Copeland/Sherry Meade Wellness Recovery Action Plan as a person centered strength based wellness model. According to the Copeland website, at a recent meeting in Washington, peer program directors nationwide reported on the positive effects of the Peer Support/WRAP connection on both personal and group recovery process.

Peer Support Work Force Training

The current Certified Peer Specialists working in Virginia have been trained in one of four models. They are: Recovery Innovations Inc. (META Model), Appalachian Consulting Group, Inc. (Georgia Model), The Mental Health Association of Southeastern Pennsylvania, and Virginia Human Services Training Center. Although each program has its own identity, they share common topics as listed below:

Recovery
Five stages of the recovery process
The impact of diagnosis on one's self-image
The Power of Peer Support Developing
Self-esteem and Managing Self-talk
Community, Culture and Environment
Cultural competency
Meaning and Purpose
Emotional Intelligence
Introduction to WRAP: The Wellness Recovery Action Plan
Facilitating recovery dialogues
Managing our differences

The role of spirituality in recovery
Survey of Serious Mental Illness
Co-occurring disorders and boundary issues in Peer Support
Telling Your Personal Story
Communication Skills
Conflict resolution
Problem solving with individuals
Understanding Trauma Substance Abuse
Being with People in Challenging Situations
Working with people who appear unmotivated
Peer Support in Action,
Preparing Yourself for Work
Employment as a Path to Recovery
Professional Skill Development
Partnering with Professionals
Workplace Issues and Boundaries
Principles and Practice of Case Management
Survey of Mental Health Services in Virginia

At this time the training offered through the Virginia Human Services Training Center is the only peer support training offered in Virginia.

C. Peer Support Workforce Development and Utilization Recommendations

Recommendation 2. Establishment of a Peer Support Workforce Development Commission. DBHDS should establish a Peer Support Workforce Development Commission composed of experienced peer support personnel and provider agency representatives. Peer and provider participants should represent both community-based and state facility settings. The purpose of the Commission will be to accomplish the following:

- Define the core competencies needed for peer support personnel who work in public and private organizations that provide mental health services.
- Develop ethical guidelines to assist providers and peer support personnel in dealing with the complexities of peer support employees working in the same organization from which they receive mental health, intellectual disability and substance abuse services.
- Develop a model career path program for peer support personnel that can be implemented by provider organizations. This initiative should include the development of model job descriptions and explore avenues for experienced peer support personnel to move into a wider range of employment opportunities over time.
- Define the data and other information that is needed on a statewide basis to validate the effectiveness (outcome and cost) of emerging peer support practices in the delivery of mental health, intellectual disability and substance abuse

services. This initiative should include a determination of how an outcome evaluation system can be supported and operated on an ongoing basis.

- Explore the value and potential benefits of establishing a certification program for peer support workers. If it is determined that such a program is in the best interest of service recipients, the peer support workforce, and provider organizations, the Commission should define the criteria that must be met by peer support workers to receive certification.
- Establish a plan to assure that adequate peer support training and development resources will be available in the Commonwealth in the future. This initiative should include:

  o Development of plans for the provision of comprehensive training for peer support specialists on a statewide and regional basis.
  o Ongoing consultation to community-based and state facility providers and consumers in the transformation of the mental health system to one that embraces a culture of recovery, promotes wellness management, peer support and supported employment.
  o Expansion of training efforts for peers to develop the knowledge and skills needed to facilitate Wellness Recovery Action Plans (WRAP). This training is currently being provided through a partnership between DBHDS and VOCAL Virginia's REACH program.

Recommendation 3. Foster an Organizational Culture for Recovery. All public and private entities that provide mental health services take intentional steps to establish an organizational culture in which the principles of recovery are central to the mission and primary values of the organization, the value of peer support is understood, peer support personnel are routinely employed in treatment and rehabilitation services, and needed structures to support peer employees are maintained.

Recommendation 4. Establish a Peer Support Website. DBHDS should support the establishment of a Statewide Peer Support Website to provide an avenue for the provision of electronic peer support services; to make information about recovery and peer support practices widely available to recipients of services, peer providers and provider organizations; and to assist those seeking jobs as peer supporters in finding employment.

Recommendation 5. Collaboration to Provide Benefits. DBHDS, DRS, public and private providers should work closely with DSS, the Social Security Administration, housing agencies and all other agencies that provide benefits to individuals with mental illness to reduce the complexity of tapered benefit services as a person regains the ability to sustain employment and independence.

Recommendation 6. Change Medicaid Provider Requirements. Virginia's Department of Medical Assistance Services ("DMAS") should take the following actions related to Medicaid:

- Change the requirements for paraprofessionals to allow life experience as a qualification or add peer support provider as a reimbursable provider.
- Request funding in the state budget process to add paraprofessionals and peer support providers as allowed providers for Mental Health Crisis Intervention and Mental Health Crisis Stabilization.
- Disseminate information to provider organizations that clarifies which Medicaid services allow reimbursement for peer support providers.

Recommendation 7. Reduce Barriers to Employment. The following actions should be taken related to the impact of barrier crimes statutes on the employability of persons with mental illness and substance abuse disorders:

a. The General Assembly should amend § 37.2-416 (Code of Virginia) to reduce the amount of time that applicants who have been convicted of barrier crimes listed in § 37.2-314 and excluding those listed in § 37.2-506 C are required to have been free of parole or probation prior to being considered for employment in a mental health or substance abuse service operated by a provider licensed by the Department of Behavioral Health and Developmental Services that is not a community services board or a behavioral health authority:

> D. The hiring provider and a screening contractor designated by the Department shall screen applicants who meet the criteria set forth in subsection C to assess whether the applicants have been rehabilitated successfully and are not a risk to consumers based on their criminal history backgrounds and substance abuse or mental illness histories. To be eligible for such screening, the applicant shall have completed all prison or jail terms, shall not be under probation or parole supervision, shall have no pending charges in any locality, shall have paid all fines, restitution, and court costs for any prior convictions, and shall have been free of parole or probation for at least ~~five~~ <u>three</u> years for all convictions. In addition to any supplementary information the provider or screening contractor may require or the applicant may wish to present, the applicant shall provide to the screening contractor a statement from his most recent probation or parole officer, if any, outlining his period of supervision and a copy of any pre-sentencing or post-sentencing report in connection with the felony conviction. The cost of this screening shall be paid by the applicant, unless the licensed provider decides to pay the cost.

b. The General Assembly should amend § 37.2-416 (Code of Virginia) to reduce the amount of time that must have lapsed after the applicant has been convicted of not more than one misdemeanor offense under § 18.2-57 or 18.2-57.2 from 10 to five years before the applicant can be considered for employment in a mental health or substance abuse service for adults operated by a private provider licensed by the Department of Behavioral Health and Developmental Services that is not a community services board or a behavioral health authority:

E. Notwithstanding the provisions of subsection B, a provider may hire for compensated employment persons who have been convicted of not more than one misdemeanor offense under § 18.2-57 or 18.2-57.2, if ~~10~~ five years have elapsed following the conviction, unless the person committed the offense while employed in a direct consumer care position.

c. The General Assembly should amend § 37.2-506 (Code of Virginia) to reduce the amount of time that applicants who have been convicted of barrier crimes listed in § 37.2-314 and excluding those listed in § 37.2-506 C are required to have been free of parole or probation prior to being considered for employment in a mental health or substance abuse service for adults operated directly by a community services board or behavioral health authority:

D. The community services board and a screening contractor designated by the Department shall screen applicants who meet the criteria set forth in subsection C to assess whether the applicants have been rehabilitated successfully and are not a risk to consumers based on their criminal history backgrounds and substance abuse or mental illness histories. To be eligible for such screening, the applicant shall have completed all prison or jail terms, shall not be under probation or parole supervision, shall have no pending charges in any locality, shall have paid all fines, restitution, and court costs for any prior convictions, and shall have been free of parole or probation for at least ~~five~~ three years for all convictions. In addition to any supplementary information the community services board or screening contractor may require or the applicant may wish to present, the applicant shall provide to the screening contractor a statement from his most recent probation or parole officer, if any, outlining his period of supervision and a copy of any pre-sentencing or post-sentencing report in connection with the felony conviction. The cost of this screening shall be paid by the applicant, unless the board decides to pay the cost.

d. The General Assembly should amend § 37.2-506.E (Code of Virginia) to reduce the amount of time that must have lapsed after the applicant has been convicted of not more than one misdemeanor offense under § 18.2-57 or 18.2-57.2 from 10 to five years before the applicant can be considered for employment in a mental health or substance abuse service for adults operated by a community services board or behavioral health authority:

E. Notwithstanding the provisions of subsection B, a community services board may hire for compensated employment persons who have been convicted of not more than one misdemeanor offense under § 18.2-57 or 18.2-57.2, if ~~10~~ seven years have elapsed following the conviction, unless the person committed the offense while employed in a direct consumer care position.

e. DBHDS should take the following actions related to the Department's responsibility established in § 37.2-506.C & D and § 37.2-416.C & D (Code of Virginia) to designate screening contractors to screen applicants to determine that the criminal behavior was substantially related to the applicant's substance abuse or mental illness and that the person has been successfully rehabilitated and is not a risk to consumers based on his criminal history background and his substance abuse or mental illness history.

   o Establish criteria for those who are to be engaged as screening contractors that are relevant to both mental illness and substance use.
   o Take steps to increase the number and regional availability of screening contractors.
   o More clearly define the payment structure for screening contractors.
   o Publicize the screening process and contact information for screening contractors in ways that will make this information available to potential applicants and providers.

f. The Peer Support Workforce Development Commission to be established by DBHDS as per above recommendation should develop a methodology for the collection and analysis of data on recidivism rates of those with mental illness and substance use disorders who have been found guilty of a barrier crime and who have been employed by providers of mental health and substance use providers.

