

The State of the Behavioral Health Workforce: A Literature Review

Introduction

In 2015, the American Hospital Association (AHA) reaffirmed its commitment to improving access to, and coverage and quality of behavioral health care by providing hospitals best practices and tools to assist them in navigating the changing behavioral health care system and understanding national, state and local activities affecting them.

In support, this paper provides a broad, systematic literature review on the state of the behavioral health workforce in order to better understand the challenges and opportunities facing hospitals and health systems, and begin to find new ways to build capacity for the future.

This literature review underscored a critical issue and revealed new findings – that is, in order to meet the growing need and demand for behavioral health care, hospitals and health systems must rethink, then redesign, the delivery of behavioral health care across the care continuum.

There are many factors driving this need for change. One of the most significant is the aging U.S. population—which is growing at a rate that is unprecedented in modern history. For example, by 2030, analysts predict that, if no workforce changes are made and other trends continue, that there will be only one geriatric psychiatrist for every 6,000 older Americans with mental illness and substance abuse issues.¹ Furthermore, the U.S. Bureau of Health Professions estimates that, in 2020, 12,624 child and adolescent psychiatrists will be needed, far exceeding the projected supply of 8,312.²

Consider the facts above compounded with the realities that in the field of psychiatry, nearly 55 percent of providers are 55 years or older and recently only 4 percent of U.S. medical school graduates have been applying for residency training in psychiatry, the specialty behavioral health workforce shortage is daunting.³

¹ Kirwin, Paul, Dan Blazer, Stephen Bartels, Frederic C. Blow, and Gary Gottlieb. “The Institute of Medicine (IOM) Report, the Mental Health and Substance Use Workforce for Older Adults: In Whose Hands? A Road Map for the Future of Our Field.” *The American Journal of Geriatric Psychiatry* 21.3 (2013)

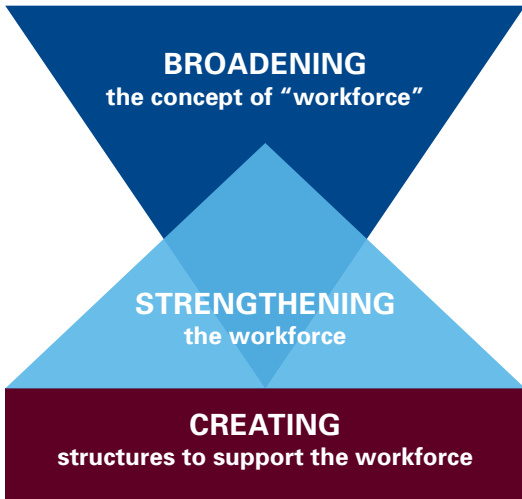
² Manderscheid, Ronald W., and Frances L. Randolph. “An Action Plan for Behavioral Health Workforce Development.” 168. (2007)

³ Weil, Thomas P. “Insufficient Dollars and Qualified Personnel to Meet United States Mental Health Needs.” *The Journal of Nervous and Mental Disease* 203.4 (2015)

Additionally, the U.S. is becoming increasingly diverse: according to the U.S. Census Bureau, by 2020, more than half of the children in the U.S. are expected to be part of a minority racial or ethnic group. Yet behavioral health providers who come from diverse backgrounds are rare: for instance, only around 6 percent of psychologists come from a diverse background.

Four key focus areas that affect workforce planning and development were identified during this review, and are outlined in this paper. They are:

Education and training | Practice environment | Financing | Recruitment and retention



The literature review highlighted The Annapolis Framework, developed by The Annapolis Coalition on the Behavioral Health Workforce. In the latter part of this paper, innovative models that aim to overcome the challenges facing the behavioral health workforce are described within the structure of The Annapolis Framework. The purpose of this framework is to offer guidance on how hospitals and health systems can modify or change their approaches to planning and developing their behavioral health care workforce in order to better meet future needs. Specifically, the framework is divided into three areas:

- Broadening the concept of “workforce”
- Strengthening the workforce
- Creating structures to support the workforce

The below statistics outline the significance and need for a larger trained behavioral health workforce.

Numbers and Status (2014)	Behavioral Health Issue
9.8 million (U.S. adults, ages 18 and older)	Have serious mental illness
22.5 million (U.S. children and adults, ages 12 and older)	Needing, but not receiving, treatment for alcohol or illicit drug use (self-reported)
11.8 million (U.S. adults)	Needing, but not receiving, mental health treatment or counseling in the past year (self-reported)

Source: Substance Abuse and Mental Health Services Administration. Accessed at <http://www.samhsa.gov/prevention>. (March 24, 2016).

Behavioral health care, defined in this paper as including both mental health and substance abuse care, encompasses a continuum of prevention, intervention, treatment and recovery support services.⁴ In order to be most effective, behavioral health needs must be addressed across the continuum of health care and in a variety of settings, including, but not limited to, inpatient physical and mental health services, primary care and emergency departments.

