

THE UNHEARD VOICES

IN THE CONVERSATION ABOUT BEHAVIORAL HEALTH IN
THE PORTLAND METRO AREA



United We Heal

Executive Summary

The Affordable Care Act and the resulting Oregon Health Plan (OHP) expansion has increased access to behavioral health services for many across the state of Oregon. The expansion of OHP has provided health insurance to an additional 375,000 Oregonians.¹ Yet, at a time when more Oregonians are receiving care to address behavioral health and substance abuse needs, the quality of care they receive remains a problem. In a 2015 survey of mental health outcomes by Mental Health America, Oregon ranked 49th, ahead of only Arizona and Nevada.² In a 2016 update to that survey, Oregon had fallen to 51st, behind every other state and the District of Columbia.³

At the same time, the community behavioral health system has benefited from large increases in resources as a result of the expansion of OHP and the restructuring of the state Medicaid system. Between 2010 and 2015, the six largest contracted non-profit agencies in the Portland metro area reported an average increase in annual revenue of forty-percent (40%).⁴ The average dollar increase was \$12.6 million in annual revenue.⁵ However, those increases in profit for contracted behavioral health agencies have not necessarily resulted in improved working conditions or pay and benefits for staff under pressure with higher caseloads and increasingly demanding performance measures.

Behavioral health professionals across the Portland area are coming together to take action and discuss issues in the behavioral health system that impact client care and their working conditions, such as high caseloads that cause burnout and high turnover. In conjunction with AFSCME Council 75, they have formed the Solidarity Alliance of Social Services (SASS). SASS members across the community behavioral health field have identified the following problems as the largest and most pervasive in community behavioral health in Portland:

- High caseloads and poor access to services for clients, behavioral health professionals report routinely being assigned caseloads of up to 110 clients. They also report that they are forced to

schedule follow up appointments from four to six weeks out in order to fit everyone in.⁶

- Workers experience significant problems with burnout which ultimately contribute to high levels of turnover and inconsistent client care.⁷
- Low wages and poor benefits, the average behavioral health professional makes far less than workers with a similar level of education.⁸

In light of these problems within the industry, AFSCME Council 75 and SASS have identified the following ways to improve behavioral health outcomes in Oregon.

- Mandated staffing ratios and caseload limits, these would ensure clients have adequate access to behavioral health care and would lessen provider burnout allowing them to stay with the same provider for a longer period of time.
- Increase agency accountability with their use of public funds by requiring non-profit agencies to publicly post their budgets and allow the public to attend their board meetings. The state of Oregon would be better able to ensure public dollars are being utilized effectively and going towards essential services.
- Whistleblower protections for behavioral health professionals and required labor peace agreements between contractors and any unions seeking to represent behavioral health professionals, the whistleblower protections would allow workers to speak up about issues in their fields and the labor peace requirement would ensure the services many Oregonians rely on are not disrupted by a labor dispute.

Many of the issues identified in the behavioral health industry relate to one central issue that runs throughout the industry – the lack of worker voice both within the workplace and throughout the state’s behavioral health system. Members of SASS and AFSCME Council 75 are mobilizing to change this dynamic in the behavioral health industry to improve client care and behavioral health outcomes in Oregon.

Lived experience of a behavioral health professional

"I am a counselor at a local community behavioral health agency. As I walk into the door at the beginning of my day, I have notes from 5 sessions to complete before they are deemed late by my supervisor. I have two full behavioral health assessments to complete and I only have one week to write them. These take 1-2 hours to write because often I have to comb through hospital records and collateral reports to get an accurate picture of my client's history and clinical presentation. I have no paperwork time in my schedule today. I have five clients to meet with, reams of texts from parents and my voicemail box is full.

I graduated from my master's program in December 2015 and started my first job in community mental health in January of 2016. I was hired to work with adolescents and then was assigned to cover another therapist's entire caseload because she went on maternity leave and management did not create an adequate coverage plan. She intended to exit the profession entirely, but if she admitted this, she would have lost access to her benefits and sick time. The additional caseload that I absorbed added an adjoining county, which in total, covers a 50-mile area.

My clients live with severe and persistent mental illness. They come from family systems that have been facing violence, poverty and addictions for as many generations as they can recall. Most do not know how their rent will be paid this month, that is, if they are housed. Despite their challenges, they each have so many unique and individual strengths. Erika is a Mexican American 17 year old and in her senior year at an alternative high school. She lives in subsidized housing with her mother who suffers significant

functional impairment due to mental illness and addiction.

Erika currently meets criteria for PTSD. She is a survivor. She has shared that some of her earliest memories involve intense domestic disputes, violence and abuse. There was even an incident that escalated in which her father held a gun to her head. The profundity of trauma that Erika has survived cannot be understated. She struggles immensely at school both socially and academically. I attend teacher conferences several times a month to address ways that her symptoms can be managed in order to create a suitable learning environment. She reports that she often feels overwhelmed and is easily distracted. She has learned to cope with this by engaging in risky behaviors and experimenting with drugs and alcohol. She holds herself responsible for the food and financial insecurity at home. After our last teacher conference, I assisted her in obtaining a box of groceries from a local food pantry. When we took it back to her house, we threw out two kitchen sized garbage bags full of rotten food. Despite her circumstances, Erika has remarkable insight. After each meeting, I feel truly humbled by the humor and grace with which Erika has learned to navigate her life. She has seen dozens of treatment providers for challenges related to her mental health symptoms. She has shared multiple experiences of suddenly losing a provider she felt connected to, and how this has made her reticent to fully engage with treatment. Erika is only one example of a client who is making strides towards mental health recovery in spite of the system, and not because of it."