CHAPTER 4. Background Report on the Case Management Workforce

A. Introduction and Background

The role of the case manager in the behavioral health and intellectual disability service systems has become significantly more complex and is now central to the achievement of positive outcomes for consumers who experience more serious psychiatric, developmental and behavioral conditions in Virginia. As the goal of serving the vast majority of individuals in community settings has increasingly been realized, the work of the case manager has become more critical and now requires a broader set of knowledge, skills and abilities. Today the case manager is expected by Virginia state regulation to have knowledge of the nature of serious mental illness, intellectual disabilities and/or substance abuse populations; different types of assessments and their uses in service planning; treatment modalities and intervention techniques including behavior management, counseling and crisis intervention; service planning; the use of medications in treatment; not only mental health, intellectual disability and/or substance abuse services, but also support and primary health care services; and all applicable federal, state and local laws, regulations and ordinances. The case manager is expected to work independently. Today, because more seriously disabled individuals are being served in the community and the use of inpatient services has been drastically decreased, case managers must provide supportive counseling to more seriously disabled individuals, spend more of their time providing crisis intervention, coordinate more complex plans of care, and spend more time monitoring the effectiveness of the entire range services to prevent the need for more intensive and expensive interventions. The case manager is often the sole continuing therapeutic support person for not only the consumer but also the family. In addition, the case manager is expected to be the consumer's consultant and advocate in helping him retain an adequate array of appropriate health, financial and social services.

In Virginia today there is no specialized training for case managers and no system for assuring that the persons who fill this role have the knowledge and skills needed to be effective. Most case managers who come to the job with formal education at the bachelor and masters degree levels have not had coursework that prepares them for their role. The primary method of developing case managers is on the job coaching by supervisors who may or may not have case management experience. As a result, the level and quality of case management services varies widely from community to community. Because there are no real career supports to assist case managers in their professional development and advancement, it is often not a role that young professionals aspire to, turnover is high, and tenure in the job is short. The impact is that this most important relationship between the consumer and case manager is interrupted too often and continuity of care is disrupted.

It is the vision of the Subcommittee on Case Management Workforce that positive services outcomes for the recipients of case management are aligned with mission-oriented goals of recovery, independence and active involvement within the communities

in which people live. This will occur as a result of a uniformed consistent certification and training process that is developed and utilized across Virginia.

The Subcommittee on Case Management Workforce conducted extensive research to identify means to assure a consistent and effective approach to case management across the spectrum of care. In reviewing data both in Virginia and nationally, this Subcommittee decided to focus both on developing practice standards and certification in case management.

Across the country and within Virginia there is no standardized curriculum focused on the competencies necessary for the successful implementation of what is required to carry out case management activities. Training programs minimally require health and safety, human rights and emergency preparedness training, yet fail to operationalize the critical components of interpersonal skills and knowledge required to successfully navigate community resources, establish positive relationships with clients, colleagues and community partners, and strive to optimize services within a system wrought with shortages of available housing, vocational opportunities and medical care.

B. Summary of Research and Data Collection

Summary of Data Collection Efforts

The subgroup of the Subcommittee on Case Management Workforce researched national competency models and various state certification programs to review best practice efforts to standardize and to develop curricula that aligns with current trends in recovery-based and person-centered models of care. The findings from three studies, which included national and state-specific data, support Virginia data regarding a lack of consistency in approach, insufficient training and preparation to assure adequate case management competencies. All reports recognized the critical role that case management plays within the states' behavioral health and developmental services systems as the main conduit across many dimensions of services from facility-based care to community integration**.**

1. Case Management Requirement in Virginia

Virginia's DBHDS defines case management and case manager qualifications in Article 5 of Rules and Regulations for the Licensing of Providers of Mental Health, Mental Retardation and Substance Abuse Services. In addition, the Virginia Department of Medicaid Assistance has recently provided guidance through its revised rules effective July 1, 2009, for the designation of a "qualified mental health case manager" by verifying that there is no degree required or any specific coursework that is required to provide Mental Health Case Management services under Medicaid. There are qualifications known as knowledge, skills and abilities that define the prerequisite knowledge base for the position. This designation is different than that of a qualified mental health professional ("QMHP"), which has more stringent requirements. It is noteworthy that the case management service within Virginia's system, one that cuts across all dimensions of care for citizens with disabilities, lacks specified coursework and required academic preparation.

- Currently, although not required according to DMAS regulations or DBHBS, the prevalent credentials and competency requirements across Virginia's system follow QMHP/QMRP definitions for case managers. These definitions call for an individual with at least a bachelor's degree in human services or related field (social work, psychology, psychiatric rehabilitation, sociology, counseling, vocational rehabilitation, human services counseling or other degree deemed equivalent to those described) from an accredited college and with at least one year of clinical experience providing direct services to persons with a diagnosis of mental illness or intellectual disabilities. These academic requirements are generally consistent with the states that we researched for minimal case manager requirements.

- While Emergency Services Counselors are required to complete a certification and the position requires master's prepared employees, case management services do not have either of these requirements. Case managers, however, make up the majority of the direct services workforce who work with the most severely disabled clientele in the community. The case managers interact with the full spectrum of service providers both within the community and facilities and within the CSB/BHA system for persons with mental illness, substance abuse, intellectual disabilities, and children with disabilities or at risk.

Office of the Inspector General Report on Case Management Services in Virginia

Reports from the Office of the Inspector General ("OIG") conducted on case management and related services spanning 2006-2008 demonstrated that more than 25,000 individuals received case management services in adult Mental Health ("MH") and Intellectual Disabilities ("ID") case management.[25] In children's services, case management was the predominant service for 42,000 children served. For adult ID and MH within the CSB system, the reports revealed that **"**case managers receive little training in topics specifically related to case management and that **"**preparation and certification of skills and abilities of case managers vary among CSB's. Recommendations in the two reports for adult case management included:

- Development of a model training program, (one that surpasses the minimum regulatory training requirements based in DMAS rules mainly in the areas of health and safety, client protection and emergency preparedness in order to address the knowledge, skills and abilities requirements to fulfill the position duties as described above)

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[25] Virginia's Office of the Inspector General, *Review Of Community Services Board Mental Health Case Management Services for Adults,* Report #128-06, (March 2006). Available at: http://www.oig.virginia.gov/documents/SS-MRCommResSvcs128-06.pdf. Virginia's Office of the Inspector General, *Review Of Community Services Board Mental Retardation Case Management Services For Adults,* Report #142-07 (June 2007). Available at: http://www.oig.virginia.gov/documents/SS-MRCM-142-07.pdf. Virginia's Office of the Inspector General, *Review of Community Services Board Child and Adolescent Services,* Report #149-08 (April 2008). Available at: http://www.oig.virginia.gov/documents/SS-CACM-149-08.pdf.

- Certification for case management
- Regional and statewide forums for training
- Incorporation of a recovery-coach approach to incorporate the use of peer providers and a person-centered, self determination models for care coordination

Virginia Association of Community Services Boards ("VACSB") Efforts in Establishing Core Curricula

- In an effort to develop model core competencies and a certification program for case management, the Human Resources Subcommittee of VACSB has begun work to establish standard core curricula for case managers across the services spectrum. While the group recognizes the necessity for subject matter expertise in the area of disability that each case manager serves, it is the Human Resources Subcommittee's belief, as evidenced by other competency-based training models, that core competencies cut across all disability areas.

- In 2008/2009 the Human Resources Subcommittee of the VACSB began efforts toward the recommendation and establishment of core competency areas and a competency-based core curricula to establish preparation standards and position expectations across Virginia's behavioral healthcare and developmental services system for case management services. The following highlights the group's activities thus far:

  o Survey conducted across CSB system in December 2008-9. Information was gleaned from clinical directors, case managers and supervisors through the Human Resources Director.
  o Human Resources Subcommittee is currently working to align the proposed system training thru e-learning vendors, established training to be converted to e-learning and/or development of new e-learning for each of 12 core competency areas.
  o Human Resources Subcommittee presented their working draft proposal to glean further input from stakeholders and to present recommended e-learning curricula for core case management curricula at the May 2009 VACSB Professional Development Committee.