The costs of not treating co-occurring physical and behavioral health conditions are significant, both in human and financial terms. Regarding financial terms, people with behavioral health issues have two to three times the health care costs of those who do not.⁵ As financial pressures continue to move care to bundled, coordinated systems, health care providers will need to deliver both behavioral and physical health care.

Health care personnel in hospitals and health systems are at the front line of providing the right care at the right time, at a reduced cost. Therefore, understanding how this workforce can best deliver quality behavioral health care is paramount.

⁴ The American Public Human Services Association. "Behavioral Health—Prevention, Early Identification, and Intervention: A Pathways Policy Brief." (2013)

⁵ Croze, Colette. "Healthcare Integration In the Era of the Affordable Care Act." Association for Behavioral Health and Wellness (2015)

Literature Review Key Focus Areas

Education and Training

The literature review revealed that there is a lack of medical and health professional students specializing in behavioral health. Additionally, the behavioral health specialist workforce is aging. Retraining the incumbent health care workforce will be critical in order to address future behavioral health needs. Consider these facts:

- There are limited instances of evidence-based treatment practices in behavioral health care delivery.
- Behavioral health students are siloed in education programs. For example, there is no curriculum in U.S. undergraduate or graduate psychology programs that focuses on primary care.
- There is a lack of behavioral health training for advanced practice registered nurses (APRNs) and physician assistants (PAs).
- Currently, more than 50 percent of patients get treated for behavioral health issues by their primary care provider (PCP); however, most PCPs have not received adequate training in behavioral health.⁶
- Increasingly, PCPs, PAs and nurse practitioners (NPs) have picked up a significant amount of the responsibility for behavioral health care.

The literature review offered some possible solutions to the aforementioned challenges. Evidence-based teaching and training approaches need to become the standard. Medical education programs and accrediting bodies must prioritize establishing curricula reform that keeps pace with emerging evidence-based practices and guidelines, quality improvement approaches, and models of care based on interprofessional teams. The boundaries between the educational silos of the numerous behavioral health disciplines, and between physical and behavioral health should be taken down in order to promote sharing of knowledge and skills across provider types, effective team functioning, common standards of care, and consensus on core competencies.⁷

⁶ Weil, Thomas P. "Insufficient Dollars and Qualified Personnel to Meet United States Mental Health Needs." *The Journal of Nervous and Mental Disease* 203.4 (2015)

⁷ Institute of Medicine. "Improving the Quality of Health Care for Mental and Substance-Use Conditions." National Academies Press (2006)

Practice Environment

Another barrier to behavioral health care is the shortage of inpatient psychiatric and substance abuse units/hospitals that can treat the approximately 2 million mentally ill or substance abuse inpatients that come from community hospitals annually. Only 27 percent of the nation's community hospitals contain a separately organized inpatient psychiatric unit, down from 80 percent four decades ago, as a significant shift occurred from institutional care at state mental hospitals to community settings focused on outpatient services.⁸

Cost-effective, quality behavioral health care can be achieved with integrated, comprehensive health services coupled with collaborative team-based care. Furthermore, as care extends beyond hospitals, community-based behavioral health integration models must be supported by technology to be an effective practice environment. However, there are challenges, such as:

- 17 percent of U.S. adults have co-morbid physical and behavioral health issues.⁹
- The social stigma associated with behavioral health care, as well as the social stigma of specializing in a behavioral health profession, increases barriers to care.

- There is a lack of collaboration between hospitals, community mental health centers (CMHC), and a variety of other community entities, statewide and nationally.¹⁰
- The lack of information detailing how many primary care practices are co-located with a behavioral health provider/in a collaborative care.

A report detailing behavioral health care at patient-centered medical homes (PCMH) supported the need for more whole-person care.¹¹ Focusing primary care practices on developing and implementing procedures for referrals, communication and patient scheduling for mental health and substance abuse patients, similar to those in place for other subspecialties such as cardiology and endocrinology, could make a significant difference. Moreover, bidirectional care is important so that the subspecialties noted above also have in place procedures to address the mental health and addiction comorbidities that often exist with physical illnesses.

⁸ Sharfstein, Steven S., and Faith B. Dickerson. "Hospital Psychiatry for the Twenty-First Century." *Health Affairs* 28.3: 685-88 (2009)

⁹ Druss, B.G., and Walker, E.R. *Mental Disorders and Medical Comorbidity*. Research Synthesis Report No. 21. Princeton, NJ: The Robert Wood Johnson Foundation. (February 2011)

¹⁰ Druss, Benjamin G., MD, MPH, and Elizabeth Reisinger Walker, MAT, MPH. "Mental Disorders and Medical Comorbidity." Research Synthesis Report No. 21 (2011)

¹¹ Kessler, R., B. F. Miller, M. Kelly, D. Graham, A. Kennedy, B. Littenberg, C. D. Maclean, C. Van Eeghen, S. H. Scholle, M. Tirodkar, S. Morton, and W. D. Pace. "Mental Health, Substance Abuse, and Health Behavior Services in Patient-Centered Medical Homes." *The Journal of the American Board of Family Medicine* 27.5: 637-44 (2014)

Financing

According to reports issued by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Disease Control and Prevention (CDC), spending on behavioral health care as compared to other health care expenditures is strikingly disproportionate¹².

