



Behavioral Health Aides

A Promising Practice for Frontier Communities

A report by the National Center for Frontier Communities prepared in consultation with the Frontier and Rural Expert Panel.

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Executive Summary: Behavioral Health Aides

Background

The prevalence and incidence of most types of behavioral health disorders is similar for urban, rural and frontier residents. However, the impact of these disorders is greater in rural and frontier areas, where people are much less likely to receive treatment due to the low availability, accessibility and acceptability of rural behavioral health services. The lack of behavioral health treatment in rural and frontier areas has led to behavioral health disparities between rural (including frontier) and non-rural residents. Rates of depression, domestic violence, child abuse, and suicide are higher in rural areas and frontier areas.

To address these problems, many workforce models are being developed which include new types of allied behavioral health workers, referred to in this report as Behavioral Health Aides (BHAs). By expanding the behavioral health workforce with locally recruited workers, these models aim to improve access to behavioral health care in frontier areas and elsewhere several ways. First, this new class of workers usually practices in their local community, making them easier for frontier clients to access than many licensed mental health professionals, who are usually located in larger communities. Second, the high level of cultural literacy of workers who come from the same culture as their clients makes them ideal liaisons between clients and the behavioral health system. Third, these workers often play the role of community educators and advocates to help raise awareness and reduce stigma around behavioral health disorders.

This paper provides information on the seven emerging BHA models:

- BHAs as Care Coordinators and Case Managers;
- BHAs as support workers;
- Mental Health First Aid certified laypeople;
- Peer Counselors and Peer Specialists;
- *Promotoras* with supplemental behavioral health training;
- Alaska's BHA Model;
- Behavioral Health Practitioners.

Conclusion

The use of BHAs is relatively new development in the field of mental health. Many BHA models are being developed, implemented, adapted and improved upon across the U.S. These models have good potential for improving behavioral health care in rural and frontier areas. However, because the use of BHAs is a new development, there is some uncertainty about the appropriate implementation of the various BHA models, either in frontier areas or elsewhere:

- There is little published research on most BHA models and their use in rural and frontier areas;
- It is difficult for organizations implementing BHA programs to exchange information with one another, because there are no national organizations or networks for most types of BHA;
- Some stakeholders have shown an interest in the creation of statewide and/or nationwide licensing or credentialing standards for various types of BHA. However, there are no nationally recognized core competencies for most types of BHA;
- Many BHA programs lack a stable source of funding.

1 Introduction

The prevalence and incidence of most types of behavioral health disorders is similar for urban, rural and frontier residents.¹ However, the impact of these disorders is greater in rural and frontier areas, where people are much less likely to receive treatment due to the low availability, accessibility and acceptability of rural behavioral health services.^{1,2}

Behavioral health services are often unavailable in rural and frontier communities due to severe provider shortages in these areas,^{1,3,4} and the rural behavioral health workforce has not increased substantially for decades.^{1,4} This creates problems of access to behavioral health services for rural and frontier residents, who must travel long distances to reach services.^{1,3,4} Additionally, frontier residents are more likely to be uninsured than their rural and urban counterparts, which can hamper access to care.³ Even where behavioral health services are accessible and available, people may not seek them because of the high levels of stigma lack of anonymity in frontier communities.¹⁻³ Studies have shown that the smaller a community is, the stronger the stigma towards mental health treatment tends to be.² Additionally, in many rural and frontier communities the available services are not suited to local cultures – there are few behavioral health professionals from racial or ethnic minority groups, and behavioral health training programs have placed little emphasis on rural settings. There is a lack of research on rural and frontier-specific behavioral health models because it is assumed that programs developed in urban settings can be scaled-down to fit more rural contexts, however this is not often the case.^{1,2} These are just some of the factors which have led to the chronic and severe behavioral health care shortage in frontier America.

The lack of behavioral health treatment in rural and frontier areas has led to behavioral health disparities between rural (including frontier) and non-rural residents. Rates of depression, domestic violence, and child abuse are higher in rural areas,² and suicide rates are 37% higher in non-metropolitan areas than in suburban areas.⁵

To address these problems, many workforce models using new types of allied behavioral health workers are being developed. By expanding the behavioral health workforce with locally recruited workers, these models aim to improve access to behavioral health care in frontier areas and elsewhere several ways. First, this new class of workers usually practices in their local community, making them easier for frontier clients to access than many licensed mental health professionals, who are usually located in larger communities. Second, the high level of cultural literacy of workers who come from the same culture as their clients makes them ideal liaisons between clients and the behavioral health system. Third, these workers often play the role of community educators and advocates to help raise awareness and reduce stigma around behavioral health disorders.