- The core competencies that have been identified to date by the VACSB Human Resources Subcommittee and related e-learning training developed to date are presented below:

  Job Knowledge – Includes regulatory requirements as well as knowledge of treatment planning and documentation, case management basics, and current philosophical approaches (e.g. motivational interviewing, person-centered planning, recovery and transformation etc.)
  Adaptability – Includes employee's ability to manage change
  Advocacy – Includes ability to act in consumer's best interest and protect confidentiality and human rights

Analytical Ability – Includes ability to assist clients in problem solving and utilizing creative approaches

Cultural & Linguistic Competence – Includes the ability to communicate and interact with people across cultures

Ethics – Includes acting in an ethical manner and maintaining professional boundaries

Exercise Sound Judgment – Includes identification of critical issues and managing high risk situations

Interpersonal and Team Skills – Includes working with internal and external teams, communication skills, and customer service

Organizational Skills – Includes time management and prioritizing multiple tasks

Professional Role Model – Includes professionalism in appearance and communication when working with and assisting consumers and community partners

Safety – Includes working in a safe manner both in the building and in the community

Use of Available Technology – Includes effective use of technology (e.g. electronic calendar, email, computer forms and other agency computer systems).

Virginia Licensure Regulations for Case Management

12 VAC 35-105-1240 of the Code of Virginia defines service requirements for providers of case management services. These requirements should be expected as part of any case management job description and tied to the certification process as minimum standards.

- Enhancing community integration through increased opportunities for community access and involvement and creating opportunities to enhance community living skills to promote community adjustment including, to the maximum extent possible, the use of local community resources available to the general public;
- Making collateral contacts with the individual's significant others with properly authorized releases to promote implementation of the individual's individualized services plan and his community adjustment;
- Assessing needs and planning services to include developing a case management individualized services plan;
- Linking the individual to those community supports that are likely to promote the personal habilitative/rehabilitative and life goals of the individual as developed in the individualized service plan (ISP);
- Assisting the individual directly to locate, develop, or obtain needed services, resources, and appropriate public benefits;
- Assuring the coordination of services and service planning within a provider agency, with other providers and with other human service agencies and systems, such as local health and social services departments;

- Monitoring service delivery through contacts with individuals receiving services, service providers and periodic site and home visits to assess the quality of care and satisfaction of the individual;
- Providing follow up instruction, education and counseling to guide the individual and develop a supportive relationship that promotes the individualized services plan;
- Advocating for individuals in response to their changing needs, based on changes in the individualized services plan;
- Developing a crisis plan for an individual that includes the individual's references regarding treatment in an emergency situation;
- Planning for transitions in individual's lives; and
- Knowing and monitoring the individual's health status, any medical conditions, and his medications and potential side effects, and assisting the individual in accessing primary care and other medical services, as needed.

Federal Centers for Medicare & Medicaid Services (CMS)
Definition of Case Management - December 2007

Services §440.169

Consistent with the provisions of section 1915(g)(2) of the Act, as added by the DRA, we will define case management services in § 440.169(a) generally as services that assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services. The intent of case management is to assist the individual in gaining access to needed services, consistent with the requirements of the law and these regulations. ''Other services'' to which an individual eligible under the plan may gain access may include services such as housing and transportation.

68092 Federal Register / Vol. 72, No. 232 / Tuesday, December 4, 2007 / Rules and Regulations § 440.169 Case management services

(a) Case management services means services furnished to assist individuals, eligible under the State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, educational, and other services, in accordance with § 441.18 of this chapter.
(b) Targeted case management services means case management services furnished without regard to the requirements of § 431.50(b) of this chapter (related to statewide provision of services) and § 440.240 (related to comparability). Targeted case management services may be offered to individuals in any defined location of the State or to individuals within targeted groups specified in the State plan.
(c) For purposes of case management services, individuals (except individuals between ages 22 and 64 in an IMD or individuals who are inmates of public institutions) may be considered to be transitioning to a community setting during the last 60 consecutive days (or a shorter time period as specified by the State) of a covered long-term, institutional stay that is 180 consecutive days or longer in duration. For a covered, short-term,

institutional stay of less than 180 consecutive days, individuals may be considered to be transitioning to a community setting during the last 14 days prior to discharge.
(d) The assistance that case managers provide in assisting eligible individuals obtain services includes:

> (1) Comprehensive assessment and periodic reassessment of individual needs
> (2) Development (and periodic revision) of a specific care plan
> (3) Referral and related activities
> (4) Monitoring and follow-up activities

FY 2010 Community Services Performance Contract

Virginia's publicly provided mental health services are provided through CSBs who enter into Performance Contracts with DBHDS. The Performance Contracts define the scope of services for the provision of case management services for the coordination of MR waiver, linkages to health care, and coordination with local psychiatric hospitals.

Under the Virginia Code, CSBs are identified as the single point of entry into publicly funded services. They are required to work with DBHDS to achieve a welcoming recovery oriented; integrated services system for individuals receiving services and their families.

The Performance Contract identifies CQI performance expectations for mental health and substance abuse case management services as follows:

> **Mental Health and Substance Abuse Case Management Services Performance Expectations:**
>
> Case managers employed or contracted by the Board shall meet the knowledge, skills, and abilities qualifications in the Case Management Licensing Regulations, 12 VAC 35-105-1250.
>
> Individuals receiving case management services shall be offered a choice of case managers to the extent possible, and this shall be documented by a procedure to address requests for changing a case manager.
>
> Case managers shall be hired with the goal of becoming welcoming, recovery-oriented, and co-occurring competent to engage all individuals receiving services in empathetic, hopeful, integrated relationships to help them address multiple issues successfully.
>
> Reviews of the individualized services plan (ISP), including necessary assessment updates, shall be conducted face-to-face with the individual every 90 days and shall include significant changes in the individual's status, engagement, participation in recovery planning, and preferences for services; and the ISP shall be revised

accordingly to include an individual-directed wellness plan that addresses crisis self-management strategies and implements advance directives, as desired by the individual. For those individuals who express a choice to discontinue case management services because of their dissatisfaction with care, the provider must review the ISP to consider reasonable solutions to address the individual's concerns.

The Board shall have policies and procedures in effect to ensure that, during normal business hours, case management services shall be available to respond in person, electronically, or by telephone to preadmission screening evaluators of individuals with open cases at the Board to provide relevant clinical information in order to help facilitate appropriate dispositions related to the civil involuntary admissions process established in Chapter 8 of Title 37.2 of the *Code of Virginia*.

Mental Health and Substance Abuse Case Management Services Performance Goals

For an individual who has been discharged from a state hospital, a private psychiatric hospital, or a psychiatric unit in a public or private hospital or released from a commitment hearing and has been referred to the Board and determined by it to be appropriate for its case management services program, a preliminary assessment shall be initiated at first contact and completed, preferably within 14 but in no case more than 30 calendar days of referral, and an individualized services plan (ISP) shall be initiated within 24 hours of the individual's admission to a program area for services in its case management services program and updated when required by the Department's licensing regulations. A copy of an advance directive, a wellness recovery action plan, or a similar expression of an individual's treatment preferences, if available, shall be included in the clinical record.

For individuals for whom case management services will be discontinued due to failure to keep scheduled appointments, outreach attempts, including home visits, telephone calls, letters, and contacts with others as appropriate, to reengage the individual shall be documented. The Board shall have a procedure in place to routinely review the rate of and reasons for refused or discontinued case management services and shall take appropriate actions when possible to reduce that rate and address those reasons.

2. **Case Management Training and Certification Programs Outside of Virginia**

In 1997, the National Association of Case Management ("NACM"), issued a report authored by Martha Hodge, M.S. and Linda Giesler, M.P.A., outlining critical elements for adult mental health case management practice. These elements remain relevant to current case management philosophy and include self-empowerment, recovery and person-centered approaches to care as well as functions of coordination, assuring consumer choice and a focus on strengths and preferences, continuity of care and outcome-oriented services planning. This project was funded by the Community Support

Program, Division of Knowledge Development and Systems Change, Center for Mental Services within the Substance Abuse and Mental Health Service Administration ("SAMHSA").

The authors highlighted that few colleges and universities specifically prepare students to practice case management and urged state and local organizations to assume the responsibility for providing pre-service and in-service training and include, in addition to training in the performance domains outlined in their report, training in crisis/relapse prevention, recovery concepts, co-occurring substance abuse problems and managed care practices.

NACM recommends a competency based approach to preparing case management personnel. Competency based training in human services and case management specifically is not well developed at this time. However, entities employing case managers should require demonstrable competencies such as developing relationships, planning for services, and service documentation in conjunction with training and experience requirements.

Texas Health and Human Services Commission 2003 Report

The Texas Health and Human Services Commission ("Texas Commission") was charged by the Texas State Legislature to conduct a study of case management practices within Texas and report on the feasibility of developing a Medicaid waiver program. During their research of several states across the nation, (Wisconsin, Oregon, Minnesota, New Jersey, Virginia) the Texas Commission recommended several general themes and initiatives toward best practice improvements to consolidate case management/care coordination services that would benefit the Texas system including the following:

- The development of a single service definition for case management and care coordination and rename case management as service coordination in order to provide common terminology across domains of service and to reduce stakeholder's resistance in some areas to the notion that they were a "case to be managed".
- The development of standardized provider qualifications applicable to all departments and programs.
- The utilization of "No Wrong Door" approaches to service coordination wherever feasible for mental health and co-occurring disorders.

Currently, Texas requires that Mental Health case managers be certified as Qualified Mental Health Providers ("QMHP"), which requires completion of training in core competency areas that is documented in the case manager's personnel record. While there is no evidence of a standardized curricula and the nomenclature for case manager remains in place, there is evidence that Texas has made strides to consolidate the required core competency areas for training for case managers across adult and child services domains.

