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On behalf of its member boards, the International Certification and Reciprocity Consortium (IC&RC) welcome the opportunity to provide comments to the Senate Finance Committee as part of their effort to evaluate and improve the behavioral health system. The challenge presented to our nation by substance abuse and addiction must be taken seriously, and innovative approaches will be needed in this new age of health care eligibility and delivery.

It is a widely held misnomer that there are no national uniform standards for the SUD counseling profession. For there is one common thread that binds counselors across the country. That is credentialing. IC&RC is the gold standard for professionalism and training in the field of substance abuse counseling. IC&RC is the global leader in the credentialing of prevention, addiction treatment, and recovery professionals. Organized in 1981, it provides standards and examinations to certification and licensing boards in 25 countries, 48 states and territories, five Native American regions, and all branches of the U.S. military. Over half of all substance abuse counselors in the United States hold an IC&RC credential. Just as physicians are “board certified” in a specialty, addiction counselors are also certified, in one of seven pursuits specific to substance abuse treatment. All IC & RC credentials are based in the latest advances in neuroscience and evidence-based practices. Credentialed substance abuse counselors are far more knowledgeable about the biology, biochemistry, psychology, and sociology of substance abuse than the average primary care physician or nurse who has not been trained in the area. A substance abuse counselor credentialed by IC&RC has undergone thousands of hours of training and supervision, as well has hundreds of hours of classroom education.

Over the past several years, Congress has demonstrated unwavering commitment to the treatment of substance abuse, and especially the epidemic of opioid overdoses. The success of the Affordable Care Act, as well as the Wellstone/Domenici Mental Health and Addiction Parity Act, has granted access to treatment to millions of newly eligible consumers. However, we must now face a harsh reality: there are far from enough qualified substance use disorder professionals in the United States to meet demand. Commitment- and access- to high quality care is meaningless unless we have a workforce that can provide. A highly trained substance use disorder workforce, from prevention specialists to counselors to peers, can no longer afford to be anything but the highest priority. Congress must offer guidance on how we can recruit, train, and retain this workforce.

Just as there has long been a stigma against those who suffer from the disease of addiction, there is too a stigma affecting those who work in the prevention and treatment universe. Addiction and substance abuse services are reimbursed at ridiculously low rates, and until recently, have been all but shunned by private insurers. Regardless of the progress made in the public perception of those who abuse drugs, and the seismic shift we have seen in policy to treat addiction as a disease rather than a crime, policy makers and the public often view the substance use disorder workforce as people who were once in recovery and are now in the profession as a result. This remains true for many, but a very high percentage of our professionals have no such background. Our profession is truly one of public heath education and work experience, not only lived experience.

Congress needs to recognize publicly that the substance use disorder workforce is one that is distinct and unique. It is viewed by too many as an amalgam of social workers, psychologists, licensed professional counselors, marriage and family therapists, and other professionals. While these other professionals do indeed take part in the treatment of substance use disorders, none are trained exclusively in the treatment of substance abuse. This distinction falls only to credentialed professionals. While these other professionals may indeed seek out credentialing, we must end the misconception that substance abuse is treated exclusively by “behavioral health” specialists. Cancer is not merely treated by doctors: it is treated by oncologists, those doctors who are board certified and trained to specifically understand the disease they treat. In addition, there are oncology nurses, physician assistants, technicians, and more. Every other endeavor in public health requires a team of professionals, yet substance abuse professionals are often not viewed in these terms. They are too often defined by catch-all phrases, and rarely is it recognized by policy makers that there are entire teams of professionals that work solely on substance use disorders.

Up until recently, HRSA has shown interest in behavioral health, but not in substance abuse specifically. In the fall of 2015, HRSA and SAMHSA announced the creation of the Behavioral Health Workforce Research Center, to be housed at the University of Michigan’s School of Public Health. While the focus is on the larger universe of behavioral health, we hope that ONDCP will closely follow the development and growth of this center, so that the substance abuse work force gets the attention it deserves and requires. No one- especially consumers- will benefit from studies and evaluations that do not have at least some focus on the single diagnosis of substance use disorders. Every health profession can be broken down into subspecialties. Doctors, nurses, physician assistants, psychologists, and many others can all be evaluated by a subspecialty, whether it be oncology or pediatrics or nephrology or dozens of other areas of practice. The same must apply to behavioral health. It is not enough to group all mental health and substance abuse professionals into one category.

Many of HRSA’s recent efforts have focused on the recruitment of new professionals, via investments in such programs as the National Health Service Corps and the STAR Loan Repayment Program. Yet we have not done enough to focus on retention of the workforce. Turnover is far too high, and professionals leave the workforce far too quickly, due in large part to low reimbursement rates and draconian reimbursement policies. According to a report in 2019 from the HHS Office of the Assistant Secretary for Planning and Evaluation, a review identified only 11 states where an SUD counselor is eligible for direct reimbursement from the state’s Medicaid plan as an independent billing provider; all of them offer licensure for SUD counseling. In states where they are not eligible to enroll as independent providers, SUD counselors must work in a facility/program that is reimbursed on their behalf. UnitedHealth/Optum, the nation’s largest commercial health insurer, requires a license as a prerequisite for independent billing status. An SUD counselor is eligible in only 13 states (out of 50 states and D.C.) among Optum’s commercial plans, all states with licensure. While licensure is a facilitator, it by no means guarantees billing eligibility across insurance plans. According to a 2017 study by the Addiction Technology Transfer Center, Treatment agencies struggle because the SUD workforce is reimbursed at a lower rate than their colleagues with similar credentials in mental health and behavioral health, even in the same agency.