This report will focus on a broad class of allied behavioral health workers, referred to in this report as Behavioral Health Aides (BHAs).^{*} There are two broad classifications of BHA.

^{*} Different states use different terms to refer to the same type of BHA (for a list of these terms, see Appendix I: Terms used to refer to BHAs). When reference is made to a specific state program, the term used in that state to refer to the BHA will be noted in parentheses.

1. Institution-based: BHAs who work as assistants to mental health professionals in inpatient mental health institutions, prisons, or other inpatient settings.
2. Community-based: BHAs who work in their communities to identify people in need of behavioral health services, connect them to the services and programs for which they are eligible, and help craft and/or implement a mental health care plan. Their focus is on early intervention and case management.

This report will focus on community-based BHAs (referred to in the rest of this report as BHAs). There is a variety of BHA models being used throughout the United States (U.S.) today. Some BHAs offer a wide range of services, while others are more specialized. The levels of training required for BHA certification, the supervision of practicing BHAs, and the funding of BHA programs vary widely among states and between different models. The following sections will highlight several BHA models being used in the U.S., with a focus on the main roles played by BHAs, their training and supervision, funding BHA programs, and the policy and regulatory issues regarding the development and implementation of programs incorporating BHAs.

2 Emerging BHA Models

In recent years, there has been an explosion in the development of models for providing certain behavioral health services using allied behavioral health workers. Many states, and in some cases individual counties within states, are developing their own BHA-type models. A comprehensive review of all BHA models currently being used and/or developed in the U.S. is beyond the scope of this paper because of the sheer number BHA models under development and the speed with which these models are developing and changing. Instead, this section will focus on a selection of established BHA programs:

1. BHAs as Care Coordinators
2. BHAs as Support Workers
3. Mental Health First Aid
4. Peer Counselors and Peer Specialists
5. *Promotoras* with Supplemental Training
6. Alaska's BHA Model
7. Behavioral Health Practitioners

This section describes the basic components of these models and the training of BHAs in each model. The title of each section reflects the main role played by BHAs in that model. However, in some states various aspects of these basic models are combined. Hence, the models outlined below are not entirely distinct from one another. Rather, there can be significant overlap between them in practice, and state programs often tailor the roles played by BHAs to the state's unique needs. The descriptions below are intended to illustrate several broad categories into which the majority of BHAs can be divided.

2.1 BHAs as Care Coordinators and Case Managers

In some states, BHAs serve as care coordinators for clients with behavioral health issues. Under the Comprehensive Community Support Services program in New Mexico, coordinating BHAs (*Community Support Workers*) develop a service plan and a crisis management plan together with clients and under supervision of a licensed therapist, encourage and support client self-management, and assist clients in

accessing support services in the community (this does not include transporting clients, which New Mexico's former case management programs did include). If necessary, BHAs also follow up with clients to make sure that the services they have accessed are meeting their needs.⁶

In Minnesota, coordinating BHAs (*Adult Mental Health Targeted Case Managers*) also assess clients, make a care plan with them, help connect them with services and monitor clients' progress towards their goals. However, the focus is less on self-management and more on facilitating access to services, which may include accompanying and/or transporting clients to appointments.⁷

In several counties in California, the focus of coordinating BHAs (*Mental Health Aides and Promotores*) is to educate community members on mental health issues, refer clients to mental health services, support mental health professionals and facilitate clients' access to services. The role of the BHA is to do outreach to identify community members in need of services and refer them to available services. Licensed professionals develop clients' care plans, and BHAs help implement these plans by helping clients understand and access the services they need, including patient transportation to services.⁸⁻

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Credentialing/training models for BHA-coordinators vary between states. In New Mexico, there are four different ways to qualify as a BHA (*Community Support Worker*). Applicants must either have a Bachelor's degree and a year of work experience with the target population, have an Associate's degree and a two years of work experience, have a high school diploma or general equivalency diploma (GED) and three years of work experience, or be a certified as a peer specialist. Individuals who can demonstrate that they have the competencies to practice as a coordinating BHA are allowed to practice without being certified or licensed.⁶

Minnesota has a state-approved training program for BHA-coordinators. Applicants can enter the training program with a Bachelor's degree, nursing degree, or 4 years of experience in behavioral health.¹¹ The program consists of 40 hours of training approved by the Minnesota Commissioner of Human Services, including a statewide, 15 hour web-based training covering the topics:⁷

- introduction to adult mental health targeted case management services,
- regulations,
- assessment and planning,
- referral and linkage,
- monitoring,
- coordination,
- documentation of services,
- privacy rights,
- vulnerable adult reporting,
- civil commitment,
- supervision,
- case manager self-care, and
- future training opportunities.