– Behavioral Health Counselor, Portland

Introduction

In 2016, behavioral health professionals from a number of contracted agencies in the Portland Metro Area contacted AFSCME Council 75 to talk about their experiences and concerns in their field. In response to the volume of employees coming forward with similar stories, the Solidarity Alliance of Social Services, or SASS, was formed. SASS is led by behavioral health professionals, in both unionized and non-union settings, working across the spectrum of behavioral health agencies and environments throughout the Portland-metro area. SASS members are working together, alongside AFSCME Council 75, to improve client care and the working conditions of employees in the behavioral health industry through community

and political organizing and advocacy for their clients.

Over the past nine months, AFSCME Council 75 has been working with behavioral health professionals to compile responses and gather their stories about working in Portland's behavioral health system through an informal survey. Behavioral health professionals are highly committed to their client's well-being, healing and recovery, playing a vital role in the behavioral health system. Almost half of survey respondents have been in the field for two or more years and 85% indicated doing work that feels meaningful is most important to them.

One respondent shared that “fresh out of grad school, I was thrown into a brand new setting, promised support and resources that were not provided, nor was needed training provided.”

— *Community Behavioral Health Survey 2016*

Behavioral health professionals take on many roles in the continuum of client care in the contracted agency setting. Master’s level clinicians assess, diagnose, and provide ongoing behavioral health treatment including individual, group, and family therapy. Case managers and service coordinators assist clients in accessing resources such as housing, medical or psychiatric care, and government assistance. Peer support specialists, recovery mentors, and skills trainers assist clients in life skill building. They provide support and coaching to increase self-efficacy, community participation, social inclusion and productivity to clients with functional impairment due to mental illness. In practice, service provision often overlaps. For example, it is not uncommon for Master’s level clinicians to engage in case management or skills training with clients. While this is helpful for continuity of care, it often places far too much responsibility on one behavioral health professional to carry out every aspect of a client’s needs. This is a significant contributor for burnout, which ultimately sets clients up for negative outcomes. What we have learned about behavioral health professionals through both the survey and conversations, is that this workforce is highly committed to their client’s well-being.

Despite their dedication to the work, behavioral health professionals report many challenges. When describing the difference between the work they are doing and what they thought it would be like, respondents talked of the work as “fractured,” noting “mechanized and impersonal care” and feeling treated as an “expendable product.” They spoke of the “barriers and complications to accessing resources” for clients they work with and “compromising professional and personal values (and personal wellbeing) at times to stay afloat or employed.”

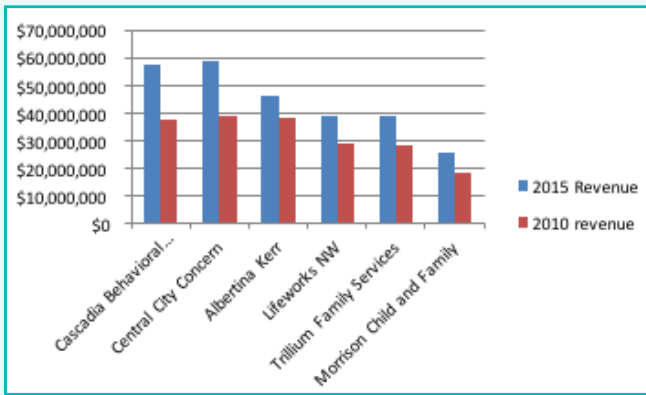
Expanded access to health insurance provided by the Affordable Care Act has led to more resources for behavioral health agencies but quality of care remains an issue.

The Affordable Care Act (ACA) and Oregon’s expansion of Medicaid through OHP has increased access to behavioral health services throughout the state. Since its implementation the state of Oregon has added an additional 375,000 Oregonians. While access to care has expanded, the state continues to grapple with how to improve health outcomes in the behavioral health system, performing well below other states across the country.

In a 2015 survey of mental health outcomes by Mental Health America, Oregon ranked 49th, ahead of only Arizona and Nevada.⁹ A 2016 update to that survey found that Oregon had fallen to 51st, behind every other state and the District of Columbia.¹⁰ In 2010 the Department of Justice opened an investigation of the state of Oregon’s mental health system under the American’s with Disability Act.¹¹ The Department of Justice issued a follow up report in 2014 stating Oregon had actually regressed in some of the areas that had triggered the investigation.¹² While the Department of Justice investigation was closed after an agreement was reached with the state in 2015, problems continue to persist in the Oregon community behavioral health system.¹³

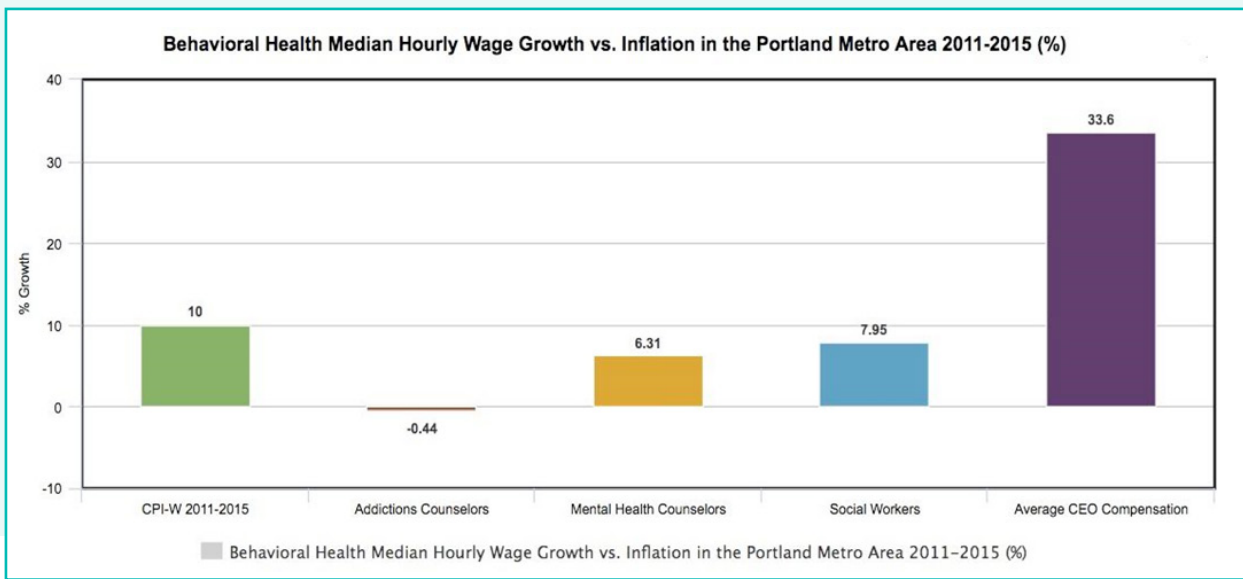
In a 2015 survey of mental health outcomes by Mental Health America, Oregon ranked 49th, ahead of only Arizona and Nevada.⁹ A 2016 update to that survey found that Oregon had fallen to 51st, behind every other state and the District of Columbia.¹⁰

