Critical Priorities Confronting State Mental Health Agencies

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The authors of this column report on an environmental scan conducted via intensive interviews of the 55 state and territorial state mental health agency (SMHA) directors who collectively oversee a $28 billion budget and serve nearly six million Americans who have a serious mental illness. Currently, a dynamic set of forces are substantively reshaping the role, resources, and capacities of the SMHA within the larger fabric of state government. As such, SMHA directors developed year 2007 priorities. These priorities include integrating health and mental health care, enhancing consumer empowerment, addressing mental health workforce crises (for example, training and recruitment), and ensuring financial stewardship. (*Psychiatric Services* 58:1148–1150, 2007)

As in past years (1,2), we report on an environmental scan conducted via intensive interviews of the 55 state and territorial state mental health agency (SMHA) directors, who collectively oversee a $28 billion budget and serve nearly six million Americans who have a serious mental illness (3). With 70% of these fiscal resources currently expended on community-based programs, the future decisions these directors make regarding the allocation of human, fiscal, and technical resources under their direct control will have profound implications for the public mental health sector. Currently, a dynamic set of forces are substantively reshaping the role, resources, and capacities of the SMHA within the larger fabric of state government. This column details the SMHA directors' year 2007 priorities, which influence the role of the SMHA within state government and with stakeholders.

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1998–2006

Past (1998–2001) SMHA priorities created efficiencies in the management of SMHAs through developing models of managed care, securing Medicaid waivers, implementing internal reorganizations, rebalancing funds between state hospital and community programs, privatizing selected facilities, and following sophisticated cost-accounting practices. More recently (2002–2003), new program initiatives—including linking criminal justice and mental health systems, initiating trauma services, serving persons with co-occurring disorders, and implementing recovery-oriented services—expanded the traditional boundaries of SMHAs. These efforts altered the traditional clinical-diagnostic perception of the client population in the public mental health sector, reconsidered the role of providers, and responded to consumers' vision of achieving recovery.

From 2004 to 2006, SMHAs developed new program models to maximize consumers' access to new second-generation psychotropic medications, dramatically reduced the use of seclusion and restraint in state-operated psychiatric inpatient facilities, implemented person-centered care, and expanded the use of performance and outcome measures.

2007 priorities

Integrating health and mental health

Persons served by SMHAs demonstrate a high prevalence of multiple and complex co-occurring conditions, including obesity, diabetes, substance abuse, coronary heart disease, and smoking-related illnesses (44% of all cigarettes are smoked by persons with mental illness [4]). The National Association of State Mental Health Program Directors (NASMHPD) Medical Directors' Council has documented a loss of 25 years from the lifespan of persons with serious mental illness (5). In response to these health issues, SMHA directors will aggressively adopt a public health approach designed to integrate health and mental health services.

A separate and challenging cohort of persons who have co-occurring substance abuse conditions is being referred to the SMHA from corrections, juvenile justice, and other public-sector agencies. These referrals are accompanied by a burgeoning forensic and violent sexual predator population that currently accounts for 33% of all state hospital expenditures (6).

The gap between need and sufficient service capacity continues to widen. More citizens are seeking care as a result of population growth and of reduced societal stigma about accessing mental health care. In addition, the nationwide shortage of public and private acute care beds results in pressures on general hospital emergency departments, which

can create poor triage, ineffective service, and waiting lists to access short and intermediate mental health care. This bed shortage has created blurring of public and private roles and responsibilities because clients with similar characteristics seek services in both sectors. In response, SMHAs plan to increase screening to prevent the risk of serious mental illness from developing through early intervention and to expand the number of persons served via public services.

Enhancing consumer empowerment

To ensure the relevancy of SMHA-funded services, consumers will have increasingly meaningful roles in the design, delivery, and evaluation of peer-support programs via Offices of Consumer Affairs within SMHAs. The new policies will also focus on increasing consumer involvement on the advisory boards of SMHA and provider agencies, targeting SMHA-funded consumer-directed or consumer-operated services, and increasing consumer involvement in developing outcome measures to be used to inform SMHA policy and data-based decision making. At the point of service, consumers will have a major role in their care by facilitating the formulation of a personal recovery plan, articulating their needs and interests to shape person-centered care, and prescribing the role that mental health professionals should have in their lives. SMHA directors indicate that consumer input is necessary to guarantee a strengths-based and recovery-oriented approach.

Addressing workforce crises

Issues related to the composition, characteristics, supply, training, and recruitment of the mental health workforce are of deep concern. A number of challenges confront SMHAs, local providers, and educational institutions that train mental health professionals. For example, there is erosion in the number of seasoned clinicians entering the public sector; an acute shortage of child, forensic, and geriatric psychiatrists; and a looming shortage of psychiatric nurses. There is also a lack of trained staff to treat co-occurring disorders, to work in rural or frontier communities, and to work with sexually violent predators.

Another issue is the need to increase cultural competence and maximize diversity of the workforce to match the diversity of persons seeking services. Currently, there is a shortage of non-Anglo and multilingual staff, and fewer persons from minority groups are entering the mental health professions. Also, there is a "graying" of the workforce plus many state and local management and clinical staff are retiring, coupled with the difficulty in attracting young workers. These factors lead to an older clinical staff that is culturally out of touch with younger persons' issues. Also, there is a lack of succession planning for key leadership positions. In addition, recruiting new employees is an issue because of low public-sector salaries, fierce competition between public and private sectors in hiring available personnel, and long work hours that create excessive overtime costs.