BHAs who have successfully completed 40 hours of training can practice case management in Minnesota without pursuing a license, as long as they complete 30 hours of continuing education every two years. Alternatively, BHAs can receive a care coordination license, registration or certification from a health-related licensing board, in which case they must fulfill the continuing education requirements of that board.¹¹

2.2 BHAs as Support Workers

In some states, BHAs act as support staff for behavioral health professionals. A supervising behavioral health professional writes an individual behavior plan with the patient or patient's family and instructs the BHA on the activities that they will perform with the client to reach the plan's goals. The role of the BHA is to practice the skills and activities introduced by the supervisor with clients. The BHA does not help create the behavior plan, however input from the BHA is used by the supervising professional to make changes to the plan where necessary.^{10,12} This model is applied throughout Minnesota (*Mental Health Rehabilitation Workers, Mental Health Behavioral Aides*), and in Monterey County (*Mental Health Aides*), California. This section will focus on Minnesota's model because the role of BHAs in Monterey County is discussed in Section 2.1.

In Minnesota, there are three classes of BHAs working as support staff, namely the Mental Health Behavioral Aide (MHBA) I, MHBA II, and Mental Health Rehabilitation Worker (MHRW). All of these types of workers must have one of the following prerequisites:¹³

- Associate degree in behavioral sciences or human services;
- Is a registered nurse;
- Has three years of personal life experience with serious and persistent mental illness, or as a primary caregiver to a person with a serious mental illness or traumatic brain injury
- Has 4,000 hours of supervised paid work experience in the delivery of mental health services to adults with a serious mental illness or traumatic brain injury
- Is fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of the mental health rehabilitation worker's clients belong and
 - Receives monthly documented individual clinical supervision by a mental health professional during the first 2,000 hours of work
 - Has 18 hours of documented field supervision by a mental health professional or practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year
 - Has review and cosignature of charting of recipient contacts during field supervision by a mental health professional or practitioner, and
 - Has 40 hours of additional continuing education on mental health topics during the first year of employment.

There are also some additional requirements to be allowed to practice as a MHBA I and II and MHRW. MHBAs, who work with children, must be at least 18 years old. An MHBA I must either "have a high school diploma or GED, or have two years of experience as a primary caregiver to a child with severe emotional disturbance within the previous ten years." An MHBA II must either "have an associate or bachelor's degree, or have 4,000 hours of experience in delivering clinical services in the treatment of mental illness concerning children or adolescents."¹³ MHRWs, who work with adults, must be 21 years

old. They must have a high school diploma or equivalent, and must “complete 30 hours of training during the past two years in all of the following areas: recipient rights, recipient-centered individual treatment planning, behavioral terminology, mental illness, co-occurring mental illness and substance abuse, psychotropic medications and side effects, functional assessment, local community resources, adult vulnerability, recipient confidentiality.”¹³

2.3 Mental Health First Aid

Mental Health First Aid (MHFA) is a training program which teaches lay people to assist others during a mental health crisis, just as traditional first aid trains people to assist others during a medical crisis. It uses a curriculum developed by Anthony Jorm and Betty Kitchener of the ORYGEN Research Center at the University of Melbourne, Australia, in 2001. MHFA training consists of a 12 hour, interactive course in which students learn how to identify and help people experiencing a mental health crisis. Students learn a “5-step action plan encompassing the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care.” Students receive a certificate upon completion of the course.¹⁴

MHFA is an evidence-based model. Several evaluations and journal articles have demonstrated the model’s effectiveness in both rural and urban communities in Australia:

“...participants gained a better recognition of mental disorders, a better understanding of treatments, more confidence in providing help to others, improved mental health for themselves, lessened stigmatizing attitudes and decreased social distance from people with mental disorders. Additional studies addressed MHFA’s impact on the community including increased help provided to others, increased guidance to professional help, and improved concordance with health professionals about treatment.”¹⁴

Based on this evidence, the National Council for Community Behavioral Healthcare, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health partnered to bring MHFA to the U.S. in 2008. These three organizations manage the curriculum and the certification process. MHFA trainings are offered across the country in a variety of settings¹⁴. In addition to the standard, 12 hour curriculum, Mental Health First Aid USA is developing materials tailored to specific groups of students, such as law enforcement officers and colleges.¹⁵

