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POINT OF VIEW

Developing the Behavioral Health Workforce: Lessons from the States

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Abstract

Recent demands for increased care for people with behavioral health problems often miss the severe shortage of skilled workers in the field. For many years, researchers, clinical administrators and policy makers have been calling for curricula revision at professional schools, increased financial incentives for employee recruitment and retention, increased reimbursement rates, and greater attention to diversity within the health care workforce. States have created special task forces and commissions to make recommendations for improving this essential element of access to behavioral health care. A review of their findings shows a remarkable similarity of recommendations and a clear path forward.

Keywords Behavioral Health Care · Workforce Development · Social Policy · Training

Introduction

The failure in this country to guarantee access to quality behavioral health care costs hundreds of billions of dollars through lost productivity, school dropouts, failed medical treatments, and incarceration (Colton and Manderscheid 2006; DHHS 2009; Insel 2008; Dupéré et al. 2018; Kaiser Family Foundation 2015; USDOE 2014). Despite the critical need, access to behavioral health care is low at 40–50% and near 10% for addiction therapies (Park-Lee et al. 2016; Parks et al. 2006; CBHSQ 2015). Primary care professionals frequently see these people, but two-thirds of physicians report an inability to secure a referral (Cunningham 2009). Patients from ethnic or racially diverse groups engage behavioral health at a fraction of the rate of Caucasians (SAMHSA 2015) and they frequently see a non-Latino Caucasian provider (Duffy et al. 2002).

The inadequate supply of behavioral health practitioners in the United States and the difficulty of attracting, retaining and mentoring this workforce limits access to care (Hoge et al. 2013). The projected supply of these workers in 2025 will be 250,000 less than required (HHS 2016), with a dearth of racial and ethnically diverse professionals (USDHHS 2001) and Geropsychology specialists (Hoge et al. 2015). The opioid crisis is calling attention to a system that lags far behind general medicine. Increased access to care will not be possible, without amplifying the availability of skilled, culturally capable professionals.

Task forces in several states have reviewed the complex issue of workforce development and they all make similar recommendations. A selective review highlights common themes and a clear course of action.

Washington State

With the goal to upgrade access to behavioral health care, Washington's legislature commissioned a comprehensive assessment of its Behavioral Health Workforce (Gattman et al. 2016; Gattman et al. 2017). The 2-year project examined the size, challenges and educational preparation of the workforce. Researchers identified a strong demand for mental health, social work and addictions counselors. Yet, agencies reported numerous open positions in these areas with long vacancies. Primary care professionals reported reluctance to order psychotropic drugs and medication assisted treatments, exacerbating an existing shortage of prescribers.

Inadequate compensation was the root cause of the failure to recruit and retain professionals. Typical was an unfilled position that required a master's degree, weekend shift work and knowledge of co-occurring disorders, assessment, psychotherapy and wraparound services that paid a salary of $32,546–$36,680. Staff with little experience in teamwork,

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evidence-based treatment and integrated care found it difficult to work in interdisciplinary settings, especially without supervision. Excessive documentation, high-acuity clients and limited professional development contributed to an unsustainable level of turnover. Retention recommendations included providing continuing education and supervision for challenging caseloads. Compensation for community agencies that educate trainees and bundled payments for their work would level the competition from hospitals, government agencies and private practices that offer better compensation. Advertising, educational programs, and licensure reciprocity were proposed as pipeline expanders (Gattman et al. 2016).

Graduate schools were encouraged to revise their curricula to ensure that students developed skills in evidence-based treatments, teamwork, co-occurring disorders, motivational interviewing, and community care. Educational programs for primary care prescribers to increase their comfort with psychotropic drugs and medication assisted treatment were suggested to offset the shortage of psychiatrists.

The main recommendations were to: adjust reimbursement rates to competitive levels; promote team-based skills with integrative care; increase student access to community-based training; expand medically-assisted treatments; and increase provider diversity (Gattman et al. 2017).

Surprisingly, save for the last recommendation, this thorough analysis paid little attention to racial disparities in behavioral care or the diversity misalignment between patients and providers.

California

Even with increased insurance coverage, California's inadequate supply of behavioral health workers limits access to care (Coffman et al. 2018). A university research team reviewed licensure records, census reports, employment data and college enrollment to determine the demand, supply and pipeline of behavioral health professionals. They found the workforce to be small, unevenly distributed, White, and aging. The Bay Area had the most professionals, African-American and Latino professionals were underrepresented, and 45% of psychiatrists and 37% of psychologists were older than 60 years. In 2028, California will have 40% fewer psychiatrists and 11% fewer psychologists than required.