Implementation of the ACA has transformed the community behavioral health system from a model dependent on government contracts with set funding maximums to a medical model where behavioral health agencies are billing insurance plans for more of their revenue. This has led to increased resources in the behavioral health system through Medicaid and private insurance reimbursement for services provided to people who were previously uninsured and unable to access care. The six largest non-profit agencies contracted by Multnomah County to provide behavioral health services saw an average increase of 40% in their annual revenue between 2010 and 2015.¹⁴ In dollar terms, the average increase of the six largest non-profit



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While OHP expansion and mental health parity laws have increased access to care for patients and benefited agency revenue in the behavioral health system, the salaries and working conditions of behavioral health professionals still lag behind. Over the same period agency revenue was increasing, the median hourly wage in three common job titles in the behavioral health industry failed to keep up with inflation, and one of the classifications actually saw a decrease in the median hourly wage.



agencies was \$12.7 million in annual revenue.¹⁵ These same agencies saw an average profit of \$4.2 million with an average profit margin of 9.4%.¹⁶

Lack of Transparency in the Privatized Behavioral Health System

One factor perpetuating this trend in the industry is the lack of transparency required for non-profit, community behavioral health agencies. The top six contracted, behavioral health agencies in the Portland area maintain total budgets that are funded by a median of 96.7% in public money in exchange for providing behavioral health services. Local, county or state agencies administering these same services would be subject to laws that guarantee citizens are able to access information and ensure public dollars are used for public services. Public agencies are subject to public records and open meetings laws. These laws allow citizens the right to

access information on public agency's budgets, public employee's salaries and the amount of services provided and the costs associated with those services. In addition, citizens are allowed to attend public meetings when policy and budget decisions are being discussed that allow citizens to weigh in on decisions being made that impact vital public services.

In contrast, private, non-profit behavioral health agencies are not held to the same standards as public agencies even while their funding comes from public taxpayers. While non-profits are required to report annual financial statements to the federal government that are available for review, they are often several years old before they are made available to the public and they do not provide the level of detail on how dollars are being spent required of public agencies. The latest available tax filings from 2014 for the six largest non-profits that contract with Health Share to perform outpatient behavioral health services reveal slightly more than one in

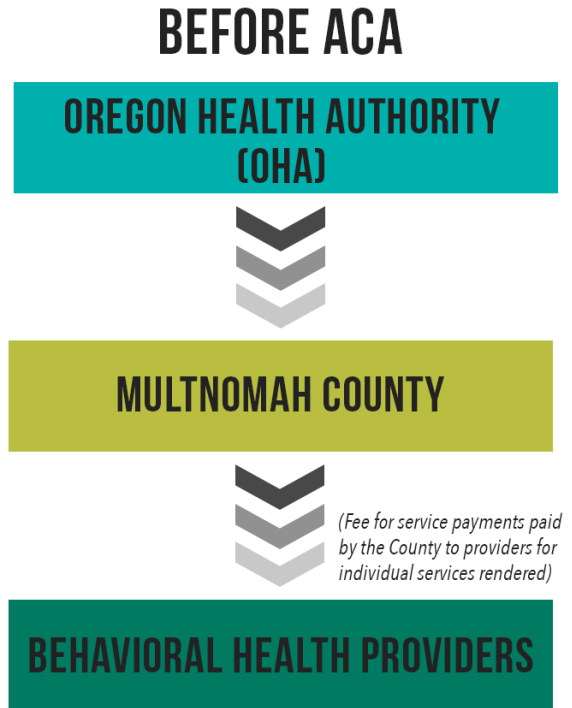
six dollars did not go toward public services. The exact amount that went to administrative costs or was reported as excess revenue was 18.18% or \$83 million. In addition, CEO's of these agencies have received an average of 33.6% raise over the last five years while employee salaries have lagged behind inflation.

Despite Increased Resources for Community Behavioral Health, Clients Continue to Report Problems with Access to Services