2.4 Peer Counselors and Peer Specialists

Peer counselors (also referred to as peer specialists) work within a variety of programs, including Assertive Community Treatment (ACT) and peer support counseling programs. Peer counselors are people who have dealt with a behavioral health disorder and overcome it. They receive training on how to use their personal recovery experience to inspire hope and provide counseling and support to others dealing with similar issues. Peer counselors can help their clients reduce feelings of stigmatization and isolation associated with mental illness and substance abuse through their shared experience with their clients.^{16,17} In addition to face-to-face peer counseling, there are also peer counseling hotlines and websites. These may be especially useful for frontier residents because it can help overcome isolation while maintaining clients’ anonymity.³ Usually, peer counseling is just one part of the treatment of an individual, because peer counselors do not provide comprehensive behavioral health counseling.

The most important prerequisite for becoming a peer counselor is personal experience using behavioral health services. The amount of experience required varies by state, but is usually around two years. Peer counselors must have successfully dealt with/recovered from their behavioral health issues. In addition, they must complete additional training and a certification exam.^{16,17}

For example, in Washington, peer counselors are certified after they have completed a 40 hour training program and passed a state exam. The training program is provided by the state or by the counties and covers the following topics:¹⁸

- The history of certified peer counseling;
- The Washington state mental health system;
- Core principles of recovery and resilience;
- The recovery process;
- Interpersonal skills;
- Establishing a relationship;
- Effective communication;
- Discovering strengths;
- Modeling recovery and resilience;
- Working with groups;
- Promoting self-advocacy;
- Natural supports;
- Formal supports;
- Goal-setting;
- Employment goals in recovery;
- Spirituality;
- Letting go at the right time;
- Working with parents and families;
- Documentation;
- Maintaining your personal safety;
- Cultural awareness;
- Ethics;
- Being a recovery ambassador;
- Resources on the job; and
- Preparing for employment as a peer counselor.

Once students have completed the training program and passed the state exam, Washington's Division of Behavioral Health and Recovery grants them certification as peer counselors.¹⁸

In Minnesota, peer counselors must complete a hands-on, 80 hour training program designed to simulate the work of a peer specialist. The Mental Health Consumer/Survivor Network of Minnesota collaborates with Recovery Innovations of Arizona to design and provide the training. Students who pass a final exam after completing the training are certified as peer specialists. Certified Peer Specialists are also required to sign a Code of Ethics to receive certification. Certified Peer Specialists can also choose to complete an additional 30 hours of training if they want to specialize in Crisis Stabilization.¹⁶

2.5 Promotoras with Supplemental Training

In New Mexico and in Texas, programs have been developed to provide special behavioral health training to *promotoras* (also known as community health workers). New Mexico bases its training program on the Mental Health First Aid curriculum, while the University of Texas has developed its own curriculum.

In Doña Ana County, New Mexico, the Department of Health and Human Services is collaborating with the Western Interstate Commission on Higher Education (WICHE) Mental Health Program to develop a mental health training program for the county's *promotoras* based on the MHFA curriculum.¹⁹ In the program, *promotoras* are trained to “recognize behavioral health problems and crises [and] learn about behavioral health resources in the community, which they can use for referrals.”²⁰ The training program uses both an MHFA curriculum tailored to *promotoras* and a peer counselor training curriculum. *Promotoras* who complete the training program are more prepared to connect community members to mental health services at the county's federally qualified health centers and crisis triage center, and are referred to as Mental Health Promotoras.* In addition to training Mental Health Promotoras, Doña Ana County also offers separate MHFA training opportunities for community members, and is developing MHFA curricula tailored for veterans, detention center workers, 911 center call takers, school personnel, and Spanish-speaking community members.²⁰

The University of Texas Addiction Research Institute has also developed a behavioral health training curriculum for *promotoras*. The curriculum, published in both English and Spanish, trains *promotoras* in “screening and referring Hispanic patients who may need substance abuse and/or mental health services ... the principles of brief intervention, and issues of stigma, legal status, and other barriers to seeking and accessing needed services.”²¹

2.6 Alaska's BHA Model

Alaska has a BHA model which combines elements of several of the models described above as well as incorporating some unique features. Alaska BHAs operate under the Community Health Aide (CHA) program. In addition to behavioral health services, the CHA program also provides basic primary care and dental care to rural and frontier Alaska Native communities. Alaska BHAs provide counseling, health education, and advocacy to people with behavioral health disorders and their families.²² Central goals of the program include prevention, early intervention and case management.²³