Minnesota: Redesigning Case Management Services for People with Disabilities in Minnesota- March 2007: Prepared by the Institute on Community Integration University of Minnesota

In its final report to the legislature as mandated by the State of Minnesota ("Minnesota Report"), a Quality Assurance Panel reported on a study based on convening focus groups involving 245 Minnesotans examining ways to improve the coordination and quality of services for case management.

- Key themes from interviews with case managers and involved stakeholders indicated, "although the different forms of case management are very similar in form and function, there is little consistency regarding qualifications and training requirements."
- The Minnesota Report also emphasized that the state lacks a comprehensive case management quality program and there are no clear standards for performance tied to expected outcomes. 80% of the case managers indicated that they had no formal coursework in case management.
- A notable need outlined in the Minnesota Report was to establish an enhanced training and certification process to build consistency and adequate preparation and training to conduct case management activities with a person-centered, consumer-directed model as emerging in the developmental disabilities services field.

State of Oklahoma

Oklahoma requires by state code that case managers be certified through meeting the following requirements:

- Must complete a the competency-based case management project
- Attend case management certification training offered by the department in their area of specialty
- Possess a bachelors degree in human services
- Complete a minimum of six weeks' supervision by a case management supervisor
- Application must be submitted in area of specialty or dual capacity (MI/SA) to the Department of Mental Health
- A signed supervision agreement between the supervisor and case manager must be in place

State of Utah

Utah's requirements to become a case manager include the following:

- Passing a written exam which tests basic knowledge, attitudes and case management skills
- Successful completion of a 20 hour case management practicum over a two-week period

- Familiarity with Medicaid regulations pertaining to targeted case management
- Completion of an application and maintain documentation of test results and practicum completion with the provider with whom they are employed.
- Recertification every three years with 8 hours of case management training required.

State of Vermont

Vermont's certification program applies to individuals providing case management as a service of the Department's Medicaid Waiver programs, which includes developmental disabilities case management and includes of the following requirements:

- Individuals providing case management must pass the DA&D Case Management Certification Exam.
- The Case Management Certification Exam must be taken by the time a case manager has completed her/his first year of employment, dependent upon when the next exam date is scheduled.
- The Case Management Certification Exam is offered at least twice a year. Case managers who have been employed 6 – 12 months are directed to consult with their supervisor to determine if they are prepared to take the exam.
- Case managers who are within their first 6 months of employment are discouraged from taking the exam unless they have substantial prior, relevant experience, to be determined by the agency with whom that individual is employed. Individuals who pass the exam will be designated as "Certified Case Managers".

Two National Case Management Models

The Case Management Society of America and the National Commission for Case Management Certification require that to become a case manager, individuals must meet the minimum requirements for the case manager position and pass a certification exam testing broad knowledge in case management. It should be noted that, although this certification exam includes the core competencies in behavioral health and long term care case management, the case management certification offered by these agencies is geared mainly for the broader healthcare industry and with limited content tied to the required activities and services principles within behavioral health and developmental disabilities services. The principle core areas that this certification exam tests for are represented below:

- Case management concepts
- Case management principles and strategies
- Psychosocial and supports systems
- Healthcare management and delivery
- Healthcare reimbursement
- Vocational concepts and strategies

C. Case Management Workforce Development Recommendations

Recommendation 8. Training for Case Management. A program of training and development for case managers in Virginia's behavioral health and intellectual disability services system should be established as described below. This program should include the following initiatives:

- Development of an agreed upon set of core competencies for case managers, being certain to incorporate principles of recovery, self-determination and person-centered planning. The Human Resources Committee of the VACSB has already begun work on this task.
- Establishment of a core curriculum that will provide case managers with the foundational knowledge that is needed to fulfill their role.
- Delivery of training programs on not only a statewide, but also regional/local basis.
- Development of a clearinghouse of documents, e-learning training courses and other materials specifically relevant to the provision of case management for behavioral health care and intellectual disabilities.

DBHDS should establish a Planning Committee composed of representatives of DBHDS, the CSBs, former and current recipients of services, and DMAS to take the following actions:

- Determine what organizational arrangement will be most appropriate for housing the program.
- Establish an initial vision and mission for the initiative.
- Develop a two to three year budget for the initiative.
- Propose funding options and develop a plan to secure funding.
- Develop a process to report progress to interested stakeholders.

Recommendation 9. Certification of Case Managers. The General Assembly should establish a certification requirement for case managers who provide case management services called for in §37.2-500 (Code of Virginia).

The General Assembly should amend §37.2-500 Purpose; community services board; services to be provided. – Second Paragraph:

The core of services provided by community services boards within the cities and counties that they serve shall include emergency services and, subject to the availability of funds appropriated for them, case management, provided by employees of the community services board who have completed a certification program approved by the Department.

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CHAPTER 5.   Background Report on Recruitment and Retention

A. Introduction and Background

As many will say, there is no "*silver bullet"* that will solve the recruitment and retention of health care professionals in Virginia, especially within the behavioral health and developmental services environment. Virginia, like other states, continues to face many challenges in providing an adequate qualified workforce to meet the increasing need of individuals with disabilities. Psychiatrists, registered nurses, licensed clinical social workers, case managers and direct support professionals appear to diminish in supply and many more in these professions continue to retire. Workforce challenges range from few qualified or new workers, high turnover rates across the industry, new staff unsure of their job roles and functions, lack of training opportunities and professional development, morale problems, to inadequate wages or benefits. The Subcommittee on Recruitment and Retention reviewed a variety of research and the work of other groups studying workforce issues in health care to support its Recommendations. The following discussion highlights some of this work.

In 2001, the DBHDS Commissioner, along with the Department of Behavioral Health & Development Services System Leadership Team, formed a Workforce Development Committee ("DBHDS Committee") to address the systemic issues around the workforce within the disability environment. The DBHDS Committee represented parties from the CSBs, private providers, family members and advocates, associations, educational institutions, and DBHDS. In December of 2001, a Workforce Summit, "Charting the Course for the Future System of Care," was held, bringing stakeholders within the system together across Virginia. As a part of the Workforce Summit, subcommittees were formed to address three workforce target areas—Licensed Clinical Staff, Direct Care Support Staff (Unlicensed), and Non-Traditional/Family Service Providers. As a result of this collaborative effort, a Workforce Advisory Council was established and a Workforce Development Plan with five major objectives was implemented. Today, more than fifteen workforce initiatives have been implemented to enhance the recruitment and retention of Direct Support Professionals, Registered Nurses, and Psychiatrists.

In 2004, Virginia, through DBHDD, was awarded a five-year, $3.5 million grant from the Substance Abuse and Mental Health Services Administration ("SAMHSA") to enhance the screening, assessment and treatment of co-occurring mental health and substance use disorders throughout Virginia. One of the primary goals is to develop the clinical workforce and identify where training needs exist in our system. As part of this effort, DBHDS conducted a survey of direct service staff. A full report of the survey is currently being prepared for release in the summer of 2010. The aging of the behavioral healthcare workforce is a significant issue around the country and Virginia is no exception. Sixty-three (63%) percent of Virginia's workforce is 40 and older; thirty-nine percent (39%) is 50 and older. Through the survey, professional clinical training, especially intervention skills, was identified as needed for professional development.

In August 2006, Governor Kaine issued Executive Order 31 creating a Health Reform Commission tasked with recommending ways to improve the broader healthcare system in the Commonwealth. The 32-member Health Reform Commission broke into four workgroups to examine the issues outlined in the executive order, one of which was the Healthcare Workforce. The mission of this workgroup was to bring stakeholders together to evaluate physician, nursing, and direct support professional shortages in Virginia and identify ways to increase the supply of qualified physicians, nurses, and direct support professionals in all areas of the state. The Workforce Workgroup developed an overall recommendation that would apply to all areas of the healthcare workforce throughout the Commonwealth. This included creating a healthcare data workforce center that would be housed in the Department of Health Professions. Other recommendations can be found in the Health Reform Commission Report, in a section called *Enhancing the Healthcare Workforce*.[26]

In 2007, The Annapolis Coalition on the Behavioral Health Workforce completed an extensive study and action plan on the behavioral health workforce development. The study incorporated: Persons in Recovery & Families Community Capacity; Recruitment & Retention Training & Education; and Leadership Infrastructure Research & Evaluation. There was overwhelming evidence that the behavioral health workforce was not equipped in either skills or numbers to respond adequately to the changing needs of the American population. The issues identified 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, and financing systems that place enormous burdens on the workforce to meet high levels of demand with inadequate resources.

The Annapolis Coalition identified the following seven strategic goals:

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 educated the workforce.
2. Expand the role and capacity of communi8ti8es 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.

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[26] The full report, *Roadmap for Virginia's Health: A Report of the Governor's Health Reform Commission*, September 2007, can be found online at:
http://www.hhr.virginia.gov/Initiatives/HealthReform/MeetingMats/FullCouncil/Health_Reform_Comm_Draft_Report.pdf.