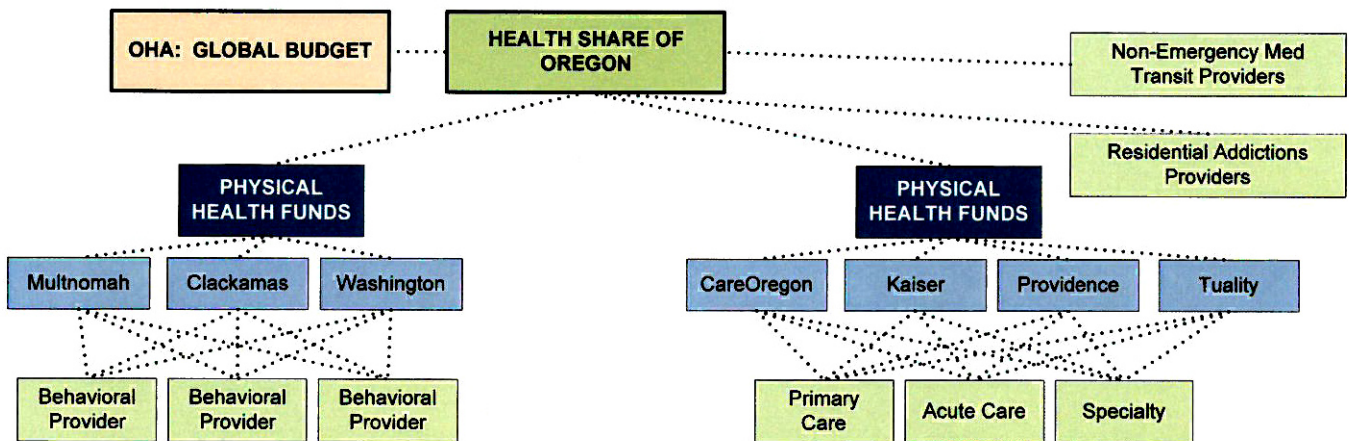
While the ACA was being rolled out and implemented nationally, the state of Oregon reformed its' state Medicaid program, the Oregon Health Plan (OHP). All OHP recipients now receive services through the newly created Coordinated Care Organization (CCO) system. As of 2016, ninety percent (90%) of enrollees on the Oregon Health Plan are now clients of a CCO.¹⁷ According to the state of Oregon, CCOs will lead to more coordinated and integrated care resulting in better behavioral health outcomes at a lower cost.¹⁸ The state provides a capitated budget to CCO's each year, and the CCOs work to find savings through providing cost-effective, preventative care instead of more costly care at the emergency room. CCOs may receive more in payments from the state if they achieve certain quality incentives.¹⁹

There are two CCOs that serve the Portland Metro area. The largest is Health Share of Oregon, an umbrella organization that is comprised of eleven different health providers in the metro area that serves about 260,000 clients.²⁰ The second is FamilyCare, a former managed care organization that serves around 130,000 clients.²¹

While the CCOs have achieved the majority of their state mandated bench marks for providing quality care, one measurement that both Health Share and FamilyCare failed to achieve was meet-



HEALTH SHARE OF OREGON: FINANCE AND PAYMENT



Behavioral health providers receive capitated payments for each person they serve from Health Share.

Source: Providence Health & Services

ing access to care guidelines.²² The Oregon Health Authority (OHA) measures how accessible care is for CCO clients through consumer surveys. In their 2015 evaluations, 15.7% of FamilyCare clients and 17.6% of Health Share clients reported having trouble accessing medical care.²³ These both were above the state guideline which recommends a baseline of 12.5% of reports citing problems with clients accessing medical care.²⁴

More specific to behavioral health, while both Health Share and FamilyCare were able to meet the benchmark around post-discharge follow up for a behavioral health issue, 28.3% of FamilyCare clients and 21.7% of Health Share clients reported not being able to access a behavioral health professional in that timeframe.²⁵

While both Health Share and FamilyCare were able to meet the benchmark around post-discharge follow up for a behavioral health issue, 28.3% of FamilyCare clients and 21.7% of Health Share clients reported not being able to access a behavioral health professional in that timeframe.²⁵

When clients are unable to access a behavioral health professional after being discharged from the hospital they are more likely to end up utilizing emergency rooms or ending up in the criminal justice system when they experience a behavioral health crisis, leading to worse outcomes and driving up health costs within the system. Even worse, lack of timely access to behavioral health appointments can lead to dire consequences for many with behavioral health needs. Suicide is one of Oregon's most persistent public problems. In 2012, it was the 2nd leading cause of death for Oregonians aged 15 to 34 years old and the age-adjusted suicide rate in Oregon was 42% higher than the national average.²⁶

“Reducing wait times for mental health services is particularly critical, as evidence shows the longer a patient has to wait for an appointment, the greater the likelihood that the patient will miss the appointment.”

— National Alliance on Mental Illness Presentation²⁷

When clients' access to medical care is impeded, outcomes are poorer. The longer a client is forced to wait for an appointment, the less likely they are to show up for appointments and receive treatment. The following data from the National Alliance on Mental Illness (NAMI) demonstrates this. According to data from the National Alliance on Mental Illness (NAMI), when a client is able to get access to a same day appointment, they show up to the appointment 88% of the time.²⁸ When a client is able to schedule an appointment for the next day, the client attends the appointment 77% of the time.²⁹ When a client is able to access an appointment within 7 days, they attend the appointment 58% of the time and it falls to 56% of the time when a client must wait 13 days for an appointment.³⁰

Nationwide, the average wait to see a behavioral health professional is 25 days and in a survey, two-thirds of primary care providers reported that their clients had trouble accessing behavioral health services.³¹ CCO provider handbooks in Oregon state that non-urgent appointments are to be made within 30 days.³² However, in practice this does not always happen. Behavioral health professionals at various agencies have reported that due to understaffing, they are routinely scheduling people for appointments beyond 30 days.³³ Client inability to schedule timely appointments ultimately contributes to poor client outcomes.

Turnover in the Behavioral Health Industry Impacts Access to Care and Client Outcomes

Another issue reported by employees of the behavioral health system impacting client care are the high rates of turnover amongst providers which can lead to inconsistent care for clients. A 2010 study found a nationwide turnover rate of 33.2% for counselors compared to a 7% rate for primary care doctors and 12% for primary care nurse practitioners and physician assistants.³⁴ At one large behavioral health agency in Multnomah County, workers reported being told in a staff meeting that the average length of employment at that agency was five months.³⁵ When there is staff turnover, clients are forced to start over in treatment each time they are assigned a new clinician. As a result, clients frequently become less willing to engage in treatment the more providers they interact with. A 2008 study found that turnover inversely correlated with behavioral health outcomes.³⁶ Not

only does high turnover affect quality of service, it also impacts clients' access to care. When providers leave the industry, their cases are usually dispersed among the remaining staff until a replacement can be found. This also contributes to larger caseloads and longer wait times for appointments.