In 2009, the U.S. spent just over \$170 billion on mental and substance use disorders.¹³ In comparison, other health care expenditures totaled:

Hospital Care	\$777 billion
Physician and Clinical Services	\$503 billion
Prescription Drugs	\$255 billion
Dental Services	\$102.5 billion

Based on these figures, as well as information from a World Health Organization brief, it is evident that behavioral health services have a low priority in the U.S., a finding that is not significantly different from other western industrialized nations. There is other evidence that shows it is a low priority, such as:

- Salaries in behavioral health professions are well below those for comparable positions in other health care sectors and in business, according to a SAMHSA report to Congress.¹⁴
- Federal financing for innovative models of behavioral health care has been provided only for short periods, leading to program cancellations.¹⁵

¹² National Center for Health Statistics. Health, United States, 2014: With Special Feature on Adults Aged 55-64. Hyattsville, MD. (2015)

¹³ Substance Abuse and Mental Health Services Administration. Projections of National Expenditures for Treatment of Mental and Substance Use Disorders, 2010-2020. HHS Publication No. SMA-14-4883. Rockville, MD: Substance Abuse and Mental Health Services Administration, (2014)

¹⁴ Hoge, M. A., G. W. Stuart, J. Morris, M. T. Flaherty, M. Paris, and E. Goplerud. "Mental Health And Addiction Workforce Development: Federal Leadership Is Needed To Address The Growing Crisis." Health Affairs 32.11: 2005-012. (2013)

¹⁵ Institute of Medicine. The mental health and substance use workforce for older adults: in whose hands? Washington (DC): National Academies Press. (2012)

According to the literature review, one of the primary reasons for the shortage of psychiatrists and psychologists is financial— because salaries and reimbursements are so much lower, medical school and Ph.D. students are avoiding behavioral health professions altogether. Additionally, since many students graduate with significant student loan debt, many may be pursuing better reimbursed clinical specialties, so they can begin to pay off this debt.

In fact, the median compensation for psychiatrists is the third-lowest among the 30 medical specialties.¹⁶ This lower income is directly related to reimbursement: in other words, reimbursement amounts for psychiatric care often do not cover the provider's costs, regardless of whether the patient is a Medicare or Medicaid recipient, or covered by private health insurance.

In a study cited earlier in this paper examining delivery of behavioral health care in PCMHs, practices reported that lack of reimbursement was the greatest barrier to mental health and substance use care.¹⁷

Current fee-for-service (FFS) codes are inadequate for reimbursing providers utilizing integrated behavioral health specialist consultation. Furthermore, FFS billing practices also are limited because of separate public and private payers and inconsistency regarding who can bill for what service. Through mental health carve-outs and carve-ins, an artificial separation of physical and mental health care occurs, which in turn prevents primary care practitioners from billing for mental health services. Prior studies examining chronic

¹⁶ Weil, Thomas P. "Insufficient Dollars and Qualified Personnel to Meet United States Mental Health Needs." The Journal of Nervous and Mental Disease 203.4: 233-40. (2015)

¹⁷ Kessler, R., B. F. Miller, M. Kelly, D. Graham, A. Kennedy, B. Littenberg, C. D. Maclean, C. Van Eeghen, S. H. Scholle, M. Tirodkar, S. Morton, and W. D. Pace. "Mental Health, Substance Abuse, and Health Behavior Services in Patient-Centered Medical Homes." The Journal of the American Board of Family Medicine 27.5: 637-44 (2014)

care management for depression treatment in primary care settings used nurses or social workers as care managers, yet these professionals may not be able to use FFS billing codes for managed care components.¹⁸

It is doubtful whether there will be an increase in the behavioral health workforce, particularly among psychiatrists, unless there is a significant increase of pre-payment incentives and payments tied to managed care and Centers for Medicare & Medicaid Services (CMS) funding.

¹⁸ O'Donnell, Allison N., Mark Williams, and Amy M. Kilbourne. "Overcoming Roadblocks: Current and Emerging Reimbursement Strategies for Integrated Mental Health Services in Primary Care." *J GEN INTERN MED* Journal of General Internal Medicine 28.12 (2013): 1667-672. Web.