There are several levels of competency-based Alaska BHA certification, namely the BHA I, II and III. A BHA I provides client intake and orientation, case management and referral, and community education & prevention services. A BHA II can evaluate clients, do treatment planning with clients, perform community evaluations and develop community prevention plans. A BHA III can provide all of the services which a BHA I and II can provide, but the BHA III has experience providing these services to clients with special treatment issues related to domestic violence, sexual assault, and brain damage. A BHA III can also perform quality assurance case reviews and lead clinical team case reviews.²⁴

A BHA I must complete 15 courses specified by the Community Health Aide Certification Board, complete a 100 hour clinical practicum, and gain 1000 hours of supervised work experience to receive

* Personal communication, Sylvia Sierra, Director of the Doña Ana County Health and Human Services Department, June 28, 2012.

their certificate. A BHA II must be BHA I certified, complete 12 additional courses, complete a 100 hour clinical practicum, and gain 2000 hours of supervised work experience. A BHA III must be BHA II certified, complete 7 additional courses, complete a 100 hour clinical practicum, and gain 4000 hours of supervised work experience.²⁴

2.7 Behavioral Health Practitioners

The Behavioral Health Practitioner (BHP)^{*} has a broader scope than other BHA-type models, but a more limited scope than a certified mental health professional (see Appendix II: Competencies and Training of Several Types of Behavioral Health Providers, for a comparison of their competencies and scopes). The key difference between BHPs and other BHAs is that BHPs are allowed to assess clients and develop treatment plans. BHPs carry out therapeutic activities as instructed by a supervising professional, assess clients, develop a treatment plan, and modify the plan as needed under the direction of a supervising professional. Generally, BHPs do not provide counseling. When a BHP does provide counseling they must be directly or indirectly supervised.^{24,25} BHPs practice in Alaska (*Behavioral Health Practitioners*) and Minnesota (*Mental Health Practitioners*).

In Alaska, BHP is the highest BHA certification level. The BHP provides services such as routine contact, screening, assessment, and evaluation of patients, treatment planning, and case management, under the general supervision of a licensed behavioral health clinician or a behavioral health professional. However, for services such as crisis management, medication management, or counseling, the BHP must be supervised directly or indirectly. The BHP also provides clinical supervision to lower-level BHAs and can lead clinical team case reviews.²⁴

In Minnesota, the role of the BHP is focused on life skills training and coaching. The BHP assesses clients and develops a care plan under the direction of a supervising behavioral health professional. The BHP carries out a variety of life skills training and support activities with clients according their care plans, including training clients in “interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, and transition to community living services.”²⁵ BHPs also provide supervision to lower level BHAs under the guidance of a behavioral health professional.¹²

Because their scope of practice is broader than other BHAs (e.g. client assessment and treatment planning), BHPs are required to have more training than other BHAs. In Alaska, a BHP must be certified as a BHA III, complete Alaska’s Community Health Aide Program Certification Board training program consisting of four courses, and complete a 100 hour clinical practicum focused on providing supervision to lower-level BHAs and on clinical team leadership. In addition, the BHP must have 6000 hours of

* The term Behavioral/Mental Health Practitioner can be confusing because it is used differently in different states. For example, Nebraska uses the term to refer to all non-psychologist professionals in the field of mental health³⁴. In New York, Mental Health Practitioner is used as an umbrella term to refer to a variety of behavioral health professions, including Creative Arts Therapists, Marriage and Family Therapists, Mental Health Counselors, and Psychoanalysts³⁵. In this report, the term will be used to describe the specific types of allied behavioral health workers described above.

experience providing village-based behavioral health services prior to certification.²⁴ In Minnesota, there are several ways to qualify as a BHP. The prospective BHP must either have:¹¹

- A Bachelor's degree in the behavioral sciences and 2000 hours of relevant, supervised work experience, or
- A Bachelor's degree in the behavioral sciences, fluency in a non-English language spoken by the majority of their clients, a 40 hour initial training, and weekly supervision until 2000 hours of supervised work experience have been completed, or
- 6,000 hours of relevant, supervised work experience, or
- A Master's or graduate degree in the behavioral sciences, but have less than 4000 hours of post-graduation clinical experience, or
- Be a graduate student assigned to a facility for clinical training.