A 2008 study found that turnover inversely correlated with behavioral health outcomes.³⁶

A study by the National Association of Social Workers (NASW) in 2002 found turnover rates at private agencies were twice as high as those at government agencies. Turnover rates were 40% at the private agencies compared to 19% at government agencies.³⁷ One factor contributing to the difference in turnover rates are the higher wages and improved benefits provided by unionized government agencies in comparison to largely non-union private firms. In the Portland metro area, the vast majority of behavioral health work is performed by contracted agencies, the majority of which are local non-profits.³⁸

“(Clients) feel abandoned by staff who leave due to low pay and poor conditions, reenacting past abandonment.”

— *Response to Community Behavioral Health Survey*

The implementation of the CCO system marked a change in funding for behavioral health non-profits. Fee for service models, in which costs are difficult to control, were shifted to capitated payments, or “case rates.” In the case rate system, CCO’s will pay a certain amount per month, per client, depending on the level of care and clinical setting. Contracted agencies are therefore incentivized to have as many clients as possible enrolled in their programs to maximize revenue.

The case rate payment system utilized by CCOs incentivizes behavioral health agencies to serve as many clients as possible to maximize revenue.

While the behavioral health agencies are accepting a higher number of clients, there has not been a corresponding increase in behavioral health professionals to maintain the level of services. This has led to an increase in caseloads for behavioral health professionals and has markedly decreased access to care for clients, as there simply is not enough time in a workday to accommodate caseloads as high as 110 clients per provider. While behavioral health professionals have always had productivity standards for client care, the implementation of these funding changes has led to an increased emphasis on quantity over quality of care.

“The client work can be stressful at times but that is nothing compared to the unrealistic expectations placed on clinicians that compromise the quality of the work we do. It feels like [the] agency’s focus is often on quantity and production rather than quality client centered approach.”

— *Response to Community Behavioral Health Survey*

Behavioral health professionals have reported they are required to meet standards for billable client care and client-related activity hours in the course of each month. A study of the effects of productivity standards for therapists in 2015 found that they were related to increased turnover and lower job satisfaction.³⁹ A 2007 study found behavioral health professionals believed the reason productivity standards existed were to ensure they were generating revenue for the organization. Behavioral health professionals also indicated they believed they led to lower quality care.⁴⁰

In Portland, behavioral health professionals have reported productivity standards have driven them to work increasingly long hours as they are not only required to meet these standards, but they are also expected to submit their paperwork in a timely fashion so the agency may receive reimbursement. In fact, at many contracted agencies, provider’s report the only way to assess a behavioral health professional’s performance is an evaluation of their productivity and note timeliness. This reality creates a grim picture of behavioral health professionals as cogs in a revenue generating machine.

“(We are) treated as “expendable product(s).” Low pay, no access to raises, lack of transparency about pay and benefits, lack of flexibility regarding scheduling.”

— Response from Community Behavioral Health Survey, 2016

In numerous conversations about behavioral health in Portland, employees of the community behavioral health system have raised the issue that working at a community behavioral health agency is seen as a stepping stone that workers just need to get through to be able to move on to something else. It is seen as a painful process by which a behavioral health professional completes the client care hours required to achieve professional licensure. In order to receive their license, a behavioral health professional must complete a certain number of hours of supervised client care. For licensed social workers these hours must be completed in an agency setting, creating

I am a Child and Family Therapist working for one of the largest community mental health organizations in Portland, OR. Most of the children in our program receive OHP insurance. In addition to their mental health symptoms our clients often come into our services with a combination of chaotic family environments, food insecurity, inadequate educational supports, and unstable housing. Most therapists are new to the field, and are expected to create change for those in circumstances regarded as some of the most challenging in the system of mental health.

Therapists in some community mental health agencies do not receive enough clinical supervision and/or the appropriate kind of supervision to meet the needs of these families. Therapists are often not given the option to “refer out” if a family’s needs are beyond the scope of competence of a clinician which may produce poorer outcomes for families and increase clinician anxiety and feelings of inadequacy.

Therapists are often given conflicting messages by management staff to provide a frequency of services that is

a captive workforce for community behavioral health agencies. With licensure, options expand for behavioral health professionals. They may transition into private practice or move onto a more comfortable job with the county or at a hospital which are far more likely to be unionized.

The overwhelming majority of clients of the community behavioral health agencies are enrolled in OHP. Recipients of OHP are required to fall below certain federal poverty line thresholds and are potentially the clients who have had the least consistent access to needed services in their lifetimes. The current system is set up in a way that provides the poorest, most vulnerable clients with behavioral health care needs to be served by the least experienced providers in the field.

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clinically indicated (or appropriate to the level of need for the family), but then pressured to meet arbitrary standards of productivity resulting in more stress and job dissatisfaction.

In addition to all of this unlicensed therapists are being paid the lowest wage on average for the amount of education required for the position, and the process for licensure (which provides upward mobility for therapists and increases their earning potential significantly) is often fraught with barriers that can delay a clinician becoming licensed multiple years.

It is this combination of factors for clinicians in community mental health that result in frequent turnover, which dramatically decreases the quality of treatment provided to families, increases the stress placed on other staff excepted to do the extra work, and leaves families feeling traumatized by a system that they have come to looking for help.

— Erica Findley, MA, LPC Intern

Improving Access to Services by Allowing Private Practice Clinicians to Serve OHP

As previously noted the contracted agencies are responsible for treating a growing amount of OHP clients in the state. These contracted agencies have demonstrated challenges with serving this influx of clients, while at the same time private practice clinicians have reported numerous barriers to get impaneled and serve Health Share clients.⁴¹ Increasing the number of private practice providers serving OHP clients and streamlining access rules could alleviate some of the burden currently faced by the contracted agencies.