Recruitment and Retention

Despite the passage of the Mental Health Parity and Addiction Equity Act of 2008, and the expansion of covered services with the passage of the Affordable Care Act, there has been a limited increase in the delivery of behavioral health services according to a 2014 *U.S. News and World Report* article.¹⁹

Following are some key facts illustrating workforce challenges in regards to recruitment and retention:

- There is a concentration of psychiatrists, psychologists and other behavioral health professionals in affluent urban and suburban areas. In contrast, it has been difficult to recruit and retain behavioral health professionals in rural areas. For example, there is a shortage of 2,800 psychiatrists in rural and underserved areas, contributing to the fact that 85 percent of federally designated behavioral health professional shortage areas are in rural locations.^{20 21}
- Many health care employers say it is hard to retain behavioral health workers, specifically those specializing in the treatment of substance use conditions, due to low wages and benefits, heavy caseloads and the stigma associated with both having addictions and working with people who do.²²
- It has been hard to recruit and retain a diverse behavioral health workforce. Only 6 percent of psychologists, 6 percent of advanced-practice psychiatric nurses, 13 percent of social workers, and 21 percent of psychiatrists come from diverse backgrounds.²³

¹⁹ Leonard, Kimberly. "Under Obamacare, Mental Health Lacking." *U.S. News & World Report*, 29 Oct. 2014. Web.

²⁰ Weil, Thomas P. "Insufficient Dollars and Qualified Personnel to Meet United States Mental Health Needs." *The Journal of Nervous and Mental Disease* 203.4: 233-40. (2015)

²¹ Hoge, M. A., G. W. Stuart, J. Morris, M. T. Flaherty, M. Paris, and E. Goplerud. "Mental Health And Addiction Workforce Development: Federal Leadership Is Needed To Address The Growing Crisis." *Health Affairs* 32.11 (2013)

²² Ibid

²³ Chao, Puihan J., John J. Steffen, and Elaine M. Heiby. "The Effects of Working Alliance and Client-Clinician Ethnic Match on Recovery Status." *Community Mental Health Journal* 48.1 (2011)

Innovative Models That Can Foster Needed Change

The literature review revealed several innovative models that can help strengthen the future behavioral health workforce. These examples are outlined using the Annapolis Framework. They are actionable and focus on future-thinking, innovative models and methods that can be learned from and built upon.



Broadening the Concept of “Workforce” Can Support Needed Change

As revealed in the literature review, the current behavioral health specialist workforce in the U.S. (i.e., psychiatrists and psychologists) is not large enough to meet the nation’s future behavioral health care needs.

The Annapolis Framework advocates for expanding the roles and responsibilities of patients and families, communities, social services and health professionals. Developing the capacity of health care providers other than behavioral health specialists to address behavioral health conditions has emerged as a possible solution and high priority.

Peer Support Can Be Highly Effective and Cost Effective

Numerous research and case studies have shown peer support, particularly in addiction treatment, is highly effective, and expanding the behavioral health workforce to include more peers is an opportunity. Peer support also serves as an added value for patients to overcome a distrust of medical providers and can therefore lead to increased compliance.

The National Academy for State Health Policy released a brief in January 2016 detailing the benefits of peer support in promoting physical and behavioral health integration. Trained peer support specialists are well-positioned to bridge the gap between physical and behavioral health services for people with serious mental illness (SMI) as part of a whole-person, recovery-oriented system of care, according to the brief. These services are delivered in a variety of ways, including peer-led curriculum-based programs; peer coaches or navigators who assist with accessing and better understanding the behavioral health system and services; and peer mentors, who provide one-on-one support to individuals to help them with their physical and/or behavioral health recovery goals.

A new program under way in five New Jersey counties to battle a drug epidemic by using peer support is gaining traction. A case study from Barnabas Health Institute of Prevention in Toms River, N.J., touts the effectiveness of peer “recovery specialists,” who are individuals at least four years into their recovery from drug addiction, and who help when hospital providers and social workers prove unsuccessful.

Of 150 cases in which social workers and other staff attempted to convince recently overdosed opiate substance users to get into a detox or drug treatment program, none agreed to go into treatment. In contrast, just a week and a half into the program, the peer recovery specialists had a 70 percent success rate.²⁴

Another peer program, developed by the Institute for Patient and Family-Centered Care (IPFCC) promotes collaborative, empowering relationships among patients, families and health care and behavioral health professionals. The Institute also facilitates positive change in all care settings by leveraging the power of patient

²⁴ Ensslin, John C. “Hopeful Message from Drug War.” *The Record*. N.p., Accessed at <http://therecord.northjersey.com/epaper/viewer.aspx>. (Feb. 5, 2016)

and family caregivers—in other words, peers. This approach often improves health outcomes and patient satisfaction. IPFCC resources include guidance publications, videos/DVDs and self-assessment tools.

Integrated Behavioral-Physical Health Care Is Needed

One key trend in medicine is a growing demand and use of integrated, comprehensive health services that blend health and behavioral health, prevention, health promotion and disease management.

