Welcome, I am Matt Clune, your host today, a SAMHSA Public Health Advisor, and also a person in long-term recovery.

During this program we will discuss the challenges faced by the behavioral health workforce, as well as strategies to address current workforce development needs. Our panel of experts today will speak about ways to strengthen the role of the behavioral health workforce in order to sustain quality in behavioral health care.

Joining in our panel today is Dr. Darla Coffey, the President and Chief Executive Officer of the Council on Social Work Education in Alexandria, Virginia. Sharon Amatetti, who serves as Chief of the Quality Improvement and Workforce Development Branch at the Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. And Dr. Gail Stuart, President of the Annapolis Coalition on Behavioral Health Workforce, and Dean of the College of Nursing at Medical University of South Carolina in Charleston, South Carolina. And lastly, Cynthia Moreno Tuohy, the Executive Director of NAADAC, the Association for Addiction Professionals in Alexandria, Virginia.

I want to thank you all for being here today. We have such a depth and wealth of talent and experience at the table and I'd like to just launch right into our panel, and if I might with you, Sharon, what exactly are we speaking of really when we talk about behavioral health workforce development? And what are some of the issues that are impacting our field today?

Sharon Amatetti:

When most people think about workforce development in behavioral health field they're talking about all of the professionals, the para-professionals who care for people with substance use disorders and mental health problems. So we're talking about psychiatrists, psychologists, alcohol and drug counselors, nurses, social workers, family and marriage therapis, school counselors, as well as para-professionals and peers, and then prescribers like physicians and physician assistants and nurse practitioners who can prescribe medication assisted treatment for people with substance use disorders. So that's really what they're thinking about generally when we talk about workforce and behavioral health.

In terms of workforce development, we're really talking about the training that people need to get into these careers, as well as what they need to keep current in what's going on, innovations and keeping up with new and best practices. That's really what workforce development is about. The reason it's so important is because we have a tremendous amount of need. We have about 19 million people, adults, in this country who have substance use disorders and only about 10% of those adults get treatment. With serious mental illness we have, again, about seven or eight million people, adults, in this country with serious mental illness and they too really have a hard time getting the treatment that they need. So there's a gap between what we have and what we need to help people get well.
Matt Clune:

Thank you so much. What a great way to lead off.

Dr. Stuart, I'd like to ask the next question of you, which really focuses on some of the segments that Sharon was highlighting. Do you see any particular segments that you'd like to highlight where we're really seeing deficits and where we should hone our energies?

Gail Stuart:

That's a great question. I think all too often we think of the specialists in the behavioral health workforce, those who have advanced training, either as psychologists, clinical social workers, advance practice nurses, etc., but that workforce will never, the specialized group, will never meet our needs. So I think we need to think about everyone who is in any way associated with health care as being part of this workforce. They're not necessarily now being prepared, but we need to think about that as we move forward. Then, the largest group of providers of care are family members and so if we think broadly about persons in recovery as well as families being part of the workforce, that opens up possibilities for more care where we really need it most.

Matt Clune:

Excellent point. Thank you.

Cynthia, if I might, I'd like to ask you the next question, which is what are the key vulnerabilities that we experience as a workforce in behavioral health care specifically and what do you think might be towards that end contributing to staff burnout, high turnover rates, inappropriate salary levels, perhaps, to keep up with market?

Cynthia Moreno Tuohy:

You hit the top one last, and that is compensation, inadequate levels of salary, inadequate levels of benefits. To sustain a workforce you have to compensate them at the level that they can sustain. Many of our counselors are making less money that they could even apply for food coupons, food stamps. So it's interesting how in some parts of the United States we have lower salaries. In other parts we're seeing an increase in salaries and beginning to see that particularly in the bachelor and the master level people.

Gail Stuart:

Can I just add to that? I think there are two other, there's many other aspects, but too is lack of a career path. People are looking towards something that they want to develop and grow in expertise in over a career, and I think we don't have clear career paths. And then there's also the issue of burnout.

Cynthia Moreno Tuohy:

Right, so I would say that one of the things we've developed with SAMHSA, particularly for the addiction workforce, is a career pathway so that we can see that people can start as a peer recovery support
specialist. Maybe they work that for a while and they decide I want to learn more and become an addiction counselor level one and bachelor and then masters. So we're starting to see more that way. We need more funding. So the other piece is we need the funding to actually develop that pipeline. As we're talking about a career ladder or career pathway we need the funding to develop that pipeline. And then in terms of burnout, you're absolutely right. This is a tough career in terms of that emotional connection that we have with clients and with families. Are we doing enough mentoring and clinical supervision to help not only with burnout, but also to help with the efficacy of the best practices. So we're learning best practices or promising practices without that clinical supervision to really make that technology transfer and integrate into the clinician. We need that kind of clinical supervision.

Matt Clune:

Perfect, and an ideal segue for Dr. Coffey. Having worked in behavioral health care, we often those in the counselor pool, if you will, often point to social workers as having figured it all out. But I'm sure everything is not as rosy as it seems. And I wonder if you might expand upon some areas of workforce development that are particularly impacting the field of social work.