3 Funding and Financial Sustainability

BHAs are not included in the CMS list of behavioral health provider types, and the services they provide are not listed in the CMS Mental Health Services Billing Guide.²⁶ However, while states often use grants to fund BHA programs initially, it is also possible to bill Medicaid for a variety of services provided by BHAs using a Medicaid waiver. For example, Medicaid allows states to bill for peer support services under section 1905(a)(13) and the section 1915(b) and (c) Waiver Authority.²⁷

A number of programs which were originally 100 percent grant-funded have come to rely more on reimbursement from Medicaid and other insurance. For example, in Minnesota, all BHA services described above are billable to Medicaid and to most of the state's publicly funded health care programs. However, Medicare only allows BHAs to bill for Partial Hospitalization services, and private insurers will pay for a limited set of BHA services which they find cost-effective, such as care coordination.²⁸ In New Mexico, the coordination services provided by BHAs are billable to Medicaid.⁶ Alaska's BHA program is also pursuing Medicaid billing codes, but currently the program still receives most funding from an Indian Health Services (IHS) grant.²⁹

4 Summary of Issues

4.1 Evidence Base

With the exception of the Mental Health First Aid program, little research has been published regarding BHA models, and almost no research on these models has been done in frontier areas. Areas in which research on BHA models is lacking include:

- The ability of the various types of BHAs to improve clients' behavioral health outcomes in general,³⁰ and especially in rural and frontier areas;
- Best practices regarding the training, credentialing, certification and licensing of BHAs;
- The relationship between training/credentialing and the effectiveness of BHA services;
- The effects BHA program funding may have on BHA services;
- The costs of the various types of BHA programs.

More research is needed in these areas to establish evidence-based BHA models.

4.2 Competencies, Credentialing and Licensing

According to a report by the Alaska Mental Health Trust Authority “there are no nationally recognized core competencies for mental health practice.”³¹ This lack of nationally recognized core competencies can hamper the movement of behavioral health workers, with states and employers creating their own sets of required BHA core competencies. This has led some stakeholders to call for more standardized requirements for various types of BHA at the state or national levels. Interest in creating licensing processes for new types of behavioral health workers has increased as well.³¹

The formalization of requirements for BHAs can have some advantages, such as increasing the recognition of BHAs as a provider type, creating new reimbursement opportunities, and improving the quality of care. However, there are also concerns about the potential negative effects of licensure requirements on the BHA workforce. Restrictive licensing requirements can prevent potential BHAs with relevant experience from entering or staying in the workforce.³² Additionally, in the absence of nationally recognized core competencies to guide the development of licensing requirements, the mobility of some types of BHAs can become further restricted as states develop their own state-specific licensing requirements.³¹

4.3 Improving and Disseminating BHA Models

Currently, various states, counties and organizations are developing, using and improving a wide variety of BHA models. However, because it is difficult to find information about these BHA programs, organizations can end up ‘reinventing the wheel’ rather than learning from past experiences with BHAs. A network or central hub to facilitate the exchange of the wealth of information, experiences and ideas regarding the use of allied workers in the field of behavioral health could help facilitate both the advancement of existing BHA programs and the implementation of BHA programs on a broader scale.

4.4 Funding Issues

As mentioned previously, an important policy issue for BHA programs is their funding. While many programs (such as Alaska’s BHA program) use grant funding to get started, most must seek additional funding sources to ensure long-term sustainability. A common source of non-grant income which BHA programs seek is billing Medicaid (fee-for-service). However, concerns have been raised about relying on CMS payments as the foundation for behavioral health systems. According to the Western Interstate Commission for Higher Education (WICHE), “reliance on Medicaid financing and billings as the foundation of behavioral health care ... limits and constrains services provided ... and places basic services at risk to changes in the Medicaid policies and program at the national and State levels.”³³ There are also concerns about funding BHAs using a fee-for-service model, because this system encourages increasing BHA caseloads, which may decrease the effectiveness of their work.

The fact that the services provided by BHAs are not typically covered by insurance remains a challenge for BAH programs.

5 Conclusions

The use of BHAs is relatively new development in the field of mental health. Many BHA models are being developed, implemented, adapted and improved upon across the U.S. These models have good potential for improving behavioral health care in rural and frontier areas. However, because the use of BHAs is a new development, there is some uncertainty about which BHA models are most appropriate for implementation in frontier areas:

- There is little published research on most BHA models and their use in rural and frontier areas;
- It is difficult for organizations implementing BHA programs to exchange information with one another, because there are no national organizations or networks for most types of BHA;
- Some stakeholders have shown an interest in the creation of statewide and/or nationwide licensing or credentialing standards for various types of BHA. However, there are no nationally recognized core competencies for most types of BHA;
- Many BHA programs lack a stable source of funding.