Appropriate care for those with addictions and serious mental illness will be difficult, without primary care professionals prescribing psychotropic drugs and medication assisted treatments. Since 19% of Californians prefer Spanish-language, bi-lingual professionals are critical to genuine access to care. To enable diverse Californians to receive behavioral health services from culturally and linguistically concordant professionals, scholarships of $10,000–$15,000 and loan forgiveness programs could incentivize underrepresented students to pursue careers in shortage areas (NHSC 2012).

Several philanthropies followed this report with recommendations for actionable strategies to close the gap (California Future Health Workforce Commission 2019). They emphasized prevention, population health improvement, and training paraprofessionals to free the time of licensed professionals. Declaring an urgent need to reinvest in educational programs to produce more professionals with the proper skills, they stressed the need for: scholarships and loan forgiveness programs; increasing the number of prescribers; curricula development in early intervention and the social determinants of health; public education about careers in health care; insurance reimbursement for peer counselors; increased racial diversity; and a "Health Care Corps" to attract new professionals. This commission distinguished itself by calling attention to the need for increased diversity in the provider workforce. It recommended that these improvements be funded through general funds, philanthropy, federal grants, and contributions from business.

Oregon

The Oregon legislature wished to assess the effectiveness of incentives to recruit and retain clinical professionals in underserved areas. A commission reviewed the number of new providers, the time employed, and the cost of replacing workers from 2011 to 2015. They concluded that: "all of Oregon's incentive programs act to increase the supply of practitioners in underserved communities in some fashion…" (Oregon Health Policy Board 2016, p. 9).

The attention paid in this study to the type, timing, and impact of reinforcers is a unique contribution to the literature. Loan Repayment was a more successful recruiting strategy than a retention tool in underserved areas. Career ladders, supervision, merit pay, and career development were important retention strategies. Immediate, meaningful, cash incentives had greater influence than delayed rewards such as loan forgiveness or retirement contributions. Team-based work, continuing education, spousal employment and community amenities retained workers and learning collaboratives that exchanged information about workforce management were effective and welcome resources.

Vermont

A Vermont workgroup reported an excessive demand for behavioral health services, an anticipated workforce crisis, and the critical need to increase compensation for agencies and professionals (Vermont DMH 2017). The experts

examined the effect of incentives such as loan repayment, tax credits, long-term contracts, funded training and internships and found that all of them reduced overtime costs and improved retention, morale and quality of care. However, they found, that without robust advertising, these programs were overlooked by employees.

Reciprocity policies for licensed professionals to practice beyond one state, loan forgiveness at the level of the cost of the degree, and clinical internships that mentored potential workers were the most effective recruiting strategies. The workgroup, also, recommended training recipients of social and disability services and those from vulnerable populations for behavioral health positions, creating career ladders for existing workers and introducing behavioral health professions to young people.

Loan forgiveness programs have demonstrated success in attracting teachers to work in underserved districts and they offset their costs by saving expenses on training and recruiting and by increased productivity (Feng and Sass 2018; Podolsky and Kini 2016). Performance bonuses of 10% of salary can impact retention and create a group of experienced colleagues to assist the work of others (Springer et al. 2016). Teachers do not leave students of underperforming schools, but those learning environments that provide little autonomy, poor leadership, few resources, inadequate opportunities for professional development, broken facilities and poor pay (Hanushek et al. 2004; Johnson et al. 2005). Longitudinal studies find that compensation, appreciative leaders, performance bonuses, and educational opportunities all influence retention (Clotfelter et al. 2008; Glazerman and Seifullah 2012). More than half of the members of the National Health Service Corps who received loan forgiveness remained working in underserved areas for 4 years after their benefit ended (NHSC 2012). There is no reason to believe that these strategies would not benefit behavioral health.

North Carolina

The U.S. Census estimates that North Carolina will be the seventh most populous state by 2030 and the existing behavioral health workforce shortage is destined to become much more burdensome (North Carolina 2008). A team of consultants and academic institutions studied the challenges faced by families and service organizations and they suggested solutions. Existing provider shortages, workforce maldistribution and inadequate provider diversity mirrored the findings from research in other states. Chief concerns were inadequate worker compensation, unreliable schedules, absent career ladders and lack of supervision. The commission offered a dozen recommendations with the following priorities: optimize wages and benefits; create positive work environments; loan forgiveness programs; career ladders and technical assistance; public awareness campaigns on the benefits of behavioral health careers; supervision; and a workforce specialist to monitor the implementation of recommendations.