Darla Coffey:

There is certainly a need for us to increase the number of specialists so that we are really preparing with top of the line, evidence-based practices, promising practices and so forth. But we need to think about the workforce much more broadly. Social workers are both specialists, and they're also the care coordinators, they've got the connections with the community and with the family. So we're really talking about bringing in many more people into a team. I really think that when we talk about behavioral health workforce we really need to be thinking about teams and how many different professions can we bring in and including the family perspective for certain, because we haven't really paid attention to the fact that these are individuals in communities, in families, and after the "crisis" subsides and is addressed long-term recovery requires the ongoing support of many more people outside of the clinical specialists that we're talking about.

Matt Clune:

What are some concrete ways that we can help train our workforce to become better integrated into primary care, and similarly how can we train primary care to recognize and accept the core competencies of our workforce?

Sharon Amatetti:

To the evidence-based practices that are important and are integrated in primary care is prescribing medication-assisted treatments. We know that primary providers are very much at the forefront of addressing the opioid use epidemic that we're experiencing right now by being prescribers of Buprenorphine. Also screening and brief interventions, or SBIRT, which is a way for not just physicians, but the whole team that works with physicians to look for substance use and particularly alcohol use disorders earlier on in a person who might be coming to them who might not be coming for that, but they'll be able to pick it up when they're seeing their physician. Those are two ways that we've done a lot of work to really prepare primary care with behavioral health lens. We also have a Center for
Integrated Health Solutions that HRSA and SAMHSA fund together, which has really looked at how to bring behavioral health care into primary care, and how to bring primary care into the behavioral health care setting.

Gail Stuart:

The primary care providers have to learn new competencies and then the behavioral health providers have to learn new competencies. SAMHSA has developed a list of those competencies, but that requires additional training. These folks are already out there in practice. So they have a busy schedule. How are we going to tool up the existing workforce? That's very challenging. And more and more gets included in primary care these days that oftentimes they feel overwhelmed. On the other hand, it really has to happen.

Cynthia Moreno Tuohy:

All of the different disciplines that the physicians and the prescribers and the social workers and the psychologists and the addiction counselors, the peers and the family, they all have a roll in the recovery, not only of the individual, also of the family system. So if you really look at putting together multi-disciplinary teams, particularly in crisis-related centers like emergency rooms and hospitals, and other clinics, then you begin having that cross-conversation that happens between the different disciplines. I agree with the training aspect. I also think part of it is actually getting people in the same room to meet each other, because oftentimes we're so busy with the work that we do, we don't meet each other and there's these silos that occur. So breaking down the silos, giving people the chance to see each other eye to eye, and setting up systems of referral. That's the other thing I see is that we need stronger systems of referral and ways to communicate, either through electronic health records, or through electronic communications, other communications, that help to support that multi-disciplinary team approach to care.

Darla Coffey:

I think that one of the things that we've learned is that multi-disciplinary oftentimes ends up being sort of parallel play, that people are not necessarily reading the same things about the client or the family, not in the same room. There just sort of operating in some sort of choreographed dance perhaps, but they're not really interacting. So I think we try to talk about things being more inter-disciplinary and inter-professional so that we can really achieve something different. Exactly what you're talking about, but I don't think that multi-disciplinary really didn't do it for us for a long time. So I think preparing practitioners in their education and training programs to work in this way in teams, and also in their practice settings, and while they're still in school, whether they be in the clinical or their residency's or field placements, that they're also beginning to experience working with other professionals in that collaborative way.

Matt Clune:

Thank you, Dr. Coffey, for that excellent comment. And thank you all for such great insights into the workforce development challenges that confront our field today. When we return panelists will discuss workforce needs required to sustain quality behavioral health care in the community.
Cynthia Moreno Tuohy:

I got into this profession because I come from a family of alcohol and drug addiction and mental health disorders. And I grew up in a family system that was so affected that my mother ran away when I was eight months old. From that piece of my life what began to happen is I became a ward of the court, and in the foster care system, and I got into a lot of trouble early in my life with using drugs so whenever I'd go to visit her the only way I could communicate with her is if I used drugs with her. So by the time I was nine years old I was into speed and crystal meth and those kind of things.

Over a course of time I realized that I was in a tough place. I had been physically abused, sexually abused, malnutrition, these are all the things that come with addiction and mental health disorders if they're not treated. And because of those things I decided I wanted to do something to change families like mine and kids like me because by the time I was 15 1/2 going into my last foster home, that was my 40th home. I had all these experiences that told me something had to be better. There had to be something better. My last foster family, both of them were educators, and they said you need to go to college. So that's what led me to college and I went to college to become a social worker and this was in the day when they just started talking about alcohol treatment. Alcoholism and alcohol treatment. So that's what led me to decide I didn't want to only do social work. I wanted to concentrate on alcohol and drug addiction as well.