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Appendix I: Terms used to refer to BHAs

- Behavioral Interventionists;
- Behavioral Management Aides;
- Community Mental Health Aides;
- Community Support Liaisons;
- Community Support Workers;
- Life Skills Technicians;
- Mental Health Aides;
- Mental Health Behavioral Aides;
- Mental Health Case Managers;
- Mental Health Practitioners;
- Mental Health Rehabilitation Workers;
- Mental Health Technicians;
- Mental Health Therapy Aides;
- Mental Health Workers;
- Peer Counselors;
- Promotora or Promotor (Behavioral Health);
- Psychiatric Aides;
- Psychiatric Nursing Assistants;
- Psychiatric Technicians;
- Psychological Aides and;
- Transporting Mental Health Aides.

Appendix II: Competencies and Training of Several Types of Behavioral Health Providers

Provider type		Prerequisite education/experience	License	Scope/competencies
Licensed Professionals	Licensed Professional Clinical Counselor - California	“master’s or doctoral degree ‘that is counseling or psychotherapy in content’” with coursework in specific areas and a 3000 hr. practicum (http://www.counseling.org/Files/FD.ashx?guid=51b1e473-b9a2-4ae9-92c9-616b04b47f5c)	State issued license	“the application of counseling interventions and psychotherapeutic techniques to identify and remediate cognitive, mental, and emotional issues, including personal growth, adjustment to disability, crisis intervention, and psychosocial and environmental problems. "Professional clinical counseling" includes conducting assessments for the purpose of establishing counseling goals and objectives to empower individuals to deal adequately with life situations, reduce stress, experience growth, change behavior, and make well-informed, rational decisions.” (http://calpcc.org/the-lpcc-law#4999.20)
	Licensed Professional Clinical Counselor - Minnesota	Masters or doctoral degree in counseling or a related field, covering specific topic areas. At least 700 hour supervised clinical practicum (http://www.bbht.state.mn.us/Default.aspx?tabid=1160)	State issued license	<ol style="list-style-type: none"> 1. the implementation of professional counseling treatment interventions including evaluation, treatment planning, assessment, and referral; 2. direct counseling services to individuals, groups, and families; 3. counseling strategies that effectively respond to multicultural populations; 4. knowledge of relevant laws and ethics impacting practice; 5. crisis intervention; 6. consultation; and 7. program evaluation and applied research. (http://www.bbht.state.mn.us/Default.aspx?tabid=1153)
	Licensed Independent Clinical Social Worker - Minnesota	“A graduate degree in social work from a program... or a doctorate in social work from an accredited university” and Four-thousand (4,000) supervised post-degree clinical practice hours” (http://socialworklicensemap.com/become-a-social-worker/become-a-social-worker-in-minnesota/#pip and http://www.health.state.mn.us/divs/orhpc/rhac/minutes/handouts/mhprofscope.pdf)	State issued license	“Practices independently without supervision. May engage in clinical practice. Clinical practice is the diagnosis and treatment of psychosocial function, disability, or impairment, including addictions and emotional, mental, and behavioral disorders, including plans based on a differential diagnosis. Treatment may include psychotherapy.” (http://www.health.state.mn.us/divs/orhpc/rhac/minutes/handouts/mhprofscope.pdf)