Massachusetts

With average salaries of $27,376, many human services employees in Massachusetts earn salaries that are 150% below the poverty level and more than $13,000 less than median wage (Citino et al. 2018). Insufficient compensation and high vacancy rates create low morale, burdensome staffing patterns, missed business opportunities and a constant churn of orientation and training. Often, the community agency's biggest competitor is the state government with stronger salaries and benefits for comparable work (Citino et al. 2017). Among the best resourced states for behavioral health professionals, the Commonwealth of Massachusetts has significant challenges with access to care.

Even with appropriate insurance, more than half of the adults who wanted to obtain behavioral health care in 2017–2018 were unable to secure an appointment (Long and Aarons 2018). Many were told that the therapist did not take insurance or was not accepting new patients. About 12% accessed a medical emergency department, but 40% did nothing; even failing to refill an important prescription. A previous study revealed that inadequate reimbursement rates, delayed reimbursement, long waits for authorization, subordinating clinical decisions to underqualified insurance clerks, lack of parity with medical treatments, and the exorbitant salaries of insurance executives discouraged private practitioners from participating on insurance panels (Citino et al. 2015).

A recent study concluded the behavioral health care in Massachusetts does not serve the consumers, but it requires patients to fit into existing structures (Anthony et al. 2019). To change things, these researchers proposed that the Commonwealth increase access by attracting and retaining a culturally competent and diverse workforce that can deliver a continuum of comprehensive, person-centered services. In addition to recommending the creation of a Behavioral Health Reform Team to align and consolidate administrative, regulatory, and purchasing functions across state agencies, they proposed: streamlining the credentialing and licensure process; offering supervision, loan forgiveness and professional development to retain existing professionals; and payment reform for agencies and providers (Anthony et al. 2019). Those who have worked within 'integrated healthcare' know how dependent these systems are upon the cottage industry of private practitioners to accept referrals from primary care providers. Unless something is done to correct

the relationship between private practitioners and third-party payers, Massachusetts will default to a two-tiered system of behavioral healthcare for wealthier patients in private practice and a public sector left to provide for those with serious mental illness and few financial resources.

Connecticut

With the assistance of a university-based team, a collaborative of parents, agency directors, people in recovery, educators, and workforce experts reviewed prior reports and held lengthy deliberations about the state's behavioral health workforce (Hoge et al. 2016). The decline in number and quality of clinical supervisors who provide support, direction, professional development and a 'holding environment' for a clinical staff with large, multi-problem, caseloads was of greatest concern. Their interest in evidence-based interventions was challenged by the lack of graduate training in these areas and in-home care. Efforts at curricula change seemed plagued by a reluctant university administration and a resistant faculty. In line with the conclusions of the Annapolis Coalition (Hoge et al. 2013), families of people with substance use and behavioral health problems and those in recovery were perceived to be a resource for community education, clinical service and advocacy.

This collaborative developed an evidence-based course on *problem-oriented supervision* for supervisors and staff that was sustained after the original grant concluded. Likewise, a paid *faculty fellowship* to evolve a one-semester course on *research-supported interventions* for in-home treatment continued. A *Peer Run Employment Service* with career counseling and advocacy around workplace equity created jobs and greater employee inclusion. An innovative six-session course in *Parent Leadership Development* offered skills in caregiving, advocacy and social change to family members.

Annapolis Coalition

For more than a decade, this prolific group of researchers has consulted nationally to attract, retain and improve the performance of behavioral health professionals (annapoliscoalition.org). In one study involving more than 5000 individuals across a 2-year period, a SAMHSA supported research team convened experts to: review workforce reports; solicit input at national meetings; identify innovations; and formulate action steps (Hoge et al. 2009).

They reported that the behavioral health workforce has licensed and unlicensed providers; graduates of eleven advanced degree programs; front-line staff with less than a bachelor's degree; and volunteers. Parents, clergy, teachers, counselors, criminal justice officers, and others, also, deliver prevention programs. These experts identified a national insufficiency of professionals to care for children, older people and those with substance use disorders. They found a critical shortage of rural workers, budgetary constraints that dominate patient care, demanding caseloads with excessive paperwork, and a discouraging environment of discrimination and stigma. Recent graduates were described as doing what was affordable and not what is effective without innovation, leadership or supervision. An emphasis on single-session psychotherapy and not evidenced-based care was common (Hoge et al. 2009). The country's diverse providers are united in being mostly urban, older, and non-Latino White (Duffy et al. 2002; Hoge et al. 2007).