In order to sustain in this field, it's really important that you're taking care of yourself. That you have a good self program, exercise, nutrition, spiritual. This is really important if you're an addiction and mental health professional because those are the professions that really take that extra energy to keep working with clients, because you will have losses in this field. People die, and people don't always recover. Sometimes we take that on ourselves that we didn't do something enough. We didn't work hard enough. We didn't say the right thing. We didn't do the right thing. Self-care is really important. If you're gonna stay in this field it's important to have some self-care, because if you're comfortable with yourself you're gonna help other people, and you're gonna be genuine and authentic, and transparent and those are the things that make the difference to the client.

Tom Andrews:

Currently, the overview of our mission is, since 1985, is to create a comprehensive delivery system for the homeless and underserved population here in Atlanta. What that means is essentially creating primary care services and other wrap-around services through fixed clinic sites, mobile sites, and even through a street medicine program, which goes out four nights a week to provide those services on the street.

Thommie Mungo:

It's a one-stop shop. If they needed primary care, if they needed vision, if they needed dental, they don't have to go outside of the Mercy Care family. They can stay here and be navigated through the Mercy Care system for services.
Tom Andrews:

Every two or three years we do a comprehensive needs assessment looking at the homeless population, the underserved populations, and we look at what types of health-related services they need. And then we try an incorporate those services into our delivery system. So over the years we started at preventive care and primary care and we've grown to be comprehensive to the nature of integrated behavioral health.

Sophia Franklin:

Behavioral health services here at Mercy Care are fully integrated with primary care. This allows opportunities for patients who arrive in our clinic to be treated both for their physical concerns and also mental health concerns. Our licensed clinicians provide opportunities for screening and treatment from anything ranging from mild depression or more severe and persistent disorders such as schizophrenia. We also have substance use disorder treatment and screening as well.

Tom Andrews:

Staff training is extremely important. So we put into place a training program with the doctors and the nurse practitioners where the psychiatrist really got them more comfortable in treating this patient without having to refer them to a psychiatrist or a licensed clinical social worker.

Sophia Franklin:

The behavioral health task force consists of a primary care physician, psychiatrist. We get feedback from our risk management team, our front desk team, and also our certified medical assistants. In addition to behavioral health consultant feedback and peer feedback, we come together and talk about best ways to eliminate barriers to care for our clients.

Thommie Mungo:

I think that it speaks volumes for organizations to continue to have peers at the forefront when it comes to addressing services and needs of peers. You someone there with a voice who can actually speak for those who may not be readily or able at that time to advocate or speak up for themselves.

Wilbur Sagna:

I met Mercy Care when I was on the street. There was one particular night I was real sick.

Joy Fernandez:

We go during the evenings to provide medical and mental health care for the people sleeping outside. So we'll load up our medicines, our clinic supplies, wound care supplies, all that stuff onto our shuttle, and then we'll head out into different areas throughout the city. We have a social worker that comes along and provides housing services for them.
Wilbur Sagna:

The main thing, they helped me out with my mental health, you know. I don't worry like I used to and have thoughts and things like I used to or hurted myself since I'm on the medicine. The medicine is good. At least I'm not on the streets no more. That's a good thing.

Joy Fernandez:

We really feel that holistic integrated care is important. Oftentimes when they try to access health care resources it's very fragmented. So they may go to one clinic for their primary care, and another place for behavioral health, and another place for dentistry. It just gets really confusing and nobody's talking to each other and nobody ever really gets the big picture of what's going on with this patient, and they don't get better. So we feel like it's really important to provide all the care that the patient needs under one roof.

Tom Andrews:

The goals for Mercy Care as we move forward, I think more collaboration with other providers in the community. We have to be able to integrate what we're doing with what others are doing to make sure that we're not duplicating services, and that we're really looking to take care of the whole person through those collaborations.

[Public Service Announcement titled: r is for Recovery]

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Matt Clune:

Hello, and welcome back to the Road to Recovery. Let's talk about the needs of today's workforce to sustain quality behavioral health care in an ever-changing society. Let's begin with cultural awareness and its impact on quality care. What is cultural awareness training, and why is it so important that our workforce be trained in it to deliver quality care to behavioral health care consumers? Dr. Coffey, if I might, I'd like to address this question to you.

Darla Coffey:

Sure, thanks, Matt. First, I would say that we need to make it a priority to make sure that the composition of our workforce actually matches the people who need services. So the racial and ethnic composition of our workforce really does not match the folks that need services, and that needs to continue to be a priority. In addition, everybody else, and those people who are also matching need to really be involved in a process where they begin to learn the health beliefs, the attitudes, the values, the cultures, the norms around help seeking behavior that's specific to culture. I think it's really important that we talk about cultural competence. That's something that we talk about in social work a lot. There's
a term that I like to use, cultural humility, which is really putting yourself in a position where you're constantly learning about the differences between you and the folks that you're working with. So it's really an appreciation, sometimes learning from and being mentored by the person from a different culture, which is something really different. So we're looking at implicit bias, some of the things that we're not aware of, and really engaging health professionals through their education process and ongoing clinical supervision as we mentioned in the earlier segment so that this continues to be something that's examined.

Cynthia Moreno Tuohy:

I really echo what you have to say about that, because cultural humility is also that you have the humility to understand that you don't really know what it's like in someone else's culture. You're looking, you're working to understand it, you're working and understanding how it is that their culture affects themselves in the society in which they live, and you're respecting that, which is a very different view than having "cultural competence." None of us are ever competent in someone else's culture.

