American Journal of
Preventive Medicine

COMMENTARY

The Future of the Behavioral Health Workforce: Optimism and Opportunity

Angela J. Beck, PhD, MPH,[1] Ronald W. Manderscheid, PhD,[2] Peter Buerhaus, PhD, RN[3]

The U.S. mental health system faces considerable challenges in delivering behavioral health care to populations in need. More than 44 million American adults have a diagnosable mental health condition, and rates of severe depression are worsening among youth.[1] Concurrently, drug overdose deaths fueled by opioid misuse are skyrocketing, having more than tripled from 1999–2016.[2] This epidemic led the federal government to declare the opioid crisis a public health emergency in 2017, bringing critical attention to the dire need for providers to engage in prevention and treatment interventions.[3] State and federal policies supporting mental health parity, reimbursement, and insurance expansion have collectively improved access to care,[4–7] yet as the rates of uninsured adults decrease, more than half of the population with mental health conditions still does not receive needed treatment.[8]

With no indication that trends will reverse in the near future, a behavioral health workforce that was already in a state of shortage is now that much more stretched. In its broadest definition, the behavioral health workforce includes all who provide prevention or treatment services for mental health or substance use disorders. This includes a multitude of licensed and certified professionals, peer workers, case coordinators, and paraprofessional workers. Although definitions vary throughout the field, all have one thing in common: No matter who is counted as a behavioral health worker, the collective supply falls far short of needed demand. A 2016 report released by the Health Resources and Services Administration (HRSA) projected the supply of workers in selected behavioral health professions to be approximately 250,000 workers short of the demand projections by 2025,[9] an astoundingly large number that may be worthy of a public health emergency declaration of its own.

This special issue of the *American Journal of Preventive Medicine* focuses on a key element of mental health system infrastructure where substantial investment is needed to effect change: behavioral health human resources. Although the supply and demand realities are highlighted within the issue, it also features the positive progress that this field of dedicated professionals has achieved. There is no question that the barriers to strengthening behavioral health workforce capacity and improving service delivery will not be easily overcome, but with challenge comes opportunity. This set of articles collectively proposes strategies and best practices to guide success of the current and future behavioral health workforce.

ADVANCES IN WORKFORCE PLANNING, PRACTICE, AND PREPARATION

Despite the numerous challenges confronted by the behavioral health workforce in providing access to high-quality care, myriad examples exist of advances in workforce planning, development, and service delivery. The Nation's first Health Workforce Research Center focused on behavioral health, funded jointly by the Substance Abuse and Mental Health Services Administration and HRSA, was established in 2015. The efforts of this Center and its consortium of partners, which represent a varied group of providers and professional organizations engaged in mental health and addiction prevention and treatment, are aimed at conducting research to strengthen workforce capacity. The article

From the [1]University of Michigan School of Public Health, Behavioral Health Workforce Research Center, Ann Arbor, Michigan; [2]The National Association of County Behavioral Health and Developmental Disability Directors, Washington, District of Columbia; and [3]Center for Interdisciplinary Health Workforce Studies, Montana State University, Bozeman, Montana

Address correspondence to: Angela J. Beck, PhD, MPH, Behavioral Health Workforce Research Center, University of Michigan School of Public Health, 1415 Washington Heights, Ann Arbor MI 48109. E-mail: ajbeck@umich.edu.

This article is part of a supplement entitled The Behavioral Health Workforce: Planning, Practice, and Preparation, which is sponsored by the Substance Abuse and Mental Health Services Administration and the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

0749-3797/$36.00

https://doi.org/10.1016/j.amepre.2018.03.004

by Beck et al.[10] summarizes the Center's work in developing a minimum data set as a foundational step for standardizing the collection of workforce data to inform workforce planning efforts. Two articles by Andrilla and colleagues detail the geographic maldistribution of providers across the U.S.[11] and barriers to seeking buprenorphine treatment for opioid use disorder because of physician prescribing practices,[12] whereas Brener et al.[13] describe how school district staffing policies related to counseling, psychological, and social services could increase availability of behavioral health services. Findings from these studies frame access to care issues for which careful workforce planning may improve availability of behavioral health services for underserved populations.

This issue also includes studies that offer solutions for addressing workforce shortages and reduced capacity through policy development and effective use of human resources. Haffajee and colleagues[14] propose policy pathways to address workforce barriers to buprenorphine provision and access and Altschul et al.[15] summarize legislation enacted in New Mexico in 2011 to systematically survey all healthcare professionals in an effort to inform policies to address shortage issues. Further, Chapman and colleagues[16] discuss the roles of psychiatric mental health nurses, an often underutilized segment of the workforce, in behavioral health care delivery; Gagne et al.[17] highlight the benefits of integrating peer workers across service settings; and Au and colleagues[18] propose strategies for reducing burnout of care coordinators in integrated care settings.

Effective workforce development is also critically important for enhancing quality of care. In this issue, Chapel et al.[19] highlight the benefits of training workers to use Project ECHO™ virtual clinics for improved clinical supervision; Keeler and colleagues[20] describe opportunities for enhanced behavioral health training through virtual mentorship networking; study results from Fraher et al.[21] demonstrate a need to refine content delivered in Master of Social Work programs to better train social workers for work in integrated care; and Chapman and colleagues[22] detail best practices in peer provider workforce development across states. Finally, HRSA highlights the Behavioral Health Workforce Education and Training program, designed to help those in need of behavioral health care by supporting provider training.[23] The research and programmatic efforts described in these articles have a shared aim of improving access to care in underserved areas and addressing the workforce capacity gaps in our nation's behavioral health workforce. We thank each of the authors for their contributions, dedication, and leadership as well as the *American Journal of Preventive Medicine* for permitting us to develop this issue.