To further improve behavioral health outcomes in Oregon, the state should also take steps to promote a robust private practice industry. Currently anti-trust law treats private practice providers, most of whom run their own one person small business, as having equivalent power with enormous health insurance companies. As such, private practice providers are barred from discussing reimbursement rates with colleagues or attempting to join together and collectively negotiate with insurance companies. This creates difficulties in maintaining a stable private practice system of clinicians. It perpetuates disparities in reimbursement, making it harder for clinicians to practice. Inequitable reimbursement rates and low transparency also create a zero sum game for providers where insurance companies can play the thousands of providers against one another and will likely have more knowledge about the market than thousands of fragmented private practice clinicians. This makes it harder for clinicians to practice and leads some to leave the field entirely, weakening the private practice industry.

Community Behavioral Health Employees Experience High Rates of Burnout

Behavioral health professionals also reported high caseloads and constant exposure to client trauma creates high levels of burnout in the Portland community behavioral health system. Burnout is defined as emotional exhaustion, depersonalization, and diminished sense of personal accomplishment. Unlike other frontline health occupations, burnout is routinely characterized as just being a part of working in community behavioral health. Studies have estimated that nationally 57% of mental health workers and an astonishing 71% of family social workers showed high burnout levels.⁴²

Studies have estimated that nationally 57% of mental health workers and an astonishing 71% of family social workers showed high burnout levels.⁴²

Burnout appears to be endemic throughout the community behavioral health system. In numerous conversations with providers, this problem and the lack of meaningful solutions offered by the industry has been raised repeatedly. The burden of dealing with this industry issue is almost always placed on the providers themselves, by indicating that employees should increase their self-care instead of addressing the underlying causes of the problem, such as staffing and hours of work. Unfortunately, in most cases, the provider has little time, energy, or funds outside of work to spend on themselves in order to properly prevent burnout. The result is a high level of turnover throughout community behavioral health agencies.

“Clients can feel our burnout.”

— *Community Behavioral Health Survey, 2016*

By its' very nature, community behavioral health work is challenging. It becomes even more so when issues regarding working conditions are not addressed and the only solution offered is self-care. A recent study found that half of community health workers polled, worked overtime in a typical week, and those who worked overtime showed increased signs of burnout.⁴³ The NASW Center for Workforce studies found that 31% of social workers said a major issue was the lack of time to complete the necessary tasks of the job.⁴⁴ Any effort made to improve behavioral health outcomes in Portland must address the working conditions of behavioral health professionals in order to have a chance at success.

Entry Level Behavioral Health Professionals Have High Education Standards and Face Numerous Financial Challenges

In addition to burnout leading to high employee turnover rates, behavioral health workers in the Portland metro area are also paid significantly less than similarly educated workers. According to the Bureau of Labor

Statistics (BLS), workers nationally with a master’s degree were paid on average \$33.52 an hour and workers with a bachelor’s degree were paid on average \$28.42 an hour.⁴⁵ The median hourly wage for workers employed as mental health and substance abuse social workers in the Portland metro area was \$18.88 in 2015. The hourly wage for substance abuse and behavioral disorder counselors was \$20.16 in the Portland metro area in 2015. Finally, the median hourly wage for a worker employed as a mental health counselor in the Portland metro area in 2015 was \$22.93 an hour.⁴⁶ All three of these are significantly below the national average for workers with a similar level of education. For comparison in the Portland metro area, Licensed Practical Nurses, a position that typically requires completing a one year program, had a median hourly wage of \$24.51 in 2015. Registered Nurses, a position which requires an associate’s or a bachelor’s degree, had a median hourly wage of \$41.80 in 2015.

On top of low wages, according to a 2013 report by The Council on Social Work Education, the average graduate with a bachelor’s degree in social work carried a student loan debt of \$31,880.⁴⁷ According to the same report, the average graduate of a Master’s in Social Work program had a student loan obligation of \$41,754.⁴⁸ Assuming this debt was made up completely of subsidized student loans from the federal government, an MSW graduate working for the median hourly wage in Multnomah County with a family of four would be making student loan payments of \$468 a month for the ten years after they graduate.⁴⁹ At the median salary in the Portland metro area, this would be the equivalent of 11.7% of gross income going to pay down student loan obligations.⁵⁰

Behavioral health professionals who work in positions that do not require a bachelor’s degree face similar problems with wages failing to keep up with inflation and the cost of living in the area. According to the Massachusetts Institute of Technology living wage calculator, a living wage for a family of four with two working adults was \$15.79 in 2015.⁵¹ In 2015, positions representing 27% of community and social service positions in the Portland metro area had median hourly wages below this amount.⁵²

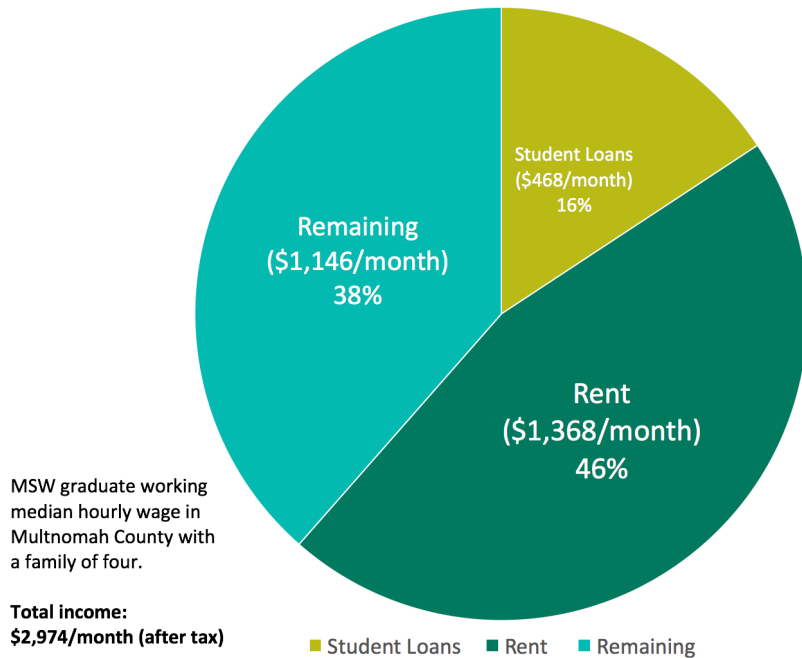
While not exempt from the problems of the industry, unionized firms in the Portland metro area report lower turnover which is tied to better health outcomes