Darla Coffey:

That's right.

Gail Stuart:

I think it also involves an appreciation that illness is expressed differently in different cultures and among different populations. So you have to use the lens differently, and not just assume that the way in which you interpret things is the way in which other people interpret or express things.

Matt Clune:

These are all tremendous insights. I use the word cultural sensitivity, but I love, I'm gonna hold on to cultural humility. I'd like to shift gears a little bit. I wonder if you, Cynthia, might talk a little bit about some of the evolution of staff roles as our field begins to evolve. And what are some ways that we might train up our workforce to better meet the needs that we're confronting our there?

Cynthia Moreno Tuohy:

Addiction has become much more complex. We understand now that addiction and mental health are so closely tied together because of the trauma that's associated with substance use disorder as well as mental health involved persons also having substance use disorder. So there's that interlocking that occurs. The roles that counselors, addiction and mental health counselors, are learning is to understand mental health issues if you're a substance use disorder specialist, and vice versa.

So we're getting more and more training around trauma and how trauma effects recovery. Recovery from substance use disorder, recovery from mental health, and recovery of the family. So as was said earlier we want to see people in long-term recovery. If we want to see people in long-term recovery we have to train our clinicians to think about long-term recovery as the goal, not just treatment today, not just treatment 90 days from now. It's thinking about long-term recovery, which includes the physical
aspects of recovery, the spiritual aspects, the mental health aspects, the financial aspects. So all of these areas, we're now looking at whole health, right? We're now understanding if we're not dealing with those areas in the counseling room, then we can't expect the client to be working through those areas in their recovery program.

Matt Clune:

Very well said. That's a lifelong illness that requires lifelong recovery support and we've got to treat the whole person. Sharon, if you might, I'd like to pick up on a trauma and foreign piece a little bit, because I know SAMHSA's done some work in this.

Sharon Amatetti:

Thanks, Matt. And I did want to mention that SAMHSA has now invested quite a lot of effort looking at trauma, because it is such a commonly shared experience of so many of the clients and people that we work with. So we have a National Center for Trauma Informed Care, which is a technical assistance and training center, but they do an awful lot of consultation around how to make your organization more trauma informed, what are some trauma specific approaches to use with clients, look at things like your policies and your staffing and how that relates to the trauma experiences of the persons that you're trying to serve. Then, I'd also to put a plug in for our technical, it's treatment improvement protocol actually, number 57, which is about trauma care for people with behavioral health concerns, so Tip 57.

Matt Clune:

Tip 57, terrific. Go to your store and get that now. I'm just kidding.

Sharon Amatetti:

It's free.

[Chuckling]

Gail Stuart:

We should also mention that many of the care providers have also experienced trauma. And so having them gain sensitivity, not only to helping others, but being in touch and helping themselves is very important.

Matt Clune:

Sharon had mentioned earlier that primary care physicians are doing greater work at earlier stages so that we pick up right in the doctor's office when folks are appearing or presenting with substance use disorder or mental health issues. We've got some brief screens deployed, SBIRT. I wonder if you might expand on that a little bit.
Gail Stuart:

I think that's excellent because I think picking up these issues earlier when they're often at a milder stage is very important, doing some brief counseling. But we still are not standardized in our use of screening tools. You go to a primary care provider and you're asked about diabetes and heart disease in your family. Are you asked about any mental health issues routinely? Primary care providers are particularly uncomfortable asking about substance use issues, partly because they don't know what to do if the person says yes, I have a problem, and partly because of some social stigma around those issues. So we have to start teaching the students who are currently in nursing school, medical school, social work school, how to approach these issues, and really do more effective screening in primary care. Then we have to have a system set up where there's some brief interventions, and then you know when to refer, and when someone needs more specialized treatment. But right now it's somewhat haphazard.

Matt Clune:

How do we get from where we are today, where we've got spotty utilization of SBIRT-like tools, but you're right, it's not uniformly or universally applied? And how can we move us from where we are today to seeing this as a more uniform concrete standard operating procedure?

Darla Coffey:

I actually feel like these things are all related. Earlier we spoke about the importance of having different professional perspectives involved in a person's care. That's basically recognizing that we need to be treating whole people. So recognizing that they're not just presenting with a physical symptom, but we're also asking questions about their emotional life, their family life, their community, the violence in their community, perhaps. I mean, lots and lots, food security, all kinds of things. So if we're asking those questions, immediately people think what are we gonna do if we find out that there is a problem? I'm not equipped to that. Well, that's where the team comes in. If there are other people on the team who are uniquely qualified to address some of those other social determinants then it's better care for the patient, and quite frankly it's also really supporting each other.

I mean, we've already talked about stress and burnout. Well, stress and burnout is absolutely, I mean, it's unavoidable if you think you're a lone soldier in all of this. If you're working independently and you think I've gotta handle everything, well you don't want to ask questions that's gonna open up Pandora's Box to things that you can't really address. But if you know you have a team that you can do a warm hand-off to, that you can do those brief screenings, I always do that, if you know that you have resources, then you're more likely to be able to ask those questions right from the beginning.