There are also specific training and education issues, which include the decline in the number of psychiatrists; efforts to offset this loss can be seen by the increased use of advanced nurse practitioners. Problems also arise because preprofessional training (for example, social work and psychology coursework) is teaching neither core competencies in evidence-based practices nor clinically relevant skills to work with persons with serious mental illnesses, and there are few opportunities for the existing workforce to receive competency-based training. The closed nature of many professional schools prevents the SMHA from having strong input into the curricula.

In addition, within SMHAs, there are currently insufficient resources to fund, recruit, and train peer specialists to promote recovery-oriented systems of care. And finally, there are virtually no state-based or federal programs to which SMHAs can send staff for continuing their management training, leadership development, and state-of-the-art service information.

Ensuring financial stewardship

As in past years, SMHA directors identified aspects of public financing for services. They noted a plateau in state general funds and tax dollars juxtaposed with increasing demand for services. Because of the increasing demand for services, the directors recommended developing strategies to assess how scarce dollars can be expended more effectively, providing funds to underwrite each consumer's recovery plan, using SMHA funds to compensate for reductions in employer-covered mental health insurance benefits, and right-sizing the system by striking a balance between state hospital and community-based program dollars and between inpatient and ambulatory services.

Virtually all directors expressed a need to depict a return on investment (ROI) for the expenditure of public funds on mental health services. Consumers, families, state legislative budget and finance committees, advocates, the Governor's Budget Office, media, and providers all exert pressures on the SMHA to justify investments in various programs and to provide evidence that targeted expenditures on new programs and continuation of traditional services are worth the investment. Unfortunately, these data are not always readily available, making it difficult for the SMHA directors to compete with other state agencies that also seek fiscal resources for programs they consider critical. SMHAs will become aggressive in applying fidelity measures to assess a program's conformity with best practice. Where ROI data are available and do not demonstrate a justification for continuing a service, SMHAs will apply sanctions related to agency licensure, certification, continued funding, and implementation of a formal plan of correction.

Issues were raised regarding trends in Medicaid financing of mental health care, with particular attention to a perceived threat that the federal Centers for Medicare and Medicaid Services (CMS) is planning to disallow bundled paid claims, not reimburse providers for case management services, or restrict Medicaid eligibility. Both CMS and state legislatures wish to contain Medicaid

costs. SMHA directors reported inconsistent interpretations of the new regulations and problems with the system of waiver approvals across CMS regional offices and the increasing paperwork required to document "medical necessity." Some states are concerned about local provider agencies that have become overly dependent on Medicaid, wherein any reductions in Medicaid reimbursements will seriously curtail these agencies' capacities to serve SMHA clients effectively.

Finally, other major funding issues include locating revenue sources to fund services for persons who are not Medicaid eligible, determining how to fund various evidence-based practices, and developing strategies to finance needed staff training and development.

As a means to calculate ROI and provide feedback to stakeholders regarding efficacy of the system, rendering accountability and developing of performance measures are absolute necessities. SMHAs' energized interest in outcomes supports their desire to realize a strategic vision that relies upon performance measures to enhance data-based decision making.

Many states are currently developing specific performance measurement systems and crafting new measures to assess the performance of county-managed mental health programs that receive SMHA funding, SMHA-operated facilities, and local provider agencies that either contract with county mental health authorities or SMHA. These same measures are being used as a response to the lawsuits, consent decrees, and investigations of the Civil Rights of Institutionalized Persons Act. To link management with a program evaluation capacity, many SMHAs use performance-based and pay-for-performance contract models between the SMHA and local service provider entities. Likewise, SMHAs use these data to document unmet need, support state and national measurement development to demonstrate and reflect "recovery," and reflect progress toward implementing a "consumer-directed system."

Finally, the increased expansion of the SMHA's data and information capacities entails the search for optimal information technology, including sophisticated online record systems on admissions, discharges, and transfers; the use of electronic medical records, linked pharmacy databases between hospital and ambulatory programs, and sophisticated paid-claims systems; and the development of benchmarks using risk-adjusted data derived from deidentified consumer records.

Embarking on new frontiers

These issues and concerns and the environment in which the SMHA exists require a break from tradition. SMHA directors are in the process of reconceptualizing and recalibrating their role within state government and in relation to the myriad stakeholders whose demands and expectations influence the SMHA's values, priorities, strategy, and behavior.

Under the mandate that SMHA must become a full partner in the broader health care delivery system, services to treat chronic health conditions must be provided as a prerequisite to consumers' having any hope of recovering and living productive lives. To recover from a mental illness only to have one's life cut precipitously short by a preventable or curable physical illness is a cruel irony. Having this realization, SMHA directors are aggressively dismantling the policy, administrative, and programmatic silos that once characterized the "specialty mental health system" and are embarking on shaping a decidedly altered approach to mental health.

One overriding realization shaping SMHA directors' future behavior is, "We can't do it alone." Whereas past directors managed a relatively circumscribed delivery system, current directors view themselves as boundary spanners, ambassadors, mediators, and dialogue facilitators within a complex and turbulent stakeholder environment. SMHAs constitute one component of a larger solution wherein diverse constituents must relinquish control, share risks, and devise means to collaborate in policy development across permeable agency lines of authority and responsibility.

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