Turnover is a large problem in the community behavioral health industry in Portland. Nationally, a 2010 study found that turnover rates for behavioral health providers were between three and four times higher than primary care providers.⁵³ A 2008 study of turnover and behavioral health outcomes found that workforce stability is very important in delivering high quality services.⁵⁴ At one large behavioral health provider in Multnomah County, workers report being told in a staff meeting that the average length of employment at that agency was five months.⁵⁵ At a different non-profit agency the average tenure was estimated at slightly over one year by employees.⁵⁶

In the public sector, many more behavioral health workers are represented by unions. In 2002 the NASW found that turnover rates for behavioral health workers employed by local governments were half those of behavioral health workers working for private agencies.⁵⁷ Turnover at Central City Concern (CCC), a large behavioral health provider in Portland that has some unionized employees, is also much lower. The average tenure of an employee at CCC is five and a half years.⁵⁸ In addition, Qualified Mental Health Professionals (QMHPs) working directly for Multnomah County have a median tenure of seven years as of March 2017. At Oregon Health and Science University (OHSU), the median tenure of a social worker was four years as of March 2017.⁶⁰

Unionized behavioral health professionals also receive higher wages and improved benefits.

Employer	QMHP Starting Hourly Wage
Multnomah County	\$28.15
OHSU	\$29.20
Cascadia Behavioral Healthcare	\$23.80 ⁶²
Lifeworks NW	\$21.63 ⁶³
Morrison Child and Family Services	\$17.36 ⁶⁴



In terms of health insurance coverage for employees, the industry trend for behavioral health agencies in the Multnomah County area is to not contribute towards dependent health coverage. At Multnomah County and OHSU, the employer pays the majority of the cost of family health insurance. Employees at Multnomah County pay a maximum of 6.75% of the premium for individual and dependent care and employees of OHSU pay 12% of the cost of dependent coverage. Of the six largest agencies in community behavioral health, only Central City Concern pays anything towards the cost of family health insurance.

More importantly, unionized employees in the behavioral health field are able to work collectively with management to address issues that can impact client outcomes like caseload and staffing levels which contribute to employee burnout and turnover. Employees of Kaiser Permanente of Northern California who are members of the National Union for Healthcare Workers (NUHW) were able to establish guidelines in their collective bargaining agreement (CBA) with Kaiser Permanente that address scheduling and staffing levels. Language in the collective bargaining agreement states:

“In order to provide more individual return time, the Employer’s intent is to construct therapist profiles to allow for four (4) individual/family returns for every one (1) new psychotherapy intake.”

“To ensure ongoing adequate access, when a ratio of 4:1 cannot be maintained for greater than one (1) month, the Employer’s intent will be to refer patients to providers outside the bargaining unit, including, at the Employer’s

sole discretion, non-KP providers, in order to return to a 4:1 ratio, as needed, by facility. If it is necessary to refer out for longer than three (3) months in a department, the Employer will adjust staffing in the department as needed in order to return to a 4:1 ratio, except in cases where the need to refer out is temporary, for example where it is due to employee leaves. While the Employer’s intent is as stated above, the Union recognizes that circumstances may require modification of new to return ratios in order to maintain appropriate access for new patients.”

“When therapists are scheduled to work in clinic, unless they are assigned to other specific duties by management, such as triage, groups, meetings, case consultation conferences, and or supervision, all of their remaining time is potentially available for individual/family therapy appointments. Of the time potentially available for individual/ family therapy, therapists are expected to average over three months at least 75% seen direct patient care. Booked and registered in person, video, collateral, and phone visits count toward the 75% standard. This schedule management proposal only applies to time spent on individual adult and child therapy within the department of Psychiatry.”

In addition, the CBA requires Kaiser to develop metrics to measure and report the amount of time spent on direct vs. indirect patient care. The reports are then compiled by facility and regionally and shared with staff at staff meetings. This CBA language agreed to by Kaiser of Northern California and employees is just one example of how behavioral health professionals with a union can address problems in the industry together that have a real impact on client’s access to care and help address caseload and burnout issues faced by staff.

Conclusion

AFSCME Council 75 and SASS Recommendations' to Improve Working Conditions and Client Outcomes

Many of the issues that have been identified in the behavioral health industry relate to one central issue that runs throughout the industry—the lack of behavioral health professional's voices both within the workplace and throughout the state's behavioral health system. Both Multnomah County and the Oregon Health Authority have implemented work groups to discuss issues facing the industry, however, neither group provides for representation of the employees who are expected to carry out the work on a daily basis and whose work is most impacted by changes to the system.

To address the lack of behavioral health professional's voices within the industry, as well as other issues that workers and clients experience, AFSCME Council 75 proposes the following solutions:

- **Require written plans to prevent disruptive labor unrest and provide whistleblower protections.**

In the last 15 years there are numerous examples of behavioral health agencies not respecting their employee's legal right to organize in Portland.

