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HOW TO PAY FOR PARAPROFESSIONALS IN MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

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Who are Paraprofessionals?

Before one can examine how paraprofessionals can be financed, it is necessary to know what is meant by "paraprofessional", in the fields of mental health and substance abuse. The literal meaning is, of course, "similar to professional". However, in today's world it is very broadly used. With the exception of RNs, who are deemed to be professional whatever their degree, it may include anyone with less than a masters degree who delivers direct care, educational or treatment services related to mental health and substance abuse. Paraprofessionals may be psychology, social work, or nurse assistants; a wide variety of counselors; activity or rehabilitation therapists; special educators; residential managers or case managers; crisis or outreach workers. They may work with the young, the old, the chronically handicapped, with substance abusers, or the mentally disturbed.

Educationally, paraprofessionals may have batchelor's or associate of arts or science degrees, high school diplomas, or no educational certificate at all. Sometimes they can have a considerable amount of in-service training or continuing education with or without formal education, sometimes their formal education may include no specialized training.

The specialized training of paraprofessionals may be very broad or very narrow. Some paraprofessionals are only trained to use one skill or to work with one problem, such as alcoholism. Others, such as many mental health associates, may have a broad training in psychology and social therapies and

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may be competent to work with many different types of client or patient;[1] essentially, they are trained as mental health generalists.

A third way of examining paraprofessionals is in terms of their social, cultural and psychological background and their similarity or dissimilarity to those they treat. Many so-called indigenous paraprofessionals come from the same background as their clients and may have experienced the same problems. They understand the circumstances and conditions of their clients' problems, speak the same language, and can serve as role models.

Paraprofessionals may work full or part-time. They may be paid, volunteers, or part of mutual aid groups. In this paper, because we are concerned with the reimbursement of paraprofessionals, we are limiting our discussion to those paraprofessionals who are paid.

How Many Paraprofessionals?

It is hard to calculate the number of paraprofessionals working in the United States today.

It is not even easy to calculate the numbers officially reported in ADAMHA statistics because, although most professional organizations do not consider mental health workers with batchelors degrees to be professional, NIMH does include them in that category.

NIMH has reported that in 1976[2], out of a total of 423,258 FTE staff employed in mental health facilities in the United States, 145,722 were other direct care staff with less than batchelors degrees. For purposes of the definition in this paper, 1,509 paraprofessional psychologists, 5,649 social workers, and an estimated 17,000 activity therapists, vocational rehabilitation counselors and special education teachers, all with batchelors degrees must be added to this number, making a total of 169,880 paraprofessionals, working in mental health programs. This does not include mental health paraprofessionals

working in law enforcement and correctional settings, or in educational rehabilitation programs, nursing homes or group or foster homes, emergency hotlines, or in specialized support programs for the elderly or for children.

The number of full-time paid paraprofessionals working in alcohol programs in April 1979 totaled 9,321[3]. Of these, 5,142 had no degrees, 1,178 AA degrees and 3,001 batchelors degrees. An additional 4,442 paraprofessionals worked full-time in substance abuse programs. Another 2,511 worked part-time in alcohol or combined programs. Altogether, 11,832 paraprofessionals in substance abuse; thus, 181,712 paraprofessionals have been officially reported by ADAMHA in the three specialties.

Where are Paraprofessionals Working?

The employment of paraprofessionals is not new. There have always been paraprofessionals, trained or untrained, employed at least in hospitals and other institutional settings. Today they are employed in many different settings and perform a broad range of functions, as demonstrated in studies such as those made by Alley[4] and his colleagues, and by Steinberg[5]. The latter found that 19 functions were performed by all professional and paraprofessional mental health workers. Mental health paraprofessionals work in inpatient, outpatient, emergency, crisis, outreach services, in community support programs, and increasingly in "wellness" or holistic health programs.

Alcohol and drug abuse counselors may work within a mental health, health, social work, personnel or general rehabilitation service, or may be employed within an independent substance abuse program in which they can advance depending on their adjudged competence and experience from beginning counselor to program director[6].

The majority of mental health paraprofessionals with less than BAs, included in official statistics, work in inpatient settings. However, NIMH

reported in 1976 that 14,536 FTE were employed in outpatient settings, 726 in day/night facilities. It was not possible to break out the number working in different settings amongst the 35,651 who were employed in community mental health centers. NIMH figures do not include paraprofessionals who are employed in centers for the elderly or semi-protected homes and work settings.[2]

The question is, therefore, not whether paraprofessionals should deliver mental health and substance abuse services, but rather how and where they can be employed most efficiently and effectively, and how they can be paid. It is necessary to examine what effect funding or reimbursement systems can have on this goal.

