The CBHSQ Report

CENTER FOR BEHAVIORAL HEALTH STATISTICS AND QUALITY

SAMHSA Substance Abuse and Mental Health Services Administration

National Survey on Drug Use and Health

APRIL 6, 2020

Behavioral Health Workforce: Quality Assurance Practices in Mental Health Treatment Facilities (Test Report)

Authors: Catherine G. Greeno, PhD, Elizabeth Hoeffel, Laura J. Sherman, PhD, Sean E. Lynch, PhD, LCSW

Summary

Background: Nationwide, there is concern about challenges in the retention of the behavioral health workforce, which includes mental health services. Members of the mental health treatment workforce benefit from continued training and clinical supervision to maintain high-quality services and prevent emotional exhaustion, burnout, and turnover. Mental health treatment facilities can play a key role in supporting their workforce through training and supervision practices. Method: Data from the 2010 National Mental Health Services Survey (N-MHSS) were used to examine the percentage of facilities that used quality assurance practices related to the behavioral health workforce and whether the percentage of facilities differed based on facility characteristics and by U.S. state (as evidenced by Cohen's h effect size ?0.20). Results: Most facilities (89.4 percent) monitored the continuing education requirements for professional staff. Almost all facilities (91.5 percent) had regularly scheduled case review with a supervisor, and many facilities (70.3 percent) had regularly scheduled case review by an appointed quality review committee; only 4.9 percent of facilities used neither type of case review practice. States differed in the use of quality assurance practices. Conclusion: Given that quality assurance practices related to the behavioral health workforce are common standard operating procedures in mental health treatment facilities, opportunities to enhance the quality of the practices should be supported.

Keywords: Behavioral health workforce, mental health treatment, mental health services, continuing education, clinical supervision, case review, training

Key Findings

- In 2010, quality assurance practices related to the behavioral health workforce were common standard operating procedures in mental health treatment facilities; however, use of certain practices differed by facility characteristics and by U.S. state.
- Most facilities (89.4 percent) monitored the continuing education requirements for professional staff. In general, percentages did not differ by facility characteristics.
- Almost all facilities (91.5 percent) had regularly scheduled case review with a supervisor, and many facilities (70.3 percent) had regularly scheduled case review by an appointed quality review committee. These percentages tended to differ by facility characteristics.
- Two-thirds of facilities (66.8 percent) used both types of case review practices (case review with a supervisor and case review by an appointed quality review committee); only 4.9 percent of facilities used neither type of case review practice.

Introduction

Nationwide, there is concern about shortages, retention, and training in the behavioral health workforce.1,2 Tremendous changes have occurred in recent years in the way mental health services are delivered, suggesting that mental health workers may need support and supervision to help them keep pace with changing practices.3 In the field of mental health, research is developing and supporting new and innovative treatment strategies, but practitioners may not be able to deliver these important evidence-based practices without training.4,5 The Annapolis Coalition, a prominent public-private partnership devoted to understanding and addressing the behavioral health workforce crisis, supported in part by the Substance Abuse and Mental Health Services Administration (SAMHSA), has made the improvement of training and staff education a primary goal.1

Members of the behavioral health workforce benefit from continued training and clinical supervision to maintain high-quality services. In addition, these practices may prevent staff from experiencing burnout2 and may assist in overcoming challenges in retention of qualified workers. For example, positive leadership (i.e., transformational leadership) has been shown to serve as a protective factor in community mental health providers' emotional exhaustion and turnover.6 Mental health treatment facilities can play a key role in supporting their workforce through training and supervision practices.

This issue of The CBHSQ Report focuses on quality assurance practices related to the behavioral health workforce that are used in specialty mental health treatment facilities in the United States (a companion report on substance abuse treatment facilities is also available). These practices include monitoring continuing education requirements for professional staff, regularly scheduled case review with a supervisor, and regularly scheduled case review by an appointed quality review committee. This report uses data from the National Mental Health Services Survey (N-MHSS) to describe the number of mental health treatment facilities that use these quality assurance practices related to the behavioral health workforce as standard operating procedures. In addition, this report examines whether the use of these practices differs by facility characteristics and by state in the United States (including territories and the District of Columbia).