Dr. Brock Chisholm, the first Director-General of the World Health Organization (WHO), was a psychiatrist and shepherded the notion that behavioral and physical health were intimately linked. He famously stated that, “Without mental health there can be no true physical health.” Half a century later, we have now built strong evidence elucidating the bidirectional relationship between behavioral illnesses — specifically depression and anxiety — and physical health outcomes.²⁵

The AHA’s previous use²⁶ of the Agency for Healthcare Research and Quality definition for “integrated care” is also used in this paper:

The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

²⁵ Kolappa, Kavitha, David C. Henderson, and Sandeep P. Kishore. “No Physical Health without Mental Health: Lessons Unlearned?” World Health Organization. Bulletin of the World Health Organization. Accessed at <http://www.who.int/bulletin/volumes/91/1/12-115063/en/>. (Jan. 2013)

²⁶ American Hospital Association. (2014, February). Integrating Behavioral Health Across the Continuum of Care. Hospitals in Pursuit of Excellence, Chicago, IL: American Hospital Association

Hospitals and care systems have a variety of frameworks to choose from when deciding on the appropriate integration delivery method. With the significant options available such as IMPACT, Reverse Integration and co-located collaborative care, hospitals and health care systems can tailor integration efforts to their own resources and community needs. Further details and descriptions of multiple integration frameworks can be found in AHA’s *Integrating Behavioral Health Across the Continuum of Care*.

Specific benefits of an integrated behavioral-physical framework for the workforce include:

- Increased provider knowledge, expertise and capacity
- Promoted understanding across the entire care continuum
- More comprehensive and better coordinated care provided
- Behavioral health concerns are identified earlier
- Facilitated communication, collaboration and treatment between providers
- Physical health providers allowed to use the expertise of trained behavioral health specialists
- Improved patient education and satisfaction

Yale New Haven’s multidisciplinary, proactive psychiatric consultation for medical inpatients illustrates an integrated care model that not only addresses an increased demand for behavioral health services, but also improves outcomes, reduces the total cost of care and enhances the patient experience.

A recent study conducted by Yale New Haven Psychiatric Hospital detailed the effectiveness of multidisciplinary intervention delivered by the behavioral intervention team (BIT) in reducing length of stay (LOS) for medical inpatients. The BIT included a full-time clinical nurse specialist (CNS), a full-time social worker and a half-time psychiatrist.

The BIT rapidly and accurately identified patients with behavioral health problems that were likely to interfere with their medical care; ensured timely co-occurring psychiatric treatment and support for these patients; and assisted the medical services staff to provide appropriate and efficient care, such as timely psychiatric disposition and appropriate sitter use. The BIT staff provided this care through a mix of education and advice to unit staff and direct involvement for the patients with more complex and demanding cases.

As a result, the average LOS was significantly lower (by 0.64 day) for those receiving care from the BIT compared to those receiving the reactive, conventional consultation. The study estimates that in the most generous accounting of outcomes (based on assumed spillover effect), the program gives a return on investment of more than 4:1.²⁷

Social Workers Can Play an Important Role in Delivering Behavioral Health Care

Multiple studies and pilot programs are demonstrating the importance of the social worker’s role in providing and navigating appropriate patient care along the continuum, including behavioral health. In one report²⁸, it was determined that, when social workers perform the initial assessments of patient needs, the entire interdisciplinary team benefits. Social workers also can assess and refer the patient to other providers, allowing physicians more time to deal with physical health issues.

Additionally, social workers can work within the primary care setting to address a patient’s environmental, psychological and financial concerns. Furthermore, social workers can help reduce costs since they are able to detect

behavioral health issues early on and intervene before they escalate, which also means there is a decreased chance the patient will need to use medical or hospital services.

However, the social worker workforce is not immune to shortages. According to a workforce report²⁹ forecasting nationwide shortages, the nation will experience a total shortfall of over 195,000 social workers by 2030, with the most severe shortages occurring in the western and southern regions of the country.

Non-traditional Health Workers Can Effectively Serve Communities

One initiative, the Institute for Healthcare Improvement’s (IHI) 90-Day Innovation Project, developed an approach to managing patients with comorbid behavioral and physical health needs in a community-based setting while utilizing non-traditional health workers (e.g., community health workers (CHWs)) to support them.

This project identified four populations that could be well-served by community-based behavioral health integration³⁰:

- 1 Individuals with serious mental illness and co-occurring medical conditions;
- 2 Individuals with multiple (three or more) chronic conditions, including a mild to moderate behavioral health condition;
- 3 Individuals with medical, behavioral and social vulnerability, and
- 4 Individuals, particularly children and adolescents, with sub-clinical behavioral health issues – focusing on wellness, primary prevention and early intervention.

²⁷ Sledge WH, Gueorguieva R, Desan P, Bozzo JE, Dorset J, Lee HB. “Multidisciplinary Proactive Psychiatric Consultation Service: Impact on Length of Stay for Medical Inpatients.” *Psychotherapy and Psychosomatics* [2015, 84(4):208-216]

²⁸ Wodarski, John S. “The Integrated Behavioral Health Service Delivery System Model. *Social Work in Public Health* 29:4: 301-317. (2014)

²⁹ Lin VW, Lin J, Zhang X. U.S. Social Worker Workforce Report Card: Forecasting Nationwide Shortages. *Social Work*. 2016 Jan;61(1):7-15.