There has been significant progress on which we can build. In developing the guidelines for FQBHCs (Or CCBHCs as they are called), SAMHSA recognized the importance of credentialed professionals. In its “Draft Criteria for the Demonstration Program to Improve Community Mental Health Centers and to Establish Certified Community Behavioral Health Clinics,” document, SAMHSA recommended that:

*At a minimum*, the CCBHC staff is composed, either as CCBHC employed staff or through formal arrangements, of the following disciplines: (1) psychiatry (board certified or eligible for board certification in psychiatry and capable of prescribing medications for the treatment of opioid and alcohol use disorders); (2) psychiatric nursing; (3) **credentialed substance abuse specialist**(s); (4) at least one licensed mental health professional trained and credentialed to perform psychological testing; (5) staff trained to provide case management; (6) certified peer specialist(s)/recovery coaches; (7) staff trained to provide family support; and (8) some combination of the following: (a) licensed independent clinical social workers, (b) licensed mental health counselors, (c) licensed psychologists, (d) licensed marriage and family therapists, and (e) licensed occupational therapists.Providers serving CCBHC consumers include individuals with expertise in addressing trauma and the needs of children and adolescents with serious emotional disturbance (SED) and adults with serious mental illness (SMI).

As the document clearly states, there is an emphasis on credentialed substance abuse specialists. They are part of the mandatory staff.

It is our hope that we can expand on this recognition. At FQHCs around the country, there is attention paid to “Behavioral Health,” yet not necessarily the single diagnosis of substance use disorders. According to the most recent studies, Mental health services are provided by over 70% of the FQHCs centers, however, Substance Abuse services are provided at only 55% of the health centers that responded. While only 10% of the FQHCs do not routinely screen for depression over 35% of the FQHCs do not routinely screen for substance abuse.

FQHCs are required to staff “behavioral health professionals,” yet there is no guarantee these professionals are equipped to handle cases of substance abuse, as their education, while strong, requires little attention to the issue. Social Workers are the predominant behavioral health discipline represented in FQHCs. Only 6% of all behavioral health employees at FQHCs are credentialed counselors. This means only 6% of all treatment for substance abuse at FQHCs is being provided by professionals who have been tested and trained in the single diagnosis of substance abuse. FQHCs see over 100,000 consumers a year for substance abuse. It is nothing short of malpractice not to provide treatment for these consumers by those who have been thoroughly trained in substance abuse treatment.

According to the National Council for Mental Well Being, The CCBHC demonstration enabled providers to hire and retain vital staff. The current behavioral health care workforce is only able to meet approximately 25% of the need for services and the gaps are much higher in rural areas; if this trend is not reversed, a shortage of more than 250,000 behavioral health professionals is projected by 2025. Most states cited expansion of staff as one of the biggest system improvements resulting from the CCBHC demonstration. Previous reports have demonstrated that CCBHCs hired and retained additional staff as part of the CCBHC certification, including adult and child psychiatrists, licensed clinical social workers, nurses, counselors, case managers and peer specialists/recovery coaches.

Nevada referred to CCBHCs’ ability to hire additional staff as “one big win for the PPS rate.” Historically, Nevada’s relatively low Medicaid reimbursement rates, coupled with a longstanding workforce shortage, resulted in significant understaffing and lack of availability of behavioral health professionals. As a result of the CCBHC demonstration, participating clinics in Nevada have been able to recruit and retain all types of behavioral health professionals by offering more competitive wages. CCBHCs in Nevada now have a substantially enhanced workforce, which state officials acknowledged as crucial for providers in rural and frontier areas. CCBHCs in areas of Nevada that rarely had access to psychiatrists prior to the demonstration now have an onsite psychiatrist and/or psychiatric advanced practice registered nurse, as well as MAT providers to treat certain types of substance use disorders.

The recruitment and retention of an SUD workforce must not be simply about quantity and quality: diversity is also essential. A disease such as addiction requires that consumers and professionals connect on a personal level. As such, the workforce we recruit must reflect our population. It must be of mixed gender, mixed race, and able to relate to the diversity of our nation.

Another segment of the workforce we must address is the role of peers. Peer recovery is experiencing rapid growth, whether it is provided by a peer recovery coach, peer recovery support specialist, or peer recovery mentor. Peer support services - advocating, mentoring, educating, and navigating systems – are becoming an important component in recovery oriented systems of care. Sharing recovery experience is deeply rooted in the addiction field, but it is a newer concept in mental health. Inclusion of peers with practical experience on teams with degreed clinicians is increasingly being emphasized by SAMHSA - in both addiction and mental health settings. Outcomes include decreases in morbidity and mortality, as well as empowerment of service recipients.

Credentialing provides much-needed standardization to the rapidly growing profession of peer recovery support. Becoming credentialed demonstrates competency, by having professional expertise and qualifications verified by an independent evaluator. It recognizes achievement of a standard of ethics, education, and experience necessary to provide quality recovery support services. IC&RC’s Peer Recovery (PR) credential is designed for individuals with personal, lived experience in their own recovery from addiction, mental illness, or co-occurring substance and mental disorders.