Cynthia Moreno Tuohy:

I think too, that in a broader view it's also putting together some national strategies that can be practically implemented at the local level. So that we're giving some guidance to communities, some clear technical assistance that helps not just treatment centers, mental health centers, clinics, hospitals, to bring people together to have that common conversation about integration.
Matt Clune:

I wonder how we might marshal the utilization of technology to better push out some of the content that we're all talking about to the workforce.

Gail Stuart:

That's great, I was going to mention that, because if we could use technology, for example, in our screening processes with iPads or something when you come into your office, that becomes part of the electronic medical record, or health care record. They do something very interesting in England. When patients, so in this country if you were gonna have surgery you go to the hospital, you're told you can't eat or drink beforehand. Then many patients, the nurses see, are going into withdrawal, because they have never pre-screened for even something as simple as caffeine. So in England they send out by email a tool ahead of time to assess for that so they're all prepared beforehand. I don't think we're yet, and again, they have a more standardized system, but there are examples that we could take and incorporate and then it builds. If it's an electronic health record it builds from one episode to another.

Matt Clune:

I love it.

Cynthia Moreno Tuohy:

And now we have telehealth. One of the technologies that will, I think, help advance us, give more access to care in a rural or frontier states, or frontier areas in some of our other states is that telehealth and being able to give service to clients and their family members when it's difficult for them to come into the office for whatever reason, whether it's transportation, child care, rural setting, it gives them that ability to get the services that they may need.

Gail Stuart:

And the behavioral health field has really been the leader in telehealth services. The VA has really taken this on and seen very good outcomes. But I think the other aspects of health care medicine are picking it up but we've really been the leader in that.

Matt Clune:

Dr. Stuart, thank you much for that wonderful insight. And thank you all really for explaining so well what our behavioral health workforce needs to look like to ensure quality care to our communities in the future. When we return we will highlight some strategies to expand and strengthen the behavioral health workforce of the future.

[Upbeat Music]
**Gerry Schmidt:**

We probably suffer more from workforce problems consistently over the years. It's become more of an issue now with the aging workforce oftentimes trying to attract qualified addiction treatment professionals, psychiatrists, nurse practitioners. It becomes a problem.

**Cynthia Moreno Tuohy:**

NAADAC is celebrating its 45th anniversary, and NAADAC was the association 45 years ago that created the addiction workforce. The beginning, we started with training, and we started with having a voice, and then moved into legislative issues and public policy and how do you advocate, and then we moved into more specialized training and helping people to learn more that way.

**Paula Horvatich:**

The goal of that is that we are able to expand treatment to communities who have not had enough of this treatment in the past, and from people who are actually trained and understand the cultural differences in these populations.

**Cynthia Moreno Tuohy:**

We do webinars that can press the whole globe people can tune into and now we're going to be doing telehealth in the future.

**Paula Horvatich:**

It is important that everyone who is in training are able to take advantage of classes that teach them more about cultural competencies. It is important for them to be able to apply what they've learned and to gain experience in providing treatment and working with all of the individuals in the diverse cultures that we have in the United States.

**Gary Schmidt:**

We have the institutions of higher education. Our challenge is getting younger students to step up and say I want to do this. And using statistics as the problem and the extent of the problem in West Virginia and how they could be part of solving that problem.

**Cynthia Moreno Tuohy:**

Why would you want to become an addiction specialist? Why would you want to do this work? Because you help people change their lives. There's nothing more rewarding than to see a person who has come to you with the ravages of addiction and then weeks, months, later having a healthy family, not using alcohol or other drugs. Having a job. There's nothing more exciting than to watch that transformation in a person.
[Public Service Announcement Titled: Voices for Recovery]

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Recovery from mental and substance use disorders is real.

Female #1:

You can recover.

Female Narrator:

It’s possible. It happens every day.

Male #1:

Never give up on yourself.

Female Narrator:

Discover hope and help.

Female #2:

The world is a beautiful place again.

Female Narrator:

Join the Voices for Recovery.

For confidential information for mental and substance use disorders call 1-800-662-HELP.

Matt Clune:

Thanks for joining us again. I'd like to talk next about ways to expand and strengthen the behavioral health workforce. Where are the greatest deficits within the behavioral health workforce? And what are some strategies that we might use to encourage young people to enter the field?

Cynthia, I'm wondering if you might pick up on that question and tell us a little bit about what NAADAC's doing and what your impressions are of the field generally.

Cynthia Moreno Tuohy:

Absolutely. We know that we have a diminishing workforce due to the aging of the population currently. So we need to bring more young people into this profession. One of the things that we're doing with SAMHSA and with single state authority directors in different states across America is to bring in a workforce forum into the college setting, inviting college students in year one and two, and inviting high school students, because what we've learned is a lot of people start making their career choices or
awareness in high school and early college. So we need to get that awareness at a younger level. Junior in high school, senior in high school, maybe kids that are taking psychology, sociology classes, kind of wetting their appetite that this is a profession, mental health, social work, substance use, that they could get into. So doing these at a college setting helps them also build that awareness that maybe I could go to college too. It helps them to see the environment, helps them to feel more comfortable, gives them the information. We have exhibitors there from treatment providers so that they get an idea of what is it like to be in a treatment setting? What different types of treatment settings are there? And it's another way to approach people to come into our profession.