³⁰ Laderman, J., Mate, K., Deen, N. “Community-Based Behavioral Health Integration: A Focus on Community Health Workers to Support Individuals with Behavioral Health and Medical Needs. IHI Innovation Report. Cambridge, MA. (2015)

The report noted that CHWs with specific training in behavioral health could help high-cost patients manage their health by helping them develop coping mechanisms, a core component of behavioral health treatment for many people. Alternative service providers such as “community paramedics” were also discussed to care for patients living with comorbid physical and behavioral illness to assist in keeping them healthy at home.

The report concluded that the dominant workforce needed to provide community-based care for patients with complex medical and behavioral health needs are CHWs. However, currently, there is a lack of standardization of CHW recruitment, training and measurements of effectiveness. Because of this, there needs to be more done to make the CHW role more consistent so it can be most effective.

Efforts are needed at the federal, state, local and non-profit organizational levels to help recruit and educate more diverse providers who can deliver behavioral health care. Enhancing the health and behavioral health workforce beyond the traditional roles by more actively including social workers, clinical case managers, navigators, community health workers, health representatives and para-professionals is needed. These workers can make a significant difference and not only serve the patient and his or her family, but the community, as well as strengthen the entire U.S. health and behavioral care delivery system.³¹

³¹ Williams, James Herbert, Teresa Chapa, and Eric A. Des Marais. “Advanced Social Work Practice Behaviors to Address Behavioral Health Disparities.” NADD. (2015)



Strengthening the Workforce

The Annapolis Framework includes the following recommendations to strengthen the behavioral health workforce:

- 1 Implement** systematic recruitment and retention strategies at the federal, state and local levels.
- 2 Increase** the relevance, effectiveness and accessibility of training and education.
- 3 Foster** the development of leaders across the workforce continuum.

The examples below connect these concepts and goals to current programs and initiatives:

National Health Service Corps (NHSC) Programs

The National Health Service Corps (NHSC) recruits fully trained professionals to provide culturally competent, interdisciplinary primary health and behavioral health care services to underserved populations. In return, the NHSC helps them pay their student loans.

In 2015, more than one in three NHSC clinicians provided behavioral health services. With 87 percent of NHSC clinicians continuing to practice in underserved areas up to two years after they complete their service commitment, this program provides a much-needed supply of behavioral health providers.

Programs that are Increasing Workforce Diversity

The low rates of diversity in the behavioral health care workforce are troubling since evidence suggests that minority health professionals are more likely than others to serve other minorities. Furthermore, studies show that patients who share a culture and race with a provider develop a stronger therapeutic alliance and have improved health outcomes.³²

The following are some programs, organizations and associations that are succeeding at improving and recognizing behavioral health care workforce diversity.

▶ *The Institute for Diversity in Health Management*

The AHA's Institute for Diversity in Health Management is committed to expanding health care leadership opportunities for ethnically, culturally and racially diverse individuals, and increasing the number of these individuals entering and advancing in the field.

▶ *The Association of Black Psychologists (ABPsi)*

The Association of Black Psychologists (ABPsi) is a national professional association dedicated to actively addressing the problems facing black psychologists and the larger black community. ABPsi's goal is to have a positive impact on the behavioral health of the national black community.

▶ *The Awards for Advancing Minority Mental Health*

The Awards for Advancing Minority Mental Health has recognized leaders in the behavioral health field for more than 10 years. This award, offered through the American Psychiatric Association Foundation, recognizes psychiatrists, health professionals, behavioral health programs and organizations that have undertaken innovative and supportive efforts to raise awareness in underserved communities, increase access to quality mental health services for underserved minorities and improve the quality of care for underserved minorities.

³² Hoge, M. A., G. W. Stuart, J. Morris, M. T. Flaherty, M. Paris, and E. Goplerud. "Mental Health And Addiction Workforce Development: Federal Leadership Is Needed To Address The Growing Crisis." *Health Affairs* 32.11 (2013)

Interprofessional Education Initiatives

► *American Journal of Public Health Report*

A 2015 *American Journal of Public Health* report highlighted a University of South Carolina program that aims to enhance interprofessional education among public health and social work perspectives.³³ Clinical and population health faculty redesigned and expanded an introductory interprofessional course to include more than 500 students from public health, social work, medicine, pharmacy and nursing. The course improved understanding of key health concepts and appreciation of interprofessional collaboration.

► *Social Work in Public Health Report*

Researchers have found that between 30 and 80 percent (depending on the study) of all primary care visits are driven in significant part by behavioral health issues, according to a *Social Work in Public Health* report.³⁴ Therefore, training in behavioral health care, along with competency in assessing psychosocial factors, is a must and should occupy a central position in all levels of health care education.