Provider type		Prerequisite education/experience	License	Scope/competencies
Certified Practitioners	Behavioral Health Practitioner - Alaska	Alaska: <ul style="list-style-type: none"> • Certified as a BHA III, • Four specialization courses • 6000 hours of experience providing village-based behavioral health services • 100 hour clinical practicum 	State licensing Board	Alaska: Under general supervision of licensed professional: <ul style="list-style-type: none"> • routine contact, screening, assessment, and evaluation of patients, • treatment planning, • case management, Rarely, and only under direct or indirect supervision: <ul style="list-style-type: none"> • crisis management, • medication management, • counseling
	Behavioral Health Practitioner - Minnesota	Must have one of the following: <ul style="list-style-type: none"> • A Bachelor's degree in the behavioral sciences and 2000 hours of relevant, supervised work experience, or • A Bachelor's degree in the behavioral sciences, fluency in a non-English language spoken by the majority of their clients, a 40 hour initial training, and weekly supervision until 2000 hours of supervised work experience have been completed, or • 6,000 hours of relevant, supervised work experience, or • A Master's or graduate degree in the behavioral sciences, but have less than 4000 hours of post-graduation clinical experience, or • Be a graduate student assigned to a facility for clinical training. 		<ul style="list-style-type: none"> • assess clients and develop a care plan • life skills training and support activities: <ul style="list-style-type: none"> ○ interpersonal communication ○ community resource utilization and integration ○ crisis assistance ○ relapse prevention ○ health care directives ○ budgeting and shopping ○ healthy lifestyle/cooking and nutrition skills ○ transportation skills ○ medication education and monitoring ○ symptom management ○ household management ○ employment-related skills ○ transition to community living
Allied Behavioral Health Workers	Peer counselor	<ul style="list-style-type: none"> • 2 years experience dealing with behavioral disorder • Recovered from a behavioral disorder • 40-80 hours of training 	State certification exam	Support and inspire peers through personal experience
	Coordinator – New Mexico	<ul style="list-style-type: none"> • Bachelor's degree +1 year experience, or • Associate's degree +2 years experience, or • High school diploma equivalent +3 years experience, or • Certified as a peer specialist 	Not required	<ul style="list-style-type: none"> • Develop a service plans and a crisis management plans with clients; • Encourage and support client self-management; • Assist clients in accessing support services in the community; • Follow-up with clients
	Coordinator - Minnesota	<ul style="list-style-type: none"> • Bachelor's degree, nursing degree, or 4 years of relevant working experience, and • 40 hours additional training 	Not required	<ul style="list-style-type: none"> • Assess clients; • Make a care plan with clients; • Help connect clients with services; • Monitor clients' progress towards their goals; • Transport/accompany clients to services.

Provider type		Prerequisite education/experience	License	Scope/competencies
Allied Behavioral Health Workers	Coordinator - California			<ul style="list-style-type: none"> • Mental health education and referrals; • Help clients understand and access the services outlined in their care plan • Transportation to services where necessary • Outreach/identification of clients
	Mental Health First Aid certificate holder	12 hour course	National certification exam	<ul style="list-style-type: none"> • Recognize signs of mental health crisis • Actively seeks professional assistance for person in crisis • Helps person in crisis until treatment is received or the crisis is resolved
	Support workers - Minnesota	<ul style="list-style-type: none"> • 30 hrs. training (MHRW only) and • Associate degree, or • Is a registered nurse, or • 3 yrs. personal experience with mental illness, or as a primary caregiver to a person with mental illness, or • 4,000 hrs. of relevant work experience, or • Is fluent in the non-English language or competent in the culture of the ethnic group to which at least 20 percent of clients belong and <ul style="list-style-type: none"> ○ Has regular individual clinical supervision by a mental health professional during the first 2,000 hours of work ○ Has 18 hours of documented field supervision by a mental health professional or practitioner during the first 160 hours of contact work with recipients, and at least six hours of field supervision quarterly during the following year ○ Has review and cosignature of charting of recipient contacts during field supervision by a mental health professional or practitioner, and ○ Completes 40 hours of continuing education on mental health during the first year of employment. 	Varies	Practice the skills and activities introduced by a licensed professional in behavioral health with clients. Follow the instructions of the supervising professional to help implement the client's care plan, e.g. through life-skills training, role-play activities, etc.

Provider type		Prerequisite education/experience	License	Scope/competencies
Allied Behavioral Health Workers	Alaska BHA	<p>BHA I</p> <ul style="list-style-type: none"> • 15 courses • 100 hour clinical practicum • 1000 hours supervised work experience <p>BHA II</p> <ul style="list-style-type: none"> • BHA I certificate + 12 additional courses • 100 hour clinical practicum • 2000 hours supervised work experience <p>BHA III</p> <ul style="list-style-type: none"> • BHA II certificate + 7 additional courses • 100 hour clinical practicum • 4000 hours supervised work experience 	<p>Exam by an independent Board</p> <p>Individualized, competency-based scope defined by supervising professional</p>	<p>BHA I</p> <ul style="list-style-type: none"> • Client intake and orientation • Case mgmt. and referral • Community education & prevention <p>BHA II</p> <ul style="list-style-type: none"> • Client evaluation • Treatment planning • Community evaluations and prevention plan development <p>BHA III</p> <ul style="list-style-type: none"> • Evaluation, treatment planning and case mgmt. for clients with issues related to domestic violence, sexual assault, and brain damage • Quality assurance case reviews • Leading clinical team case reviews