Matt Clune:

I love the idea and another thought occurred to me that may be of some use which is that our recovery high schools and collegiate recovery programs, which are just booming right now, are a natural training ground for folks who want to enter the field after they've achieved some level of sobriety.

Cynthia Moreno Tuohy:

Exactly.

Matt Clune:

One part of this question talked about strengthening the quality of the behavioral health care workforce. And I know that SAMHSA's doing some work through our ATTC's and other mechanisms to push out evidence-based practices and really train up our workforce.

Sharon Amatetti:

Yeah, thanks, Matt. SAMHSA, right now, is really looking at the way that we provide support to the field, technical assistance and training, and are most interested in providing a really regional approach so that we get the services that are needed in the regions that are most appropriate for those regions. So we do have the Addiction Technology Transfer Centers, which really is addressing the professional needs for substance use disorder professionals. But we're also doing similar work with opioid providers and we're going to be providing resources soon to do a similar regional approach to TA for mental health and for prevention. So it's pretty exciting time.

Gail Stuart:

I might comment on that, and I think across the board now, evidence-based practice is really incorporated into most curriculum. It's required by your crediting bodies, etc. What we find though, is that when the students or the graduates, the new graduates, go into a clinical setting they don't see it being practiced. So there's a saying, you put a good person in a bad system and thy system wins every time. So what we really have to think about is getting organizations to adapt these evidence-based practices in their clinicians. There's a variety of strategies. First of all, they have to be valued. They have to be known. They have to be articulated. They have to be reimbursed so that you do do what gets paid. And then the organization needs to say this is something that is the way in which we operate. It is not optional. Everyone cannot do whatever they feel is best in their heart because that's not necessarily
evidence-based practice depending on the clinician. We can start with education and teaching the folks who are in the pipeline, but we also have to look to the existing care delivery systems.

Cynthia Moreno Tuohy:

And that's why clinical supervision is so important. Because without that clinical supervision, you don't have fidelity and evidence-based practices. The more clinical supervision is out there, and reimbursement for clinical supervision, that's part of the issue around clinical supervision, is the lack of reimbursement. So again, systems change is important if we're gonna have quality care, and figure out how do we do that well so that people get not only the resources that the TA Centers are giving, but the clinical supervision to back that up.

Matt Clune:

Dr. Coffey, I do know that from my experience as a treatment provider that social workers are the ones that worked on my team. They not only needed ongoing supervision, they needed ongoing training. We often could not provide everything that they needed, and so there's this dance that we do within the behavioral health care field where we're trying to usher along well trained behavioral workforce with the practicality of what really lies in the field. I'm wondering to what extent your organization has done some thinking about how to marshal those forces.

Darla Coffey:

One of the things that we talk about a lot in social work education is the sizable number of hours that we expect our students to do in their field placement or in their clinical settings. Those are in fact required to be supervised by a social worker and so forth, and so we're reluctant to give that up. Partly, that's because we've seen erosion of supervision after the education period and so unfortunately, it's like you get it while you can and while you're a student you might as well suck up as much supervision that you can. The other part that we need to really think critically about is, is it necessary, if we're talking about teams, is it necessary for the supervision to be only by a social worker? Is there room for a nurse to provide lead supervision, or for an addiction counselor, for the physician and so forth. So can we rotate a little bit so that we can support that inter-professional education building for collaborative practice? I think those are the kinds of things that we try to balance.

Gail Stuart:

And can we use technology for supervision?

Darla Coffeey:

That's true.

Gail Stuart:

Telesupervision, especially in rural communities where there's very difficult access to providers to begin with, can we better use technology to accomplish some of the goals that we're hoping to achieve?
Matt Clune:

Excellent point.

Cynthia Moreno Tuohy:

This was one thing we were talking about just yesterday in South Carolina with the peers and how important it is that they have access to not just clinical support, we call it clinical support, also because many of them are two, three years in their own recovery and need that kind of clinical support for their own recovery pieces when they're faced with dilemmas that are similar to what they've just recently recovered from. So I think clinical support is very important and clinical telehealth will be important in that delivery of service.

Matt Clune:

Thanks so much for that excellent answer. And I'd like to turn to you, Dr. Coffey, if I might. We've talked a lot about salary issues, burnout amongst our behavioral health care workforce, but retention seems to be this big elephant in the room that I don't think we've fully gotten our arms around. Might you offer the audience some insights about how we might hold onto to our well trained staff for the long haul.

Darla Coffey:

Incredibly important. As much attention is being paid to the recruitment of new folks into the health professions to assist people with behavioral health and substance use, we have to be paying attention to retention. So we've actually talked about these issues in previous segments because it's all related. We talked about trauma-informed systems of care and how many of our caregivers actually have experience of trauma themselves. Well, if we're building trauma-informed systems of care we're building places that are safe and welcoming for staff as well as the clients.