Comprehensive Education and Training

A recent webinar presentation from Cherokee Health System (CHS) focused on the effectiveness of integrating behavioral health training into primary care. Cherokee Health System's 30-plus year history of training health professionals includes an American Psychological Association (APA) accredited psychology internship program, an APA-accredited school psychology consortium, training partnerships with five local academic institutions and national training academies for integrated care.³⁵

³³ Addy, Cheryl L., Teri Browne, Elizabeth W. Blake, and Jennifer Bailey. "Enhancing Interprofessional Education: Integrating Public Health and Social Work Perspectives." *American Journal of Public Health* 105.S1. (2015)

³⁴ Wodarski, John S. "The Integrated Behavioral Health Service Delivery System Model." *Social Work in Public Health* 29:4: 301-317. (2014)

³⁵ Health Resources and Services Administration. Accessed at <https://hrsa.connectsolutions.comp7ns3pnhzdd/?launcher=false&fcsContent=true&pbMode=normal>. (January 19, 2016)

Agency for Healthcare Research and Quality (AHRQ)

► *"The Academy": Integrating Behavioral Health and Primary Health Care*

The Academy offers timely and relevant information to support and advance behavioral health and primary health care integration. In addition to other resources, the Academy presents free webinars on topics related to integration featuring experts in the field, integration partners and other federal agencies.

► *Core Competencies for Integrated Behavioral Health and Primary Care*

This 24-page, free downloadable resource, *Core Competencies for Integrated Behavioral Health and Primary Care*, was developed by SAMHSA and the Health Resources and Services Agency (HRSA) Center for Integrated Health Solutions. It not only includes valuable information, but actionable steps that an organization can begin to implement immediately to help them integrate primary and behavioral health services.

This resource was designed specifically for provider organizations as they shape job descriptions, orientation programs, supervision and performance reviews for workers delivering integrated care. The competencies also serve as a resource for educators as they shape curricula and training programs on integrated care.³⁶

³⁶ Hoge, M.A., Morris, J.A., Laraia, M., Pomerantz, A., and Farley, T. *Core Competencies for Integrated Behavioral Health and Primary Care*. Washington, DC: SAMHSA - HRSA Center for Integrated Health Solutions. (2014)



Creating Structures to Support the Workforce

The Annapolis Framework includes the following recommendations to create structures to support the behavioral health workforce:

- 1 **Establish** financing systems that enable employee compensation commensurate with required education and levels of responsibility.
- 2 **Build** a technical assistance infrastructure that promotes adoption of workforce best practices.
- 3 **Implement** a national research and evaluation program on behavioral health workforce development.

The examples below connect these concepts and goals to current programs and initiatives. Hospitals and health care organizations seeking new ways to create structures to support their workforces should consult these resources for new ideas and insights.

Financing to Support the Workforce

Although there is currently little research on funding mechanisms, this paper highlights important examples of innovative reimbursement models and funding initiatives directly or indirectly supporting the workforce.

► *Chronic Care Management: DIAMOND*

DIAMOND (Depression Improvement Across Minnesota, Offering a New Direction) was developed in 2008 as a bundled payment model to support chronic care management (CCM) for depression treatment in Minnesota. The program is based on a collaboration among commercial health plans, the Minnesota Department of Human Services and medical providers within the state. Under DIAMOND, primary care providers receive a negotiated monthly bundled payment from the six major insurance companies in the state for every patient needing depression care – including reimbursement for costs for care managers' salaries/benefits, as well as supervision time from a psychiatrist. According to the report³⁷, the bundled payment mechanism encouraged many diverse practices to accept the burden of CCM startup

costs and practices opened up exploring ways of expanding the program to other mental health diagnoses.

► *SAMHSA-HRSA's Center for Integrated Health Solutions*

SAMHSA-HRSA's Center for Integrated Health Solutions is creating financial structures to support education and practice within integrated behavioral health primary care settings. From 2014-2018, more than 700 awards for Behavioral Health Integration (BHI) and Substance Abuse programs (with a maximum of \$250,000 per award) will be given. The goal is to improve and expand delivery of behavioral health and substance abuse services.

These awards are designed to improve and expand the delivery of behavioral health services through the integrated primary care and behavioral health providers at existing Health Center Program grantee sites. Currently 1,200 health centers operate more than 9,000 service delivery sites that provide care to nearly 23 million patients across the nation.³⁸

³⁷ O'Donnell, Allison N., Mark Williams, and Amy M. Kilbourne. "Overcoming Roadblocks: Current and Emerging Reimbursement Strategies for Integrated Mental Health Services in Primary Care." *J GEN INTERN MED Journal of General Internal Medicine* 28.12 (2013): 1667-672. Web

³⁸ Ross, Alexander F. "Integrating Behavioral Health Into Safety Net Primary Care Settings: The Role of HRSA in Supporting Education and Practice." *Health Resources and Services Administration*. (2016)

► *Other Programs*

Some funding and pilot programs at the federal, state and local level are being implemented. However, there is no evidence yet that any of these strategies will have a meaningful impact on the workforce size or effectiveness. Furthermore, the time-limited, issue-focused agendas of often-changing government administrations also pose a challenge, since workforce development requires long-term, sustained action.³⁹

Telehealth and Teleconsultation

Technological tools are being used to break down barriers to behavioral health, care such as access and availability. Furthermore, telehealth and teleconsultation often allows for greater anonymity and avoidance of the stigma that can be attached to being a behavioral health patient. Additionally, it can extend care interventions outside the bounds of traditional care sites, and enhance communication between the patient and providers.⁴⁰

Telehealth also may build the primary care system's capacity to treat mild-to-moderate behavioral health conditions. Findings demonstrated that technology-based interventions can be applied in-home or in-office to enhance virtually the entire continuum of care, including patient assessment, psychoeducation, self-managed care, client-provider communication and direct treatment.