The Subcommittee on Recruitment and Retention concluded for this research that it was imperative that Virginia's system of delivering services to individuals with mental illness, developmental disabilities, and substance abuse issues incorporate a focused vision that "establishes effective, consistent and comprehensive recruitment and retention tools and practices that will enhance the ability of organizations to fully staff and retain critical skill roles in the behavioral health and developmental services fields." It should also take a range of specific actions to ensure these retention tools and practices are implemented as quickly as possible.

B. Summary of Research and Data Collection

The Subcommittee on Recruitment and Retention reviewed the literature, including reports from within Virginia, nationally, and within the southeastern states to identify trends, survey data, and best practices for the critical shortage areas within the behavioral health and developmental services health care environment. The findings are described briefly below.

Virginia's Characteristics:

Virginia extends more than 400 miles from east to west and 200 from north to south. It is the 12th most populous state in the United States with more than six million people. Some counties have doubled in their populations in the last decade. Virginia's culture is varied from the eastern urban corridor to the central farming area and the western mountains. The metropolitan areas have had an influx of immigrants in the last 10 years and have become culturally diverse. The population of the Commonwealth is aging and many of those moving into the state are older adults. There are great disparities in income within localities as well as across the Commonwealth. Efforts have been made to make health care more accessible but consolidation in the health care system has strained community resources for out-of-hospital care. The major reasons for hospitalization in Virginia are childbirth, mental illness, heart and pulmonary diseases.

Psychiatrists

Experts across the country predict severe shortages in the numbers, specialties, and distribution of psychiatrists. Recruitment of psychiatrists, particularly in more rural areas, already challenging, will face even greater challenges. This predicted shortage of psychiatrists is due to three primary factors:

> 1. The number of physicians training for psychiatry has remained static for the past ten years. In 2008, approximately 870 residents and fellows completed their training in general psychiatry. There are likely several reasons for this but a key one is the low reimbursements for psychiatric care. Furthermore, shortages among some specialties may be worse than the average. Among those training for psychiatry, for example, relatively few (282 in 2008) specialized in Child and Adolescent care.

(2) The population of psychiatrists is aging and many are retiring. Approximately 82% of the psychiatrists in the US are over the age of 45, and 53% are over 55. Because the average age of physician retirement also has decreased from 65 to 61 and the number of retirees now far exceeds those coming out of training there is a net loss in the total number of psychiatrists in practice.

(3) The service demand for behavioral health is rapidly increasing. According to the Bureau of Health Professionals, the demand for child and adolescent psychiatrists is projected to increase by 41% by 2020, and that for general psychiatry is projected to increase by 16% for the general population by 2020 (using 2005 as the baseline)[27]

Psychiatrists in Virginia

As of December 2005, the American Medical Association ("AMA") reported that there were 1,261 psychiatrists in Virginia or 2.6 per 10,000 people statewide. . Although this average does not rise to the Health Services and Administration's ("HRSA") designation of an area with a "manpower shortage" qualifying for federal support, it does mask local deficiencies because seven localities accounted for half of the solo or primary practice psychiatrists—Fairfax County, Henrico County, Albemarle County, City of Richmond, City of Virginia Beach, City of Charlottesville, and the City of Norfolk.[28] The shortage is not consistent statewide with 47 localities, mostly rural, not having a psychiatrist. In addition, the shortage is attributed to Medicaid reimbursement rates are lower than the rates paid by Medicare and private insurance.

Currently, DBHDS has 72 psychiatrist positions filled across the Commonwealth with a range of 7 to 10 vacancies, mostly in southwest Virginia. When recruiting psychiatrists within the state system, it is reported that in some cases it has taken over 2 years to fill the position. Locum Tenens, or wage psychiatrists, have been used as a "stop gap" during these vacancy periods but this is a particularly expensive solution to the shortage, costing up to $1,170 per day. Of the CSB's reporting, many use or supplement with contract psychiatrists to provides psychiatric services within their locality. Turnover for CSB-based psychiatrists was reported as high as 28% as compared to 18% for state behavioral health facilities.

In accordance with the Watson Wyatt Survey data (2007) for the Mid-Atlantic States, the median salary for a psychiatrist is $180,500. Virginia's salaries are lower, which may explain some of the challenges of recruiting. The median salary for DBHDS is $167,637

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[27] Health Resources and Services Administration, Bureau of Health Professions, *Physician Supply and Demand: Projections to 2020*, October 2006. Available at: ftp://ftp.hrsa.gov/bhpr/workforce/PhysicianForecastingPaperfinal.pdf.

[28] HRSA'a designation of a manpower shortage area is a function of the ratio of other mental health professionals as well as psychiatrists, the level of need for mental health services, and geographical barriers as well. See the following information published by the American Psychiatric Association: http://www.psych.org/Departments/HSF/UnderservedClearinghouse/Linkeddocuments/fedmanpowershortagecfm.aspx. HRSA's guidelines for designating a manpower shortage area are not necessarily the same as setting a recommended ratio of psychiatrists to population.

and for southwest Virginia, where it is difficult to recruit, the salary is $187,994. According to the Bureau of Labor Statistics Survey, of 550 psychiatrists surveyed in Virginia the average salary was $169,300 (2007).[29]

Virginia mirrors the national trend and with decreasing numbers entering the psychiatric medical profession and the retirement of current psychiatrists. The behavioral health and developmental services system faces a severe shortage, particularly in the rural areas of the Commonwealth.

One of the programs that has been successful in recruiting and retaining psychiatrists in Virginia, specifically in the rural areas, has been the Physician Loan Repayment Program. This program offers substantial financial assistance for repayment of qualified medical education loans for primary care physicians*, psychiatrists,* nurse practitioners, and physician assistants. This Virginia program allows payment of $25,000 a year, up to a maximum of $50,000, with a minimum service obligation in Virginia for two years. Subsequent extensions of the loan repayments are entitled to annual loan repayments of up to $35,000. The loan repayment program is for two years and may be extended for a third year. The cost of the Physician Loan Repayment Program vs. the costs associated with the repeated recruitment or replacement of psychiatrist's positions, including locum tenens fees is minimum.

Another program found to be successful in recruiting medical students to the field of psychiatry in Virginia and nationally, has been offering psychiatric fellowships. This program offers a full-time one-year fellowship designed to provide a comprehensive and practical training experience for medical students. Stipends paid for fellowships range from $58,000 to $63,000 per fellowship. The fellowships, which are paid by employers under agreement with the medical school, have been shown to increase the likelihood that participants will stay with the organization or the area.

Nursing

The current demand for full-time-equivalent ("FTE") Registered Nurses ("RNs") in the United States significantly exceeds the available supply. A growing shortage of registered nurses has been projected over the next 15 fifteen years, with a 20 percent shortage by 2015. [30] A recent study found that despite the current easing of the nursing shortage due to the recession, the U.S. nursing shortage is projected to grow to 260,000 registered nurses by 2025. A shortage of this magnitude would be twice as large as any nursing shortage experienced in this country since the mid-1960s.[31] The projected shortage is the result of the expected increase in demand coupled with a relatively stable supply of RNs.

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[29] Watson Wyatt Survey, 2007; U.S. Bureau of Labor Statistics (2007).

[30] HRSA, Bureau of Health Professions, *Toward a Method for Identifying Facilities and Communities with Shortages of Nurses,* February 2007. Available at: http://bhpr.hrsa.gov/healthworkforce/nursingshortage/default.htm.

[31] Buerhaus, Peter I., Auerbach, David I., and Staiger, David O. "The Recent Surge In Nurse Employment: Causes And Implications," Health Affairs, 28, no. 4 (2009): w657-w668 (Published online 12 June 2009).

Policy, legislation, and budgetary changes will be necessary to help ease the burden of the nursing shortfall shortfall.

Nurses play a critical role within the healthcare community. Meeting the existing and future demands for nurses is vital to the stability of Virginia's healthcare system. The shortage of registered nurses and other allied health professionals in Virginia is a critical workforce issue that the Commonwealth must continue to address and emphasize through policy, legislation, and budgetary decisions. Key findings of the 2004 report of the State Council on Higher Education for Virginia (SCHEV"), *Condition of Nursing and Nursing Education in the Commonwealth*,[32] indicate that:

> 1. The demand for nursing services in the Commonwealth is growing. General population growth, an increase in Virginia's aging population, and trends in healthcare services utilization are major causes for the increasing demand for qualified nurses.
> 2. The supply of RNs will become inadequate as demand continues to grow. Additional nurses are needed to meet this demand and to replace those nearing retirement.
> 3. Numerous nursing education programs are located in Virginia, but serious limits exist in the number of applicants that can be accepted. Any expansion of nursing education programs is dependant on having an adequate number of and well-prepared nursing faculty.

As the segment of Virginia's population above age 65 increases, so does the demand for qualified nurses. At the same time, factors both within and outside the healthcare profession have rendered increasing the supply of nurses and nursing faculty difficult. Combined, these conditions have left Virginia with a nursing shortage that is anticipated to escalate. Although the RN shortage is a national problem, Virginia's projected supply shortage is slightly higher than the national average based on the growing demand for medical care. The demand for FTE RNs in Virginia is expected to increase by roughly 43 percent between 2000 and 2020. The supply of FTE RNs in Virginia is anticipated to be 47,000 by 2020; however, demand is expected to exceed 69,600. This is a shortfall of 22,600 or 32.6 percent. To meet this demand it is expected that RN supply will have to increase by 60 percent.