Matt Clune:

I want to thank you both for those excellent points and thank the panel generally for the useful strategies and examples that have been presented in this segment. When we return the panelists will discuss some successful programs and initiatives to implement recovery-oriented practices.

[Upbeat Music]

Kathryn Power:

SAMHSA is working to ensure that the behavioral health workforce has access to the information needed to provide successful prevention, treatment, and recovery services. It is also important to offer incentives to encourage entry to the behavioral health field in order to bolster the workforce and improve care. Some incentives include federal financial incentives to support recruitment in the behavioral health field and to encourage professionals in training to focus on selected populations, such as persons with severe mental illness. Many states also have funded professional training through grants and contracts to academic programs or through tuition assistance to state employees interested in
pursuing an advanced degree. Incentives, like the NAADAC Minority Fellowship Program, in conjunction with SAMHSA's Center for Substance Abuse Treatment have provided graduate and post-graduate level training, and educational opportunities that directly address recruitment and retention. Providing compensation that is commensurate with the level of education, experience, and responsibility of the employee is essential for recruiting and retaining a qualified workforce. Forms of training in areas, such as technology, credentialing, licensing, data management, systemic protocol, leadership, peer support, and work life balance are the most effective in strengthening and unifying the capabilities of the behavioral health professional. SAMHSA's National Network to Eliminate Disparities in Behavioral Health, NED, promotes workforce development for community-based behavioral health organizations that serve diverse racial, ethnic, and sexual minority communities.

[Upbeat Music]

Narrator:

For more information on National Recovery Month, to find out how to get involved, or to locate an event near you, visit the Recovery Month website at recoverymonth.gov.

Matt Clune:

Welcome back. Let's continue this discussion about workforce strategies to support recovery-oriented practices. Specifically, Cynthia, how can peer training and certification bodies ensure that we have a peer workforce equipped to meet the demands of current and future behavioral health care challenges?

Cynthia Moreno Tuohy:

I think it's reaching out to communities where there are recovery-oriented systems of care, or recovery centers and helping to train standardized curriculum so that we know people are getting the specific training that they need to help the person with mental health and substance use disorders. They're also getting the training in terms of boundaries and what is in their scope of practice. They're getting training on physiology so that they're clear when to make a referral when there's a medical situation going on, so they're more integrated with that. I think certification and licensure systems that also promote standardization so that we can help people transfer from one state to another.

This transportability is very important. If we don't have transportability, then we basically reduce our workforce, because situations happen in families. People need to sometimes go to the home state of their parent or to where their children are. They need to be able to move. And you need to be able to take your credential with you. So transportability is gonna be a huge issue because it will affect standardization, also affects reimbursement. If I know what the standards are and I'm a managed-care organization then I know what to count on whether it's in Washington State or Florida, Alaska, or California, New York, or Nebraska. It's all the same standards so I'm not wondering who you are as a person, or as a discipline, what are your scopes of practice, and what do you really do. I think putting those standardizations together into the peer recovery network is gonna help us build a stronger peer recovery network.
Matt Clune:

When we talk about peers and recovery support it automatically links up to the larger recovery-oriented or ROS paradigm. We talked earlier about whole health, addiction, mental illness being chronic conditions that are a lifetime. Are there any particular recovery-oriented systems of care or recovery-oriented systems that you can think of where we're doing this real well and you'd like to highlight the strategies that are being employed and some special anecdote that might be helpful to our audience.

Gail Stuart:

In the general medical sector there is chronic care management. It's now been adopted widely, which involves self-care management for patients and their families, etc., and the use of community health workers. So a less expensive workforce that is actually the person you see in your church, or in your soccer game with the other parents. I think there are there are some models out there that could be adapted for us. It's really an issue of scalability and application of some models that are very good.

Matt Clune:

Sharon, I'd like to ask you if you might be able to describe for us and our audience a more family-centered approach to treatment and recovery support, which you might see particularly working well out there. And why is it so important that clinicians and peers alike think about family as an integral component of this approach?

Sharon Amatetti:

Right, thanks, Matt. I think the reason that we focus on family care now is because for so long we didn't. We really just focused on the individual, that we wanted to fix them ad fix their problems, and then send them back to where they came from and hope that they get well or stay well, and we realized that really wasn't what was happening for individuals, that they're part of system. They're part of a family, there's part of a community. So in terms of actual, the treatment experience, treatment programs are trying to support the family system in terms of providing care for mothers and children. We used to just treat mothers. Now we have their children involved. We also have their fathers, their extended family involved, and we realize that that's really essential for the whole family to get well for us to have a more family-centered care.

And also to respond a little bit to what you were asking about good models. I think the key piece for family care, but also just for care in general, is a sense of community is so important, and we look how vitally important the 12 step programs have been for so many people to recover, because they have a community of people going through the same thing that they've gone through, and that's absolutely essential. And similarly a lot of our faith-based programs, whether they're connected to a congregation or not, or if they're a recovery community that has strong faith-based that can be very powerfully important in helping people feel connected. So community and family, we're not talking about individuals in isolation that we are trying to "fix" and then send back.
Matt Clune:

Thank you so much. I'd like to talk about some of the technical assistance and training that's available out there to communities?