States play an important role in supporting telehealth programs. According to a National Academy for State Health Policy report, states can enhance adoption by amending regulatory restrictions limiting reimbursement, fostering or mandating multi-payer support, providing education and guidance on pertinent legal considerations and leveraging federal funds to develop broadband infrastructure in rural areas.

States also can implement policies to provide behavioral health care reimbursement for telehealth services on behalf of the state employees or Medicaid and Children's Health Insurance Program (CHIP) enrollees. As of April 2015, 48 state Medicaid programs reimbursed for some level of telemedicine and tele-behavioral health services.⁴¹

National Research and Evaluation Programs

The Behavioral Health Workforce Research Center is a joint initiative of HRSA and SAMHSA.

Established in September 2015, the mission of the center is to help produce a behavioral health care workforce of sufficient size and skill to meet the nation's behavioral health needs. The center is located at the University of Michigan School of Public Health and works with a national consortium of partners and experts in mental health, substance abuse and health workforce research.

³⁹ Hoge, M. A., G. W. Stuart, J. Morris, M. T. Flaherty, M. Paris, and E. Goplerud. "Mental Health And Addiction Workforce Development: Federal Leadership Is Needed To Address The Growing Crisis." *Health Affairs* 32.11. (2013)

⁴⁰ Ramsey, Alex T., and Katherine Montgomery. "Technology-Based Interventions in Social Work Practice: A Systematic Review of Mental Health Interventions." *Social Work in Health Care* 53.9: 883-99. (2014)

⁴¹ Townley, Charles, and Rachel Yalowich. "Improving Behavioral Health Access & Integration Using Telehealth & Teleconsultation: A Health Care System for the 21st Century." *The National Academy for State Health Policy*. (2015)

7 STEPS to Strengthen Your Behavioral Health Care Workforce

The literature review offers a broad overview of the current state of the behavioral health workforce. The key focus areas of education and training; the practice environment; financing; and recruitment and retention offer a systemic perspective on the myriad issues facing the health care field, many of which are interconnected and self-perpetuating.

An antidote to the challenges described here are the innovations that are already occurring within the behavioral health workforce arena, and The Annapolis Framework offers a clear path to categorizing these innovations and learning from them, as described above.

A next step for hospitals and health systems is to understand their particular behavioral health workforce needs and issues. These seven steps have been developed in concert with the AHA's internal staff work group, and are meant as a guide and to spur dialogue among the many internal and external stakeholders who impact and are impacted by behavioral health workforce issues.

STEP 1: Assess your current workforce and patient population. This analysis will allow you to pinpoint weaknesses and strengths of behavioral health care access and continuum within your hospital or health system. Not only is this important, but an analysis of the knowledge and skills of your workforce as a whole to address behavioral health concerns is crucial.

STEP 2: Ensure your workforce is knowledgeable about the socioeconomic determinants of health and challenges facing your community, as well as culturally competent, in order to effectively engage patients and their families. Building a workforce that is in tune with the population being served will improve patient and family engagement, quality of care and desired outcomes. The National CLAS Standards provide a blueprint to implement culturally and linguistically appropriate services.

Step 3: Train your entire workforce in behavioral health screening techniques. Training in behavioral medicine and interventions, especially around de-escalation of potentially serious or violent incidents, along with competency in suicide risk screening and assessing psychosocial factors should be a top priority for anyone working in health care. Training in trauma informed care is another

opportunity for providers to support and understand patients who have experienced different types of trauma in their lives, with the goal of preventing re-traumatization in the health care setting.

STEP 4: Set up a procedure of assessment, treatment and referral so that behavioral health care is happening at the site of visit, if possible.

STEP 5: Utilize interprofessional education and training and team-based care for your current and future workforce to begin integrating primary and behavioral health care.

STEP 6: Contact higher education programs in your area to establish partnerships that address the needs of the population your hospital or health system serves, as well as enhance the recruitment and retention of behavioral health professionals.

Step 7: Engage the broader community, including community groups, community health centers, mental health care and substance abuse treatment providers, and social service agencies to strengthen care transitions and integration with the broader community workforce as a population health approach.

Conclusion

It is evident that the workforce challenges within behavioral health care are significant, and that they touch on many of the challenges that face the evolution of the way behavioral health is and will be administered, financed and provided in the near future.

The literature review and findings described in this paper are designed to be a first step in an evolving process of developing a better understanding of, as well as tools and resources for, the behavioral health workforce in the context of the care continuum.

For more information, access all of the AHA's resources on behavioral health at www.aha.org/behavioralhealth.

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