Nurses play a key role in assuring quality, cost-effective health care. They work to diagnose and treat responses to health or illness. Nurses are employed in all sectors of health care and business and have considerable impact in promoting health. The health of the population is at risk when there is an inadequate supply of nurses or if they are inappropriately prepared to meet the present and future demands for health care. Women -- who make up about 95 percent of the nursing profession -- today have far more career options than did their mothers, many of whom became nurses because other jobs were inaccessible. The strong economy has lured bright young people into other professions.

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[32] Available at: http://www.schev.edu/Reportstats/ConditionOfNursingReport-Jan2004.pdf?from=

The Virginia Board of Nursing licenses over 80,000 RNs over 30,000 licensed practical nurses ("LPNs"), and 35,000 certified nurse aides. More than 4,000 of the RNs are licensed as nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists. However, no data exist about the distribution, age, race/ethnicity, employment status, and educational background of these licensees.

Nationally the average age of a nurse is 44 years old and shortages of advanced practice nurses and faculty are being reported (Moses, 1996).[33]. Without data on the education, age and race/ethnicity of the largest number of health care providers in the Commonwealth, planners are unable to determine if the workforce is adequate and representative of the population. Nurse educators, health care providers, regulators, and health policy and educational planners cannot effectively determine whether Virginia's nurses are appropriately educated and geographically located to deliver effective health care to Virginia's citizens.

Nursing in Virginia

Within six years, Virginia's demand for nurses will be 30 percent greater than its supply. In 2010, the first of 78 million baby boomers will turn 65, an age when people often start to need more medical care. In Virginia, individuals over 65 and make up 11 percent of the population but represent 35 percent of the hospital population. This increases the need for nurses and other health care workers.

Hospitals already are having trouble filling vacancies. A 1999 report from the American Organization of Nurse Executives found that half of all hospitals were having trouble finding critical care nurses and 40 percent were struggling to find qualified emergency and medical/surgical nurses. The Virginia Hospital and Health Care Association conducted a survey of its members in 2000. The findings indicate that Virginia follows the national pattern for nursing vacancies, recruitment and retention. Nurse shortages have led hospitals to close beds, reduce admissions and surgeries and to divert patients from emergency rooms. Replacing a nurse takes an average of nearly three months and new graduates are being recruited to positions that were available only for experienced nurses in the past. Virginia hospitals lose about 18 percent of their RNs every year, which leaves some units perpetually understaffed. Turnover is even greater in urban areas, where much of the population is transient.

Traditional measures of increasing student enrollment in schools of nursing, offering bonuses to nurses and even raising salaries are not enough to address the looming shortage. New ways of recruiting, educating and employing nurses are essential to meet the health needs of the citizens of the United States.

As many recruitment and retention initiatives have been implemented across the country, the shortage remains the same in many areas of the country, including Virginia, especially psychiatric nurses. In the research of the Subcommittee on Recruitment and Retention, a new initiative that has not been implemented was the possibility of extending

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[33] SHEV (2004). Con*dition of Nursing and Nursing Education in the Commonwealth*, Richmond, VA.

the Loan Repayment Program for nurses. With the high costs of education and the burden of financial loans encumbered on this profession, this incentive offers a significant recruitment and retention tool for the system.

Licensed Clinical Social Workers and Case Managers

Virginia faces a critical shortage of mental health professionals. Most of these shortages are most prevalent in disadvantaged urban and rural areas. Existing supply gaps in providers are likely to deepen in the future. The shortage within the core disability professions—social work and counseling will continue as the aging workforce begins to retire and fewer people enter these professions.   The projected growth in job demand for these selected professions by 2012 may increase by more than 20%. Some studies have concluded that counselor's working in hierarchical organizations were significantly more emotionally exhausted. In addition, fair distribution of workload and rewards also contributed to emotional exhaustion and turnover.

In Virginia, the demographics continue to demonstrate in health care professionals, such as counseling and social work, a large percentage of women (75%), Caucasian, and more than 65% over the age of 40. 26% have worked in behavioral healthcare for more than 20 years and more than 43% have a Master's degree and 27% have a Bachelor's degree. Less than 8% have an Associate's degree.

Continuing clinical workforce data is being collected to enhance the screening, assessment and treatment of co-occurring mental illness and substance use disorders in Virginia. One of the primary goals is the development of the clinical workforce that is trained to address the complex needs of consumers. Major obstacles still are prevalent such as training budgets, logistical barriers such as training and travel limitations and workload of these healthcare professionals.

As with psychiatrists, social workers in the Virginia labor force are predominately in the following localities: Charles City-Goochland-Henrico-New Kent; Chesterfield-Powhatan-Colonial Heights; Fairfax-Falls Church; Prince William-Manassas; City of Richmond; and the City of Virginia Beach.

As with many healthcare clinicians, licensed clinical social workers, predominately in rural areas, remain to be in short supply. The Subcommittee on Recruitment and Retention recognized that the Loan Repayment Program, known to be successful in recruiting psychiatrists and nurses, might also benefit the demand for social workers in the rural areas of the Commonwealth. With the rising costs of education and the burden of financial loans encumbered on this profession, this incentive offers a significant recruitment and retention tool as well for the system.

A statewide taskforce to study this workforce initiative could be beneficial.

Direct Support Professionals

Direct Support Professionals ("DSP"s) take on many different roles and provide care to a wide range of people. The Subcommittee on Recruitment and Retention decided that using the term direct support professionals truly encompassed the tough, demanding, challenging, and varied work these professionals take on. Included under this heading are the following job titles: certified nurse aides, orderlies, attendants, home health aides, personal care aides, home care aides, personal care attendants, psychiatric aides, direct care workers, direct services associates, paraprofessionals, medication aides, and community health workers.

The country's population is aging. In fact, those who are 85+ will be the fastest growing segment of the population until 2050. In addition, there are millions of Americans below the age of 65 who have some type of permanent or long lasting disability. In the Supreme Court's 1999 Olmstead decision, states are required to offer community based services as an option. There is expected to be a significant increase in the need for direct support professionals due to the aging of the population and the growing number of Americans with disabilities.

Between 2004 and 2010 it is projected that number of jobs available in the long-term care sector will increase by 45 percent. This is significantly higher than the increase in total U.S. employment of 15 percent and even outpaces the increase in registered nurses and licensed practical nurses. While there is expected to be tremendous growth in the number of jobs available, clients and providers currently face many challenges including high vacancy and turnover rates. Vacancies create significant problems for clients, who often go without the needed support until a worker can be found. In addition, high vacancy rates are challenging for providers who often have to use contract labor to fill positions and may have a difficult time recruiting people into these roles. Turnover rates are challenging in that they can disrupt a client's care and can cost providers a significant amount of money in training, orientation, education, etc. Various issues negatively impact the direct support professional workforce and the recruitment of people into this field. This is a segment of the healthcare workforce that has low wages, limited access to health insurance, limited access to paid-time off, vacation days, and/or sick days, and a challenging work environment.

Across the country the average wage rate for DSP workers is $8.21, which is not significantly different from the federal minimum wage. Between 1999 and 2002 the average wage rate increased by 9.2 percent. While this is a positive trend, the base wages are so low that it does not retain or recruit more people into the DSP workforce. In addition, employers of DSPs are often competing with the retail sector. Retail employers offer comparable wages and have a less stressful and arduous work environment. Finally, the DSP workforce is often considered a secondary labor market that requires little skill. Few aspire to do the work and policy makers and educators have historically not spent time focusing on the needs of this workforce and its clients.

Direct Support Professionals in Virginia

Like the nation, Virginia is experiencing an aging of its population. In fact, Virginia's elderly population is growing at an increased rate relative to the rest of the nation. In 2000, 792,333 or 11.2 percent of Virginia's population was aged 65+, a 19.2 percent increase since 1990.[34] The U.S. Census estimates that by 2030 Virginia's elder population will increase 132.7 percent. During this same time, the traditional care giving workforce, women aged 25 to 44, is only expected to increase 15.9 percent. Based on population demographics alone, the Commonwealth must act now in order to increase the supply of the DSP workforce and must work to recruit different individuals, particularly those from non-traditional labor pools. Virginia's long-term care support system includes a network of institutions, federal and state funded community programs administered through various agencies, and over two hundred home health service providers. According to a 2002 survey by the American Healthcare Association, the statewide vacancy rate for Virginia certified nurse aides, was 8.2 percent, and the turnover rate was 73.2 percent.[35] It is expected that these numbers will continue to worsen as the population ages. Coupling this with the turnover and vacancy rates, the 'care gap' between those needing care and those available to care will widen.

Many studies have documented that DSPs are essential to delivering high quality services to an individual with disabilities. However, direct service work is physically and emotionally demanding and the working conditions are often unfavorable when compared to alternative employment possibilities so both recruitment and retention for such work is difficult. To improve services, reduce high turnover, and create an improved learning environment, a pilot program to improve the recruitment and retention of DSPs was launched in 2003. In 2005, improvement of DSP recruitment and retention was made a priority of the DBHDS Workforce Advisory Council by the development of a Direct Support Professional Career Pathway Program ("DSP Program").