The Organization and Funding of Mental Health and Substance Abuse Services

Mental health and substance abuse services are delivered organizationally in many different ways: by individual practitioners in private practice; through group practice; or by for-profit, non-profit or public agencies and institutions. Some services are independent and free standing. Others form a component of medical health services.

Funds may be provided by the client, an insurance company, a foundation or community fund, or by local, State or Federal governments, or any mix of these. Money is drawn from many sources.

Individual providers working independently in private practice may be paid for a specific service on a fee basis, or may work on a personal service contract to provide time or services. Services delivered through organizations may be bought on a fee-for-service basis; paid to the agency or the chief provider on a per capita basis; or agencies and institutions may obtain funds through annual budgets, grants or contracts which provide for salaried

positions, require the delivery of a specific amount of service or guarantee the furnishing of specific numbers of beds or treatment slots.

The Organization and Funding of Paraprofessionals in Mental Health and Substance Abuse Services

Because paraprofessionals are not generally viewed as fully qualified to work as independent practitioners, they most frequently work in organized settings under professional supervision. Some workers in some States are trained and licensed to perform very specific functions either on their own or through organizations. A number of States license alcohol and/or drug abuse counselors.[7] In other States, the employing organization or supervising professional is held responsible for the quality of service.

The vast majority of mental health paraprofessionals are working in hospitals, where the staff is hired and paid for by the institution. Public hospitals have annual budgets provided by the legislature. Private hospitals are generally paid for the direct care and administrative services, which they provide, by fees from patients and third-party reimbursers. The selection of the staff, within broad standards, is left to the institution's discretion. Accreditation standards such as those of the JCAH[8] are now imposing some limits on this discretion. Although there may be some professionals on the staff who are also paid for on salary, most physicians are paid for by a fee for their services, except in State mental hospitals.

Paraprofessionals who work in community mental health centers and substance abuse and alcoholism programs have also been paid on salary. Most such programs are funded by grants or contracts and the staff are reimbursed through a full-time or part-time annual salary. In the past, these programs have been free to hire staff in accordance with their boards and directors perception of an adequate staffing pattern. This has varied greatly. However, as grants ran out, community mental health centers are increasingly dependent on third-party

payment, either from private insurance plans or Titles XVIII and XIX of the Social Security Act.[9] These programs limit the services which may be delivered and who may deliver them. Many States don't even recognize non-medical mental health professionals as providers of services let alone paraprofessionals.[10] Consequently, as Federal grants run out in these centers, there has had to be a change in staffing patterns toward the use of more professionals and more medically supervised programs.[11]

There is a trend to increase the reimbursement for alcohol and substance abuse services under Titles XVIII and XIX of the Social Security Act[9, 13] and by private insurers. However, reimbursements are, in the majority of States plans, designed to cover inpatient detoxification in medical settings; non-medical detox, rehabilitation and outpatient services are much less frequently covered. This sets severe limits to the services provided, the settings and staffing in programs which must rely on third-party reimbursements. If services are provided under Title XX, there are fewer limitations on staff. Newman, et. al., in studying funding for alcoholism, comment that there are two streams of funding, the medical and the social rehabilitative.[6]

In some organizations, only a licensed or certified professional provider can take responsibility for the provision of service and obtain reimbursement. Under these circumstances, it is not always clear whether services delivered by paraprofessionals under professional supervision may be signed for and reimbursed under the professional's provider number. To clear this problem ADAMHA[12] proposed provider status for CMHCs and substance abuse programs (1978). New Jersey[14] has developed standardized costs for units of service delivered by qualified staff.

Some community or neighborhood health centers provide mental health services.[16] Very frequently, in these settings, outpatient counseling and

emergency treatment is delivered by the nurses or paramedics at the sites. Some centers employ mental health professionals either to deliver services or to train and consult with the allied health staff. These centers, like CMHCs, may be funded in a variety of ways. Staff may be employed on State salaries or funded through grants and contracts. Where there is reliance on fee-for-service third-party reimbursement the use of paraprofessionals will be limited.

Health Maintenance Organizations (HMO)

Prepaid health services, such as HMOs[17], which are funded on a capitation basis would appear to lend themselves to the employment of paraprofessionals. Mental health and substance abuse services may be provided within the HMO or may be contracted out to a provider organization or to individual professional providers. Many BA social workers, nurse practitioners and physician assistants are employed within HMOs on salary. Some of these provide mental health services under medical or mental health professional supervision.

When mental health services are contracted out by the HMO to other organizations, the contractor may make payments on a retainer, capitation, or fee-for-service basis to the organization or to an individual provider within the organization. If payment is made to the organization, the latter may decide to provide service through a range of providers subject to the laws of the State or the conditions of the contract. Some paraprofessionals can be employed under such arrangements. However, their employment may be limited by State HMO enabling legislation specifying types of staff which can be used or by the State laws and regulations governing the licensure and employment of mental health providers.

