

Health and Human Services Committee
Legislative Resolution 592
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Blaine Shaffer, MD, Chief Clinical Officer
Division of Behavioral Health
Department of Health and Human Services

Thank you, Senator Campbell and members of the Health and Human Services Committee, for the opportunity to provide information, and to Senator McGill for introducing this resolution. My name is Blaine Shaffer, B-L-A-I-N-E, S-H-A-F-F-E-R. I am a board certified psychiatrist and serve as the Chief Clinical Officer for the Division of Behavioral Health in the Department of Health and Human Services.

In addition, I am on the Medical Directors' Council of the National Association of State Mental Health Program Directors, a member of the Opioid Treatment Network for the National Association of State Alcohol and Drug Abuse Directors, and on the editorial board of the Journal of Psychiatric Administration and Management. Prior to my work with DHHS, I spent 26 years in academic psychiatry, including serving as director of two psychiatric residency programs and so I am very passionate about workforce development in this field.

The Division of Behavioral Health is the chief behavioral health authority for the state of Nebraska and directs the administration and coordination of the public behavioral health system. State Statute 71-806 (also referred to as LB 1083) requires the Division to promote activities in research and education to improve the quality of behavioral health services, recruit and promote retention of behavioral health professionals, and provide access to behavioral health programs and services.

While the Division has never been funded for behavioral health education or workforce development, LB 603, in 2009, created the Behavioral Health Education Center of Nebraska for that purpose and funded it within the University of Nebraska Medical Center (UNMC).

The intent was to realize the commitment made in LB 1083 to improve community-based behavioral health services by increasing the number of

behavioral health professionals and increasing training in evidence based practices, tele-health, and other programs.

The Division has worked closely with BHECN and I currently serve on its two Advisory Councils. We have a good relationship with BHECN, yet we do not have an official role in their workforce development to serve the needs of people in the public behavioral health system. As the state continues to move to community-based services, the workforce shortage for the people we serve is increasingly an issue across the state.

Currently, the focus for workforce development by BHECN is in the area of mental health integration with primary care. This is important, yet there are needs beyond integration with primary care necessary to best serve people who rely on the public behavioral health system.

This is, in part, because the majority of people served through the public system often do not have primary care physicians. I would encourage broadening the scope of focus to include providers trained to work with consumers with severe and persistent mental illnesses (SPMI), substance use disorders (SUDs), and sex offenders. While all behavioral health providers are in short supply, we also need more certified peer specialists and certified behavioral health prevention specialists.

I'll speak to each of these populations:

Consumers with SPMI have unique needs and priorities. They die 25 years earlier than the general population. They smoke 47% of all cigarettes sold in Nebraska. They have high rates of diabetes and obesity. They generally receive little dental care. The overall quality of health and well-being is less than the general population. Persons with SPMI are often not well-served in primary care settings due to stigma and lack of provider training, and are often better served in behavioral health settings with embedded primary care providers. This has been done by Community Alliance in Omaha and is working very well.

Consumers with **co-occurring mental illnesses and substance use disorders (SUDs)** also have unique needs and challenges, and there is a significant shortage of providers trained in evidence-based best practices to effectively work with them.

Nationally, only about 1 of 10 people with SUDs receive any treatment at all and of those, most do not have a physician included in their care. Physicians in general are currently not well trained to assess or treat substance use disorders. In fact, most consumers with addictions who receive care from primary care providers do so for the consequences of their addictions, but not for their addictions which often go unrecognized.

We need to develop a diverse behavioral health workforce trained in recovery-oriented and trauma-informed care models able to work with consumers in both medical homes and behavioral health homes.

Inadequate treatment leads to increased costly and preventable hospitalization, incarceration, loss of economic productivity, homelessness, public safety issues, as well as the pain and suffering of the consumers and their families.

A particular need in Nebraska is physicians trained to use medication assisted treatment, or MAT. There are several FDA-approved medications for the treatment of alcohol and opioid dependence that are very effective when used with other psychosocial interventions. Nebraska ranks very low nationally in the number of physicians who use MAT. In fact, we have only 3 opioid treatment programs in Omaha and Lincoln able to use methadone, serving roughly 500 individuals, and only a couple dozen physicians certified to use buprenorphine across the state.

I'm designated as Nebraska's federally-recognized State Opioid Treatment Authority, and am concerned about our ability to address the small but growing problem of the abuse of opioid pain medications and of the increased use of heroin in the state. Opioid overdoses are on the rise and, nationally, deaths now exceed those from motor vehicle crashes annually.

Another shortfall are providers willing and able to work with **sex offenders** as part of their community management, including providers for behavioral health consumers who are also convicted sex offenders as well as providers specifically trained to do sex offender treatment.

Another key component in the continuum of care for behavioral health is **prevention**. The prevention workforce in Nebraska is moving beyond just the historical prevention of substance use disorders and into mental health promotion and mental illness prevention. These latter initiatives are new and not

as well established. A trained, competent, certified workforce in prevention is needed. Forty-four states have a prevention credential for their prevention workforce and I believe Nebraska should develop this as well.

To make the discussion even more complicated, we have identified about one dozen separate and distinct behavioral health systems in Nebraska. These include the VA, Federally Qualified Health Centers, Private Insurance, Medicaid, etc. All serve specific populations, have specific funding sources, and usually don't regularly interact with each other. The systems compete with each other for the small number of trained providers.

The Division of Behavioral Health, as the state behavioral health authority, is the only agency interacting with all of the other systems in the state. We can assist in providing leadership in workforce development and will continue our work with the Health and Human Services Committee, BHCEN and others across the state to develop, recruit, and retain a competent, caring and effective behavioral healthworkforce across the continuum, in a coordinated way, so that all Nebraskans can live the good life. Because there is no health without behavioral health.

Thank you.