The DSP Program encompasses the direct support service employee completing a web-based training program, College of Direct Support, competency check-offs consistent with the National Community Skills Standards, and the continuation of career studies certificate programs offered by the Virginia Community College System in mental health,

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[34] Center for Workforce Studies. *Key Physician Data by State with Virginia Highlights,* (2006). Association of American Medical Colleges.

[35] American Healthcare Association. (2003). Survey of Nursing Staff Vacancy and Turnover in Nursing Homes. Retrieved July 20, 2007, from: http://www.ahca.org/index.html. Washington, D. C. Many other studies, reports and handbooks have been published from across the country to address these challenges over the past years. Some noted, include CMS Direct Service Workforce Demonstration, Promising Practices in Marketing, Recruitment and Selection Interventions, prepared by University of Minnesota, Research and Training Center on Community Living in partnership with The Lewin Group (December 2006); Staff Recruitment, Retention, & Training Strategies For Community Human Services Organizations by Sheryl A Larson, Ph.D., & Amy S. Hewitt, M.S.W., Ph.D. with invited contributors, the American Network of Community Options and Resources, 2008 Direct Support Professional Wage Study and their Performance Excellence Benchmarking: National Facts and Figures to Guide the Future of Supports and Services, Will the Last Physician In America Please Turn Off The Lights? By James Merritt, Joseph Hawkins, and Phillip B. Miller to The Annapolis Coalition.

developmental disabilities, and human services. With more than 8,000 learners participating in the College of Direct Support curriculum statewide, the DSP Program has progressively shown success in increasing the value of services offered and developing a profession in Virginia for direct support workers. The Subcommittee on Recruitment and Retention found the continuation and expansion of the DSP Program to be beneficial in increasing competencies of the DSP workforce, adding value to the services provided, and providing professional growth to a workforce that is often overlooked, underpaid and undervalued.

Data Review and Analysis

In 2003, DBHDS completed a survey of system stakeholders with a 31.4% response that collected data on the workforce recruitment and retention of Direct Service Workers, Registered Nurses, Psychiatrists, Licensed Clinical Social Workers, and Masters Level Non-licensed Social Workers ("DBHDS Workforce Development Survey"). The DBHDS Workforce Development Survey results indicated that the two top impact items for any of the disciplines were "compensation rates" and "competition from other employers." Adequate staffing levels for any of the disciplines ranked third or fourth.

As a result of the DBHDS Workforce Development Survey and the collaborative work of a Workforce Subcommittee making recommendations, charged by the DBHDS's System Leadership Team, DBHDS established a Workforce Advisory Council and the Department's first Workforce Development Plan in 2004.

As a part of this Subcommittee's examination of recruitment and retention of behavioral health professionals in Virginia, we conducted a mini-survey in of our state facilities and CSBs regarding the critical staffing needs or hard-to-fill healthcare positions.[36] Our survey collected data related to six professional positions including: Psychiatrists, Registered Nurses, Licensed Clinical Social Workers, Case Managers, Therapists and Direct Support Professionals. The data collected included:

- # of filled positions
- service
- turnover percentage
- # of employee eligible to retire
- average age, average salary
- % of minorities; and % of females

Due to our limited ability to survey the private sector this Subcommittee relied on a recent study by the American Network of Community Options and Resources ("ANCOR") that included Virginia.[37] In addition, we reviewed DBHDS's Virginia

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[36] The Subcommittee's survey was sent to all 40 CSBs and all state facilities. 13 CSBs (32.5 %) responded and 100% of state facilities responded to the survey.

[37] The American Network of Community Options and Resources is a national association representing more than 850 private providers of community living and employment

Service Integration Project ("VASIP") efforts in workforce across the Commonwealth. The findings of this Subcommittee's survey as well as the review of the other sources of data are discussed below.

DBHDS Survey Data Summary

Turnover rates for behavioral health professionals in state facilities and CSBs are high requiring a constant effort to recruit replacements. These rates vary somewhat by profession as shown in the table below.

Professional Category	Turnover Rate	Average Age
Direct Support Professionals	25%	43
Registered Nurses	20%	50
Psychiatrists	18%	54
Licensed Clinical Social Workers	13%	46
Case Managers	8%	49

As the data show, the highest turnover rates are for the DSP's who tend to have the least training, lowest pay, and most client contact. However, turnover rates for registered nurses and psychiatrists, at 20% and 18%, respectively, are also alarmingly high, particularly since recruitment for these positions tends to be more difficult. It is also notable that the ages across all of these professional categories are high and, unless significant efforts are made to attract younger professionals, waves of retirement will further decimate the Safety Net Workforce. Together, the aging workforce and the shortage of workers entering and staying in our public mental health system will continue to have a significant impact.

Community Service Boards Data Summary

The CSBs data provided the Subcommittee on Recruitment and Retention with both a rural and metropolitan perspective on the Safety Net Workforce.   Psychiatric staffing of the CSBs varied with some opting for contract psychiatrists and others utilizing both staff and contract psychiatrists for the most flexibility. The average age of staff psychiatrists was 56.

Similarly to the case with the state facilities, turnover rates for all professional categories was high and the average ages of the behavioral health personnel in CSBs was relatively old. A summary of this data is shown in the table on the next page.

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supports and services to more than 400,000 individuals with disabilities. The ANCOR Wage Study can be accessed at: http://www2.ancor.org/.

Professional Category	Turnover Rate	Average Age
Direct Support Professionals	42%	42
Case Managers	31%	40
Psychiatrists*	28%	
Nurses	28%	51
LPC and LCSW	17%	49

*Data for psychiatrists was limited. The 28% was reported by one CSB.

Again, the data indicated an aging workforce and health care professionals separating at high rates will add to impact on the quality of services provided within our system.

American Network of Community Options and Resources Wage Study

Medicaid is the largest source of funding for disabilities services in the United States. As the ANCOR Wage Study relates to individuals with developmental disabilities, it provides data within our system of the wage differential between public and private organizations for DSPs. An aggregate overview of the 2008 ANCOR Wage Data Analysis follows:

NATIONAL

Nationally, there are substantial differences in the average entry level for DSPs in the private versus the public sector, which may explain much of the difficulty in recruiting DSPs in Safety Net facilities. DSPs can expect to earn 42% more upon entry at private facilities. This public/private differential becomes even greater with experience, a likely factor in the high turnover rate at public behavioral health facilities. The ANCOR Wage Study shows that the overall average wage differential for DSPs employed in the private sector to be 57% higher than in the public sector.

Aggregate	DSP Private Entry Wage	DSP State Entry Wage	Wage % Difference State vs. Private Entry	DSP Private Average Wage	DSP State Average Wage	Wage % Difference State vs. Private Average
	$8.53	$13.13	42%	$9.85	$15.48	57%

VIRGINIA

The situation is not quite so bleak in Virginia where wages for the public sector DSP positions are higher and for the private sector a bit lower than national averages. However, public entry-level wages are still 11% lower than those for the private sector and, with experience, this differential jumps to 35%. It would seem likely that although the challenges in recruiting for public DSP positions versus private DSP positions might not be as great as in other locals, retention remains a serious challenge.

Aggregate	DSP Private Entry Wage	DSP State Entry Wage	Wage % Difference State vs. Private Entry	DSP Private Average Wage	DSP State Average Wage	Wage % Difference State vs. Private Average
	$10.32	$11.50	11%	$11.11	$15.03	35%

DBHDS Virginia Service Integration Project Data Summary

One of the primary goals of DBHDS's Virginia Service Integration Project ("VASIP") is the development of a clinical workforce trained to address the complex needs of consumers with co-occurring disorders. To identify where training needs exist, VASIP conducted a survey of direct service staff that provide mental health and/or substance abuse treatment services in Virginia's CSBs, and state hospitals ("VASIP Survey").[38] The VASIP Survey was designed to measure demographic information, educational background, professional experience, and training needs of the workforce as part of its primary goal of workforce development. The VASIP Survey was designed to assess the current ability of the Safety Net Workforce to address the complex needs of the Safety Net Workforce, as well as to determine what training and educational needs exist. The survey instrument was developed over an 18-month period with the assistance of a variety of public and private agencies on the national, state, and local level. Over 3,000 workers from CSBs and state facilities responded and took part in the online VASIP Survey.

The VASIP Survey confirmed that Virginia's behavioral healthcare workforce was aging (over 63% were more than 40 years old) and disproportionately female (75%). Both demographics require close attention given the increasing difficulty in attracting new people into training programs in mental health, generally, and growing educational levels of women who might well opt for higher paying professions. Further the VASIP Survey found a high level of interest in greater educational and training opportunities in 30 identified areas. Highest among them were training in intervention skills, co-occurring disorders,

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[38]VASIP Workforce Survey Report, Prepared by The Virginia Service Integration Program (VASIP) Team Virginia Department of Behavioral Health and Developmental Services, December 14, 2009. Available at: https://www.dmhmrsas.virginia.gov/vasip/documents/vasip-Survey-WS-Report.pdf.

identification of mental health disorders, counseling, evidence based practice, and screening and assessment. Geographical and financial barriers to ongoing training were cited. Nearly two-thirds of this workforce was interested in internet-based trainings, and nearly three quarters of them have the ability to take part in such training.