Sharon Amatetti:

We have to mention our Bringing Recovery Support to Scale Technical Assistance Center. The name of that program really describes what the aim is. The mission is to bring recovery supports to scale, because we know that what happens in treatment is a piece of it, but of course, it's everything that happens afterwards that is so absolutely essential for people to stay well. The Brass Tacks TA program really is about providing consultation, guidance to recovery community organizations, to peers, to any treatment provider that wants to develop a bigger sense of what happens after treatment or begins in treatment and continues later. It's a wonderful actual TA center for both mental health and substance use that SAMHSA runs and is available for people to access.

Cynthia Moreno Tuohy:

Some places, in many communities, there are community mental health centers, community health centers, and community substance use disorder centers. Many of those centers have resources available to go out in the local community. So if you're looking at grassroots building, grassroots up to national level where they're going to SAMHSA for some of that information, you look at what do you have in your local community, what does your state offer. Some states have different technical assistance, and then what do you have at the federal level? What do you have national? We have layers of ways to help support people with training. And then you look to your associations such as the Social Work Association, the Addiction Association, NAADAC. We're doing training and technical assistance. We also have different training programs that people can get involved in and understand. Public information so that they're getting information about what is addiction? What is this opioid crisis? What's the marijuana tsunami coming at us? So that people are getting that information and have access to it. I know you're doing some work along those ways as well.

Darla Coffey:

One of the things that I think about all the time is that technical assistance is really a way to address something that we talked about earlier. And that is the stress and burnout of just coming in day after day after day working with folks that have complex conditions that need to be addressed, oftentimes traumatic experiences from their past, but technical assistance brings evidence-based practice, breathes life into an organization again, develops a set of camaraderie among the treatment professionals. So it really is a way to also keep our health workforce, our behavioral health workforce activated and engaged, and really wanting to connect and wanting to learn about all the new practices.

Matt Clune:

Thank you so much. We have a moment here for anything that we haven't put out on the table and introduced our audience to for final thoughts. Sharon, if I might start with you, any final thoughts?
Sharon Amatetti:

Just to not get discouraged. I think that we feel discouraged sometimes, that we've been working at this so long and trying to solve these problems, but there are quite a lot of innovations and incremental things that are being done to build upon the work that we've all done and that people coming behind us. That would be my message is to not get discouraged and keep chipping away and trying to move the needle.

Matt Clune:

I like that message. Dr. Stuart?

Gail Stuart:

I think it's very important for each of us to do succession planning. When we talk to students about what specialty they want to go into or what they want to do, it's usually based upon a role model that they have seen and they have admired that person, and they thought that's the field I want to go into. So I'd like for each of us in the field to think about taking on someone who can then replace us when we phase out of the workforce ourselves.

Matt Clune:

So you mean we're not gonna be working forever? Thank you very much.

Gail Stuart:

You're welcome.

Matt Clune:

In all seriousness, Cynthia, any final thoughts?

Cynthia Moreno Tuohy:

I'm with Sharon. I think understanding how important it is to be encouraged and hope. I always believe that there's hope for the future. We know that in terms of recovery without hope there is no recovery. I think that's true about any discipline that you work in that's a helping discipline, that you have to carry that sense of hope with you and the belief that people do recover, lives get better. In my brain the other piece of that is generational recovery. So we're not just now talking about this generation being in recovery. We're talking about employing systems that cause generations in that family system to be in recovery. And that's where I see the big hope.

Matt Clune:

I love that and it's all kind of building. Dr. Coffey?
Darla Coffey:

What's interesting is that I'm actually gonna build on what you said and kind of loop it back to something that Sharon said earlier. The reason, it makes good sense for us to engage whole people and their families and communities to really maximize the potential for a full recovery. But we also do some good important prevention work in all of that. So when you're working with children of a parent who has a mental health or substance use disorder, then you're engaging that child. So it's important prevention work that we're doing along the way. That's building on that generational recovery, I think that you were just mentioning.

Cynthia Moreno Tuohy:

Treatment sometimes is prevention. You know, and doing good treatment, and particularly family treatment as you spoke to, Sharon, is so vital because that is part of the hope that the children are gonna learn some of that because the parents change. If I change my brain, I can change my children's brain. I can influence it. We know that about the brain today, so that's part of the encouragement and the hope and the excitement about these fields is that we actually can change brain patterns. Wow.

Gail Stuart:

And children see a successful outcome with their parents they may be interested in going into this field in the future.

Matt Clune:

You got it. Gail, thank you for making such an important point.

point. This concludes today's episode of the Road to Recovery Show, which focused on building and sustaining a strong behavioral health treatment and recovery support workforce. A big thank you to all of our knowledgeable panelists and to all of our viewers and listeners for joining us. I want to remind you all to celebrate Recovery Month each September and throughout the year. For more information, please visit Recovery Month website at recoverymonth.gov and thank you again for joining us today.

[Upbeat Music]