DATA AND METHODS

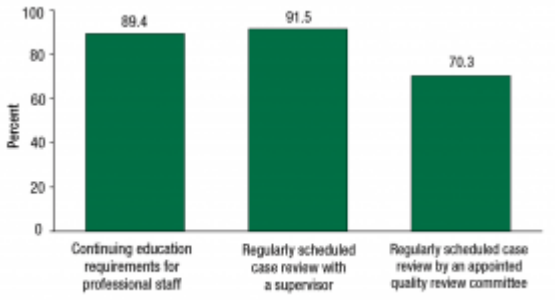
N-MHSS, conducted by SAMHSA, is an annual7 survey of all known public and private mental health treatment facilities in the United States. N-MHSS is the only source of national and state-level data on the mental health services reported by publicly and privately operated specialty mental health treatment facilities. N-MHSS is used to collect basic data on the number, location, and characteristics of specialty mental health treatment facilities and the people they serve throughout the 50 states, the District of Columbia, and other U.S. jurisdictions.8 N-MHSS is a point-prevalence survey that provides a picture of facilities' activities on a typical day but may not represent the full scope of practice in a given year.

The 2010 N-MHSS data are used for this report.9,10 There were 10,374 eligible mental health treatment facilities that responded to the survey. The response rate was 91.2 percent. Basic facility information, service characteristics, and client counts were reported for 9,139 of the 10,374 facilities. This report examines use of three types of quality assurance practices: (1) monitoring continuing education requirements for professional staff, (2) regularly scheduled case review with a supervisor, and (3) regularly scheduled case review by an appointed quality review committee. There was some missing data for each quality assurance practice; the numbers of facilities reporting data for each practice were 9,117, 9,116, and 9,101, respectively. There was also some missing data for facility characteristics (facility operation and service delivery setting). The percentages described in this report were calculated using available data for each analysis presented, and the totals used to calculate the percentages are listed in the tables.

Because N-MHSS is considered a census of facilities and provides actual counts rather than estimates, statistical significance and confidence intervals are not applicable. The differences between percentages mentioned in this report were assessed using Cohen's h. The results described here have a Cohen's h effect size ?0.20, which indicates that there were meaningful differences between the groups.11

QUALITY ASSURANCE PRACTICES IN MENTAL HEALTH TREATMENT FACILITIES

In 2010, quality assurance practices related to the behavioral health workforce were common standard operating procedures in mental health treatment facilities. Specifically, 89.4 percent of mental health treatment facilities monitored continuing education requirements for professional staff as a standard operating procedure; 91.5 percent of mental health treatment facilities used regularly scheduled case review with a supervisor as a standard operating procedure; and 70.3 percent of mental health facilities used regularly scheduled case review by an appointed quality review committee as a standard operating procedure (Figure 1).



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Mental Health Services Survey (N-MHSS), 2010.

QUALITY ASSURANCE PRACTICES ACROSS FACILITY OPERATION

The percentage of mental health treatment facilities that monitored the continuing education requirements for professional staff did not vary by type of facility operation with one exception (Table 1). Specifically, facilities operated by the U.S. Department of Veterans Affairs (VA) had a higher percentage of facilities monitoring continuing education requirements for professional staff as a standard operating procedure than the U.S. percentage overall (98.2 vs. 89.4 percent).

The percent of mental health treatment facilities that used regularly scheduled case review with a supervisor as a standard operating procedure varied. Compared with the U.S. percentage overall, a smaller percentage of facilities operated by a regional or district authority and by the VA used this practice (79.9 and 78.3 vs. 91.5 percent, respectively; Table 1).

The percent of mental health treatment facilities that used regularly scheduled case review by an appointed quality review committee as a standard operating procedure varied. Compared with the U.S. percentage overall, a lower percentage of facilities operated by a regional or district authority used this practice (55.9 vs. 70.3 percent), whereas a higher percentage of facilities operated by the VA used this practice (79.6 percent).

	Continuing education requirements for professional staff				Regularly scheduled case review with a supervisor				
	Total	n	Percentage	h[1]	Total	n	Percentage	h[1]	T
U.S. total	**9,117**	**8,147**	**89.4**	**N/A**	**9,116**	**8,342**	**91.5**	**N/A**	**9**
Facility operation									
Private for-profit	875	821	93.8		874	769	88.0		
Private nonprofit	6,099	5,449	89.3		6,099	5,652	92.7		6
State mental health agency	656	577	88.0		655	590	90.1		
Other state government	249	222	89.2		249	225	90.4		
Regional or district authority	169	148	87.6		169	135	79.9	↓	
Local, county, or municipal government	838	704	84.0		839	790	94.2		
U.S. Department of Veterans Affairs	221	217	98.2	↑	221	173	78.3	↓	
Other	10	9	90.0		10	8	80.0	↓	

1 Cohen's h was calculated by comparing the percentage of facilities in each facility operation with the overall U.S. percentage. Only comparisons in which Cohen's h was ?0.20 are noted with an arrow indicating whether the percentage was higher or lower than the overall U.S. percentage.
Note: Totals vary across quality assurance practices because of missing data.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Mental Health Services Survey (N-MHSS), 2010.