1. In 2004, workers at the Parry Center, managed by Trillium Family Services, went on strike for nine weeks and management eventually permanently replaced some of the striking workers in an effort to break their union.⁶⁵
2. In 2008, workers at Cascadia Behavioral Healthcare (Cascadia), the largest behavioral health provider in the Portland metro area, attempted to form a union and management responded by hiring professional anti-worker attorneys. After spending thousands of dollars on legal fees, Cascadia almost went bankrupt and the county was forced to step in and redistribute some of the contracts Cascadia had been awarded to

other non-profits to preserve behavioral health services in the area.⁶⁶

3. In 2015, the CEO of Lifeworks NW responded to conversations about organizing by issuing anti-union e-mails to her employees. These same e-mails were later reworded as part of an anti-union message by Cascadia Behavioral Healthcare in 2016.⁶⁷
4. In 2016, workers at Volunteers of America's (VOA) inpatient programs formed a union despite the opposition of management. VOA management hired an anti-worker attorney and forced their employees to sit through captive audience meetings with anti-union propaganda in the run up to the union election.⁶⁸ After the election VOA released their initial attorney and brought in a new attorney who is known for causing bitter labor disputes.⁶⁹
5. In 2016 and 2017, Cascadia Behavioral Healthcare sent out two anti-union letters in response to employee conversations about organizing. Cascadia also had supervisors read prepared statements attempting to dissuade employees from unionizing.

Despite increased financial resources due to reform being experienced by the industry, employee issues are not being considered and their voices are not being heard. While the administrative costs of the non-profits have risen in the last 5 years, the median hourly wages of occupations in the behavioral health industry have not kept pace with inflation. Furthermore, when behavioral health workers have tried to exert their legal rights and address their working conditions, they have been fought every step of the way by non-profit management.

By refusing to recognize the rights of their employees to have a voice in their workplaces, the leadership of

non-profit agencies actually make it more likely that their worksites will be the site of a labor dispute. This would have negative outcomes for clients and could potentially disrupt the system as a whole. Therefore, in the interest of promoting labor peace, Multnomah County should require that any subcontractor performing behavioral health work agree to a written labor peace agreement with any union that wishes to represent behavioral health workers.

In addition, the County must ensure there are increased whistleblower protections for any behavioral health employee who has concerns regarding fraud, neglect or abuse in the system. As direct care providers, employees are often the first to know when there is an issue that should be reported to a regulatory body for non-compliance with billing, client care and fraud.

- **Implement regulations mandating staffing ratios and caseload limits.** Employees at several non-profits have reported facing unsustainable caseloads which lead to burnout and turnover. This issue impacts clients because they are unable to keep their same provider, increasing the risks that they will drop out of the system altogether. To prevent this from happening, the Oregon Health Authority (OHA) should implement regulations that require staffing ratios for inpatient settings and limit caseloads for outpatient settings. This will lead to increased access to care for clients and provide a sustainable and safe environment for behavioral health workers.
- **Increase agency accountability with use of public funds and evaluation practices.** The state of Oregon requires coordinated care organizations (CCO's) to develop quality management and improvement programs in order to maintain eligibility for Medicaid reimbursement. Thus, behavioral health organizations are required to report scores from The Healthcare Effectiveness Data and Information Set (HEDIS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS), or other performance measures. The HEDIS and CAHPS are nationally recognized healthcare performance surveys; however, they both centrally focus on primary care and physical health outcomes.

While behavioral health organizations are permitted to utilize their own performance evaluations, they often place singular emphasis on the performance of individual providers and neglect to track other valuable measures of client success including housing, community support, and social inclusion as well as educational and vocational advancement. Community behavioral health agencies receive public funds and should be held accountable through the implementation of thoughtful and standardized performance evaluation measures. Client outcomes should focus on indicators in many different domain areas of life that accurately reflect behavioral health. Positive client outcomes indicate soundly developed programs and services provided by well-resourced staff.

- **Increase agency transparency in their use of public dollars.** While the community behavioral health agencies have seen a tremendous growth in resources, this money is not always going towards client care. Slightly more than one out of every six dollars that went to the non-profit agencies that contract with Health Share to perform outpatient behavioral health work ultimately did not go towards services for the public.⁷⁰ In order to ensure an efficient use of public funds, the state of Oregon should require non-profit agencies with more than \$100,000 in annual revenue to publicly post their budgets online for 30 days, to have their board of directors meetings be considered public meetings, and to submit to and cooperate with audits from the Secretary of State office, and adhere to public records law.
- **Change regulations to improve client choice.** OHA should require CCOs make increased efforts to empanel more private practice providers. This will ease some of the burden currently being felt by the behavioral health agencies and will ease some of the access to care issues that clients are facing. Furthermore, the state of Oregon should create an anti-trust exemption for private practice clinicians so they can freely discuss reimbursement rates. This will ensure there is a stable private practice workforce in Oregon. OHA

should also establish more regulations to promote coordinated care not only between agencies but within agencies as well. Agency policy should be implemented in a way that allows clients to stay with their provider of choice if they want to in order to promote continuity of care and improve client outcomes.

- **Promote professional development opportunities for direct service employees.** Numerous employees have reported that their peers see their work in community mental health as a steppingstone to get their licenses and move on. In practice, this means community behavioral health workers are viewed as expendable components of the system that can be replaced often. This acceptance of high turnover contributes to poor working conditions and client outcomes. It creates a system set up to provide the poorest, most vulnerable clients with behavioral health care served by the least experienced, lowest paid employees.

To alleviate this problem, OHA should create a continuing education fund that behavioral health professionals can access to receive training and advance within their fields. Finally, the state of Oregon should recognize the contributions of Peer Support employees and require CCOs to compensate agencies for the services they provide. By giving all behavioral health professionals sustainable paths to stay in community behavioral health, OHA can ensure it has a sufficiently trained workforce that meets the demands of a growing client base across the state.

In addition to an OHA created training fund and increased recruitment efforts, Multnomah County should also work with its' subcontracted provider agencies to improve working conditions and create a career path so employees who really want to stay in community behavioral health are able to do so. This will lead to improved client outcomes and more satisfied workers which will create a more sustainable and successful community behavioral health system.

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