A series of nine recommendations, organized in three general areas comprise the *Annapolis Framework* (Hoge et al. 2013). A unique element is the priority given to engaging family members and those in recovery in both treatment planning and teaching to capitalize on their experience and need for care as well as to reduce the burden on the healthcare system. The framework emphasizes competency-based education for providers and valid measures to assess outcomes. Strengthening recruitment and retention of workers through scholarship support and loan forgiveness as well as providing supervision, technical support, continuing education and ongoing research were recommended. Departments of Labor were urged to benchmark salaries and reimbursement rates to improve compensation and organizations were advised to create career ladders, professional development, leadership training and access to supervision. Integrating evidence-based treatments, competency training and experiential learning were keys to improving graduate training. The largely anecdotal state of workforce development knowledge needs a national effort to disseminate evidence-based practices and strategies.

Summary

"Recruitment and retention are closely linked. Recruiting healthcare and social service providers and acclimating them to a community and facility are often expensive, and lengthy endeavors. It is important to recruit workers who are well-suited to the community in which they will work, and to be proactive in retaining those providers." (Report to Vermont Legislature 2017, p. 2)

These states report overwhelming evidence that the country's behavioral health workforce lacks the size and skills to assist the significant portion of our population with serious behavioral health problems. The plurality of behavioral health systems offers non-competitive wages, limited opportunities for professional advancement, poor access to supervision, burdensome paperwork, few professionals of color and sizeable caseloads of people with high-acuity problems.

After years of agencies hiring the least expensive provider and eliminating positions for seasoned supervisors, there are too few leaders with enough expertise and gravitas to support clinical staff and to engage in a process of continuous improvement. Unless they have enough resources to access the network of private-pay professionals, people across the country wait an extraordinary time for treatment at agencies with employee vacancies and high turnover. This is not the case for general medicine and it should not remain the case for behavioral health.

Disappointing, is the inattention in these reports to developing a workforce that resembles the racial, ethnic, gender and disabilities distribution of our country. Ignoring diversity and the challenges associated with access to care is the strongest argument for increasing the number of leaders who represent our country's multiracial and multicultural people. With every state experiencing a shortage in the behavioral health workforce, genuine access to behavioral healthcare is unavailable to people of color. The country must declare enthusiastic interest with appropriate funding to successfully recruit and support clinicians to properly serve our diverse population.

Many argue that improving provider wages and reimbursement is the sine qua non of workforce development and that Secretaries of Labor and Workforce Development must lead with comparative compensation analyses of to guide insurers and employers. Scholarships and loan forgiveness programs have a demonstrable effect on attracting students to the profession and career ladders, supervision and continuing education will keep them there. Including licensed mental health counselors as Medicare providers, easing reciprocity for licensed professionals, training family members and persons in recovery and reducing paperwork requirements will add hours for clinical care. Graduate curricula that include evidence-based treatments, competency-based care, co-occurring disorders, interdisciplinary teamwork and reimbursement to agencies for internship training will improve professional competence. Refreshing the supply of skilled supervisors will support staff and reinvigorate leadership. People with chronic mental illness and addiction need non-psychiatric professionals to prescribe psychotropic drugs and medication assisted treatments. Creating a Vista-type program that introduces college graduates to careers in behavioral health offers recruiting opportunities for both agencies and graduate schools.

Making a Difference

A recent report notes that, while there has been some progress in strengthening the behavioral health workforce, "it is also clear that the actions that have been taken, whether at the federal, state or local level, have been small in comparison to the breadth and depth of the challenges" (Hoge et al. 2017, p. 42). Why is this so? Does the country not see the magnitude of the cost of untreated behavioral health problems? Have we not made the connection between having an available workforce and offering accessible behavioral health care? Is the efficacy of psychological treatment in doubt? Do we expect things to improve on their own?

Understanding the resistance to change, while making a case for its urgency, is an essential next step to improving workforce development. Accepting "stigma" as the default answer to why we are not addressing a crisis that impacts everyone's family is a weak response; where there is leadership, a supportive work environment and appropriate compensation, professionals work enthusiastically in equally challenging areas. The path ahead is evident.

Compliance with Ethical Standards

Conflict of interest The author declares that he has no conflict of interest.

Informed Consent This article did not involve subjects nor materials that required informed consent.

Research Involving Human Subjects/Animals This article does not contain any studies with human participants performed by any of the authors. This article does not contain any studies with animals performed by any of the authors.

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