Best Practices Summary

In addition to reviewing data about the composition of the Safety Net Workforce, and challenges to recruiting and retaining behavioral health professionals, this Subcommittee examined "best practices" within and outside of the Commonwealth. Both state and community organizations were surveyed which included state facilities and CSBs. In May 2009, the following states' recruitment and retention strategies and practices were surveyed: North Carolina, South Carolina, Georgia, and Florida. In addition, additional information was collected regarding best practices across the nation including: PHI Resource Guide On Recruitment and Retention For Direct Service Workers in Long Term Care, CMS Direct Service Workforce Demonstration Promising Practices in Marketing, Recruitment and Selection Interventions, Annapolis Coalition Report, and the information collected with the Commonwealth's Health Reform Commission.

The following is a summary of the "best practices" information concerning state facilities within DBHDS this Subcommittee reviewed:

- Sponsorship of the College of Direct Support and the DSP Career Pathway Program;
- Internet Recruitment;
- Targeted recruitment, including bi-lingual candidates;
- Career/Job Fairs, Open House and Tours;
- Sign-On Bonuses, Relocation Allowances; and use of the Total Compensation Calculator;
- International RN Recruitment Program;
- Mentorship Programs;
- Referral Bonuses; spot awards; employee recognition programs/awards; self-scheduling for nurses;
- Partnerships with the local SkillSource Programs; and
- Partnerships with military organizations.

In examining the responses from the sample CSBs, the following is a summary of the information provided:

- Tuition reimbursement;
- Advancement and career progression programs;
- Compensation and Benefits, including sign-on bonuses;
- Wellness Programs;
- Field practicum for ICSW or lPC License;
- Credit for years of job related service ;

- Case Management Productivity Incentives;
- Credentialing bonus to new hires; and
- Training Academy/University and Case Managers in Training Programs (CMT)

The following is a summary of the following Southeastern States' recruitment and retention strategies and practices that were surveyed. The States included: North Carolina, South Carolina, Georgia. And Florida.

- Sign-On Bonus
- Referral Bonus
- Retention Bonus
- Educational Leave
- Paid Practicum
- Loan Repayment
- Tuition Assistance
- Military Outplacement Services
- University Career Centers
- On-boarding Techniques
- Paid Time Off
- Flex Work Schedules
- Employee Assistance & Wellness
- Employee Recognition
- Staff Development & Training
- Employee Suggestion Program (EAP)
- Tax Credit for Rural Setting

Other resources examined were the CMS Direct Service Workforce Demonstration Promising Practices in Marketing, Recruitment, and Selection Interventions, the American Network of Community Options and Resources (ANCOR—2008 Direct Support Professional Wage Study, and the Annapolis Coalition of Behavioral Health Workforce with SAMSHA, and the U.S. Department of Health and Human Services ("DHHS").

In evaluating the information, this Subcommittee believes that the action plan proposed by the Annapolis Coalition of Behavioral Health Workforce ("Annapolis Coalition") and partners sums up much of which is needed not only in Virginia's behavioral health system but across the country and is consistent with this Subcommittee's findings and Recommendations incorporated in this report. As their Goal 3, the Annapolis Coalition recommended implementation of systematic recruitment and retention strategies at the federal, state, and local levels. Their objectives outlined are as follows:

- Disseminate information and technical assistance in effective recruitment and retention strategies;

- Select, implement, and evaluate recruitment and retention strategies tailored to the unique needs of each behavioral health organization;
- Expand federal financial incentives, such as training stipends, tuition assistance, and loan forgiveness, to increase recruitment and retention;
- Provide wages and benefits commensurate with education, experience, and levels of responsibility;
- Implement a comprehensive public relations campaign to promote behavioral health as a career choice;
- Develop career ladders;
- Expand the use of "grow your own" recruitment and retention strategies focused on residents of rural areas, culturally diverse populations, and consumers and families; and
- Increase the cultural and linguistic competence of the behavioral health workforce.

This Subcommittee also examined other initiatives or programs that appear to have merit in recruiting and retaining behavioral professionals including the potential of tax credits for training or working in underserved areas, On-boarding programs,[39] and resource development, such as expansion of a centralized website for all stakeholders on a state-wide basis.

The Subcommittee on Recruitment and Retention urges that a study be done to examine whether the tax credits, currently allowed in some states for physicians who work in rural or underprivileged areas, could be made available for nurses and clinical social workers.

An additional consideration should include, establishing a model On-boarding Program that can be utilized by public and private providers of behavioral health and developmental disabilities. This program would offer a process for integrating employees into their new work environment. On-boarding focuses on: a strong employer welcome; affirmation of the employee's right of choice in a job; affirmation that the employee fits into the organization, and long-term relationship building. The On-boarding Program not only includes new employee orientation but is much more comprehensive approach and can last from 3 months to 2 years, depending on the position. A well-designed On-boarding Program may reduce costs, hasten time to productivity, and improve retention for the system.

Many states have a website resource for workforce development and planning. Although website on Workforce Development and Innovation was developed in 2003 by DBHDS, this Subcommittee recognized the continuing need to expand this resource to include additional resources, best practices and compensation toolboxes for critical health care professionals was needed. This would enable the sharing of resources and reduction of duplicative efforts in provider organizations and allow for collaboration and partnerships to be developed in addressing systemic issues in recruitment and retention.

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[39] SHEV. (2004), Condition of Nursing and Nursing Education in the Commonwealth, Richmond, VA

C. Recruitment and Retention Recommendations

Recommendation 10. Continue and Expand a Physician Loan Repayment Program.
It is recommended that the Physician Loan Repayment Program, which has helped to
recruit and retain physicians to rural state facilities, be continued and expanded. This
program was recently eliminated as a result of budget reductions. This program has been
offered through the Bureau of Health Professions ("BHPr"), Division of State,
Community and Public Health & the Virginia State Loan Repayment Program (VA
SLRP) a loan repayment program for medically underserved areas of the state, especially
for psychiatrists. The cost of these programs is $25,000 and $35,000 per year for a
maximum of two years per physician. The biennial cost for 10 physicians ranges from
$500,000 to $700,000.

Recommendation 11. Establish Psychiatric Fellowships. DBHDS should establish
psychiatric fellowships through a partnership between DBHDS and medical schools
located in Virginia. Each one-year fellowship costs approximately $60,000. The biennial
cost of 10 fellowships is approximately $1.2 million.

Recommendation 12. Expand Direct Support Pathway Program. It is recommended
that the Direct Support Pathway Program be expanded to create a new level of direct
service position entitled Direct Support Professional in Virginia for state facilities,
community services boards and private providers. This program provides for an increase
in compensation for direct support employees who develop additional competencies. The
Direct Support Pathway Program is provided through a collaborative partnership
involving DBHDS, the College of Direct Support and the Virginia Community College
System. The anticipated biennial cost of this program would be approximately $1.5
million dollars.

**Recommendation 13. Loan Repayment Program for Nurses and Clinical Social
Workers.** DBHDS should establish a statewide task force to study the potential value
and cost of creating a Loan Repayment Program for nurses and clinical social workers in
Virginia.

**Recommendation 14. Examine Tax Credit Changes for Nurses and Clinical Social
Workers.** DBHDS should propose changes in the Code of Virginia that would enable
expansion of the Tax Credit Program that currently allows certain tax credits for
physicians who work in rural and underprivileged communities to also be available to
nurses and clinical social workers.

Recommendation 15. Develop a Model On-Boarding Program. DBHDS should
establish a statewide taskforce to develop a model On-Boarding Program that can be
utilized by public and private providers of behavioral health and intellectual disability
provider organizations across the state. On-boarding is the process of integrating

employees into their new work environment. It is the last stage of the recruitment process and the first step toward retention. These programs continue well past the traditional new employee orientation and can last from 3 months to 2 years, depending on the position and the employee.

Recommendation 16. Expand Workforce Development Website. DBHDS should expand its Website on Workforce Development and Innovation (WDI) to include resources, best practices and compensation toolboxes for critical health care professionals. This will enable the sharing of resources and reduction of duplicative efforts in provider organizations. It will also lead to the implementation of more effective recruitment and retention practices statewide.

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APPENDIX

ACRONYMS

ANCOR	American Network of Community Options and Resources
BHPr	Bureau of Health Professions
CIMH	The California Institute of Mental Health
CMS	Center for Medicare and Medicaid Services
CSB	Community Service Board
DBHDS	Department of Behavioral Health and Developmental Services
DHHS	U.S. Department of Health and Human Services
DMAS	Department of Medical Assistance Services
DRS	Department of Rehabilitation Services
DSP	Direct Service Provider
DSS	Department of Social Services
KSA	Knowledge, Skills, and Abilities
LEAD	Leadership, Educating and Developing
MVP	Managing Virginia Program
NACM	National Association of Case Management
OIG	Office of the Inspector General
PACT	Program of Assertive Community Treatment
SAMHSA	Substance Abuse and Mental Health Services Administration
SCHEV	State Council on Higher Education for Virginia
SEI	Senior Executive Institute
HRSA	Health Research and Services Administration
VaCPM	Virginia Certified Public Manager
VACSB	Virginia Association of CSBs
VHST	Virginia Health Services Training
VOCAL	Virginia Organization of Consumers Asserting Leadership
WRAP	Wellness Recovery Action Plan