QUALITY ASSURANCE PRACTICES ACROSS SERVICE SETTINGS

A higher percentage of facilities offering inpatient services monitored continuing education for professional staff compared with the U.S. percentage overall (95.4 vs. 89.4 percent), whereas facilities that offered outpatient or residential settings were not different from the U.S. percentage (89.3 and 87.7 percent, respectively) (Table 2). It should be noted that these service delivery settings were not mutually exclusive; thus, some facilities offered services in two or more settings.

A lower percentage of facilities offering inpatient services used case review with a supervisor as a standard operating procedure compared with the U.S. percentage (79.5 vs. 91.5 percent), whereas facilities offering services in outpatient and residential settings were not different from the U.S. percentage (93.1 and 94.6 percent, respectively; Table 2).

The percentage of facilities using case review by an appointed quality review committee as a standard operating procedure did not vary by service delivery setting (Table 2).

	Continuing education requirements for professional staff				Regularly scheduled case review with a supervisor				
	Total	n	Percentage	h[1]	Total	n	Percentage	h[1]	T
U.S. total	**9,117**	**8,147**	**89.4**	**N/A**	**9,116**	**8,342**	**91.5**	**N/A**	**9**
Service setting[2]									
Inpatient	1,845	1,760	95.4	↑	1,846	1,468	79.5	↓	1
Residential	1,950	1,711	87.7		1,949	1,844	94.6		1
Outpatient	6,946	6,206	89.3		6,944	6,464	93.1		6

1 Cohen's h was calculated by comparing the percentage of facilities with each service setting with the overall U.S. percentage. Only comparisons in which Cohen's h was ?0.20 are noted with an arrow indicating whether the percentage was higher or lower than the overall U.S. percentage.
2 Service settings were not mutually exclusive; thus, some facilities offered services in two or more settings.
Note: Totals vary across quality assurance practices because of missing data.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Mental Health Services Survey (N-MHSS), 2010.

CASE REVIEW PATTERNS

The majority of facilities (66.8 percent) used both types of case review practices as standard operating procedures (regularly scheduled case review with a supervisor and regularly scheduled case review by an appointed quality review committee; Figure 2). The next most common pattern (24.8 percent) was for facilities to use regularly scheduled case review with a supervisor as a standard operating procedure but not case review by an appointed quality review committee. The least common pattern (3.6 percent) was for facilities to use case review by an appointed quality review committee but not case review with a supervisor. The remaining 4.9 percent of facilities used neither case review practice as a standard operating procedure.

	Continuing education requirements for professional staff				Regularly scheduled case review with a supervisor				Regularly scheduled case review by an appointed quality review committee			
	Total	n	Percentage	h[1]	Total	n	Percentage	h[1]	Total	n	Percentage	h[1]
U.S. total	**9,117**	**8,147**	**89.4**	**N/A**	**9,116**	**8,342**	**91.5**	**N/A**	**9,101**	**6,399**	**70.3**	**N/A**
Service setting[2]												
Inpatient	1,845	1,760	95.4	↑	1,846	1,468	79.5	↓	1,837	1,201	65.4	
Residential	1,950	1,711	87.7		1,949	1,844	94.6		1,950	1,350	69.2	
Outpatient	6,946	6,206	89.3		6,944	6,464	93.1		6,937	5,016	72.3	

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Mental Health Services Survey (N-MHSS), 2010.

STATE RESULTS

States varied in their use of the three quality assurance practices examined in this report (Table 3). Delaware was the only state with a higher percentage of facilities using all three practices compared with the percentage for the United States overall.