Substance abuse providers for HMOs are more likely to be paraprofessional in terns of our definition and indeed some directors of alcohol and drug abuse

programs may not have any degrees. Although employee assistance programs have been more likely to employ non-medical mental health professionals, they have not usually supported paraprofessional counselors.[18]

In private practice, there may be tasks which a mental health professional could well delegate to a paraprofessional, but under present fee reimbursement systems, this is usually not an option in mental health, although there are models in other health areas. For instance, the dental hygienist who works in a dentist's office under supervision and whose functions are clearly defined and certified.

Community Support Systems

Many paraprofessionals are employed in community support systems for chronically handicapped mental patients.

In community mental health centers and other mental health service programs in the community, one sees a wide variety of staffing patterns in day treatment programs, half way houses, 24-hour emergency telephone services and crisis outreach programs. "Hotlines" are often staffed by volunteers with paid paraprofessional supervisors and professional back-up. Funds for the paid staff are quite often obtained by grants from community chests or sometimes with contracts from the State. Day treatment programs which concentrate on resocialization or chronic care are likely to employ a higher proportion of paraprofessionals than those providing intensive psychotherapy.[15] An NIMH monograph describes four levels of staffing for half way houses from no to full-time professional staffing. Many such paraprofessionals work quite independently. Case management for the chronically handicapped is sometimes vested in the social welfare worker who is more likely than not to be a paraprofessional with an AA or BA degree and paid for on an annual salary through the local social service department. Funding may be a mix of Federal Social Security funds and State monies.

Many deinstitutionalized mental patients are placed in nursing homes, and the day-to-day care and treatment is usually provided by salaried professional and paraprofessional nurses. Funds may come from private or public fees or through contracts, such as from the Veterans Administration or from the State.

Staffing of residential treatment centers is, to a considerable extent, determined by the source of funding and the laws of particular States. Although the inmates may be the same, funding under Titles XVIII and XIX,[9, 10] and Title XX,[17] require different staffing, the latter permitting greater use of paraprofessionals to provide treatment and the former mandatory medical supervision.

Therapeutic group and foster homes, whether they are paid for under contract from a State or local government, or by private or public fees, are usually managed by paraprofessionals, often with professional consultation or supervision from a mental health or substance abuse program.

Reimbursement for paraprofessional mental health and substance abuse care and treatment reflects the multiple sources and modalities of all mental health and substance abuse funding. It is clear that the organizational structure and conditions of funding may affect the feasibility of employing paraprofessiona

Delivery of service is severely distorted by this fragmented non-system and rational decisions regarding the most effective use of professional and paraprofessional staff have to be modified by considerations of where the money can be found. Up to this date, there have been relatively few studies of the cost effectiveness[20] of different types of service. A recent study by Hall of Washington University of a sample of community mental health centers, which employed different mixes of professionals and paraprofessionals or changed their staffing patterns over the years, suggests that paraprofessionals are

cost-effective, at least for certain populations and functions. A study of a detox and rehabilitative alcohol program in Illinois[21] comparing inpatient and outpatient detox using different mixes of professionals and peers resulted in the program moving to outpatient detox and paraprofessional staffing for the treatment of most of its patients. However, there is great need for further study on the cost effective use of different kinds of paraprofessionals.

Summary

At the present time, many paraprofessionals are employed in the delivery of a wide variety of mental health and substance abuse services. The statistics indicate that the majority of paraprofessionals are employed in inpatient programs and paid for on salary. However, there are increasing numbers of paraprofessionals employed in a wide variety of community services with varying degrees of supervision. Most of these are also paid for on salary.

Paraprofessionals appear to be more easily employed in organizations which are funded under grants, contracts, appropriations or on a capitation basis rather than under fee-for-services rendered.

Restrictions on the qualifications of those who may be reimbursed through third-party payments, State licensing practices, and standards for institutional accreditation, limit the flexibility of agencies to employ a range of paraprofessionals in their programs. There is insufficient evaluation of the cost effectiveness of these restrictions and their effects on staffing patterns.

Two major models of payment appear to be on the horizon. One in which each unit of service and its appropriate provider is defined, costed out, and reimbursed; a second in which organizations are accorded provider status and paid to render a range of services.[22] Such organizations are permitted greater flexibility in their staffing patterns but are required to be accredited. The individuals employed in such organizations may be required to be credentialed.

Each of these models is potentially capable of accommodating the employment of paraprofessionals in the delivery of health and mental health services.

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