	Continuing education requirements for professional staff				Regularly scheduled case review with a supervisor				T
	Total	n	Percentage	h[1]	Total	n	Percentage	h[1]	
U.S. total	**9,117**	**8,147**	**89.4**	**N/A**	**9,116**	**8,342**	**91.5**	**N/A**	**9**
Alabama	181	140	77.3	↓	181	160	88.4		
Alaska	51	47	92.2		51	48	94.1		
Arizona	118	114	96.6	↑	118	111	94.1		
Arkansas	154	152	98.7	↑	153	140	91.5		
California	829	702	84.7		830	795	95.8		
Colorado	158	94	59.5	↓	158	133	84.2	↓	
Connecticut	181	164	90.6		181	175	96.7	↑	
Delaware	40	40	100.0	↑	40	40	100.0	↑	
District of Columbia	24	21	87.5		24	24	100.0	↑	
Florida	375	354	94.4		373	349	93.6		
Georgia	191	182	95.3	↑	191	172	90.1		
Hawaii	32	23	71.9	↓	32	29	90.6		
Idaho	40	38	95.0	↑	40	38	95.0		
Illinois	446	386	86.5		446	415	93.0		
Indiana	233	215	92.3		235	226	96.2		
Iowa	129	121	93.8		129	105	81.4	↓	
Kansas	94	89	94.7	↑	95	81	85.3	↓	
Kentucky	211	184	87.2		211	188	89.1		
Louisiana	132	113	85.6		132	108	81.8	↓	
Maine	110	101	91.8		110	108	98.2	↑	
Maryland	165	157	95.2	↑	165	139	84.2	↓	
Massachusetts	267	233	87.3		266	250	94.0		
Michigan	301	274	91.0		302	261	86.4		
Minnesota	209	195	93.3		209	195	93.3		
Mississippi	159	143	89.9		158	137	86.7		
Missouri	193	183	94.8	↑	193	168	87.0		
Montana	59	55	93.2		59	53	89.8		
Nebraska	84	80	95.2	↑	84	78	92.9		
Nevada	39	33	84.6		39	34	87.2		
New Hampshire	61	48	78.7	↓	61	54	88.5		
New Jersey	230	198	86.1		230	207	90.0		
New Mexico	94	90	95.7	↑	94	88	93.6		
New York	628	529	84.2		629	603	95.9		
N									
N									

1 Cohen's h >.20, state percentage compared to U.S. percentage. Arrow indicates whether percentage is higher or lower than U.S. percentage.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, N-MHSS 2010.

DISCUSSION

The 2010 N-MHSS data used in this report indicate that quality assurance practices related to the behavioral health workforce are common in mental health treatment facilities. Regularly scheduled case review with a supervisor was the most commonly used practice, followed closely by monitoring continuing education requirements for professional staff. Although regularly scheduled case review by an appointed quality review committee was a less commonly used standard operating procedure than review with a supervisor or monitoring continuing education requirements, it was still common in facilities. About two thirds of facilities used both types of case review in their standard operating procedures. Facilities operated by a regional or district authority had lower percentages of both types of case review when compared with the U.S. total. Although compared with the other settings, facilities offering inpatient services had higher percentages of monitoring continuing education requirements for professional staff and lower percentages of regularly scheduled case review with a supervisor as standard operating procedures.

Facilities can play a role in supporting the behavioral health workforce by including the practices outlined in this report in their standard operating procedures.1,2 The best quality outcomes are likely to be produced when they go beyond the provision of basic continuing education and clinical supervision.12,13 For example, continuing education that is interactive or tailored to individuals' practices and clinical supervisor expertise, especially in the areas of competencies and procedural knowledge, tends to yield better outcomes.12,13,14 Furthermore, studies indicate that formal documentation and evaluation are important when supervision is conducted in groups,15 which has implications for case review by a quality review committee. Some practices may be more easily integrated into existing facility procedures, such as monitoring the continuing education requirements for professional staff, compared with other practices that require greater time, resources, coordination, and funds (e.g., case review by a quality review committee). Online tools, video conferencing, and electronic health records might facilitate case review for facilities in understaffed or under-resourced areas.16,17 Additional resources to support the behavioral health workforce can be found at http://www.samhsa.gov/workforce and http://www.integration.samhsa.gov/workforce/education-training.

End Notes

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SAMHSA's mission is to lead public health and service delivery efforts that promote mental health, prevent substance misuse, and provide treatments and supports to foster recovery while ensuring equitable access and better outcomes.

This report is prepared by The Center for Behavioral Health Statistics and Quality (CBHSQ), SAMHSA.

Learn more about National Mental Health Services Survey: https://dev-samhsa-data-website.icfng-sites.com/data/taxonomy/term/382

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