DEVELOPING A VISION FOR THE FUTURE BEHAVIORAL HEALTH WORKFORCE

The articles in this issue provide an opportunity to look forward, develop new ideas, and redouble focus. From a research perspective, it is imperative that an implementation plan be developed for the behavioral workforce minimum data set to address the limitations of existing data sources. Clearly, workforce planning to address issues of maldistribution and shortage of providers needs to be informed by accurate data. The articles highlighting service delivery models and effective use of workers, such as psychiatric mental health nurses, social workers, and peer workers, will likely prompt discussions around scope of practice. As scopes of practice vary dramatically from state to state, with some providers practicing outside their scope and some practicing under their full scope, much more work is needed with state entities to find ways for the behavioral workforce to evolve in ways that make sense and allow each individual to contribute in the most productive way possible.

There are other major opportunities. Efforts should be made to retain providers who are baby boomers on a part-time or volunteer basis post-retirement. This group represents a large segment of the current behavioral health workforce. Efforts also should be made to interest high school and undergraduate students in future behavioral health careers, and much more needs to be done to exploit modern information technology for communication and care for persons with behavioral health conditions. The possibilities are exciting!

The vision for the future of the behavioral health workforce is one of real hope. The increased national and state focus on mental health and addiction services has mobilized the field. There are committees, task forces, and other groups of dedicated people and organizations committed to changing the status quo, improving the life of individuals, and creating a different and better future. Healthcare organizations, communities, foundations, and governments are willing and eager to work collaboratively to ensure a successful future for the field. The portfolio of efforts highlighted throughout this issue are strong evidence of this energy and enthusiasm.

ACKNOWLEDGMENTS

This work was funded by the Health Resources and Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) through cooperative agreement number U81HP29300. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by SAMHSA, HRSA, the U.S.

Department of Health and Human Services (HHS) or the U.S. Government.

Angela J. Beck is an Assistant Editor for AJPM, and did not have any role in the editorial review process for this article. No financial disclosures were reported by the authors of this paper.

SUPPLEMENT NOTE

This article is part of a supplement entitled The Behavioral Health Workforce: Planning, Practice, and Preparation, which is sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under U81HP29300-03-02, Behavioral Health Workforce Research Center.

REFERENCES

1. Substance Abuse and Mental Health Services Administration (SAMHSA). Key Substance Use and Mental Health Indicators in the United States: Results From the 2016 National Survey on Drug Use and Health. Rockville, MD: SAMHSA. www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.pdf. Published September 2017. Accessed February 2, 2018.
2. Hedegaard H, Warner M, Miniño AM. Drug overdose deaths in the United States, 1999-2016. *NCHS Data Brief*. 2017;294:1–8. https://www.cdc.gov/nchs/products/databriefs/db294.htm. Accessed April 6, 2018.
3. Johnson J, Wagner J. Trump declares the opioid crisis a public health emergency. *Washington Post*. October 26, 2017. www.washingtonpost.com/news/post-politics/wp/2017/10/26/trump-plans-to-declare-the-opioid-crisis-a-public-health-emergency/?utm_term=.4e8f18b52d3d. Accessed February 2, 2018.
4. Centers for Medicare & Medicaid Services. The Mental Health Parity and Addiction Equity Act. www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html. Accessed February 2, 2018.
5. U.S. Centers for Medicare & Medicaid Services. Mental health & substance abuse coverage. HealthCare.gov. www.healthcare.gov/coverage/mental-health-substance-abuse-coverage/. Published 2016. Accessed February 2, 2018.
6. National Council for Behavioral Health. Americans with mental health and substance abuse disorders: the single largest beneficiaries of the Medicaid expansion. Washington, DC: National Council for Behavioral Health. www.thenationalcouncil.org/wp-content/uploads/2017/01/Medicaid-Expansion-Behavioral-Health-UPDATED-1-24-17-1.pdf. Published 2017. Accessed February 2, 2018.
7. HHS. *Benefits of Medicaid expansion for behavioral health*. Washington, DC: HHS, 2016. https://aspe.hhs.gov/system/files/pdf/190506/BHMedicaidExpansion.pdf. Accessed February 2, 2018.
8. Nguyen T. State of mental health in America, 2018. Alexandria, VA: Mental Health America. www.mentalhealthamerica.net/issues/state-mental-health-america. Published 2017. Accessed February 2, 2018.
9. HHS Health Resources and Services Administration. *National projections of supply and demand for selected behavioral health practitioners: 2013–2025*. Rockville, MD: HRSA, 2016.
10. Beck AJ, Singer PM, Buche J, Manderscheid RW, Buerhaus P. Improving data for behavioral health workforce planning: development of a minimum data set. *Am J Prev Med*. 2018;54(6 suppl 3):S192–S198.
11. Andrilla CHA, Patterson DG, Garberson LA, Coulthard C, Larson EH. Geographic variation in the supply of selected behavioral health providers. *Am J Prev Med*. 2018;54(6 suppl 3):S199–S207.
12. Andrilla CHA, Coulthard C, Patterson DG. Prescribing practices of rural physicians waivered to prescribe buprenorphine. *Am J Prev Med*. 2018;;54(6 suppl 3):S208–S214.
13. Brener N, Demissie Z. Counseling, psychological, and social services staffing: policies in U.S. school districts. *Am J Prev Med*. 2018;54(6 suppl 3):S215–S219.
14. Haffajee RL, Bohnert ASB, Lagisetty PA. Policy pathways to address provider workforce barriers to buprenorphine treatment. *Am J Prev Med*. 2018;54(6 suppl 3):S230–S242.
15. Altschul DB, Bonham CA, Faulkner MJ, et al. State legislative approach to enumerating behavioral health workforce shortages: lessons learned in New Mexico. *Am J Prev Med*. 2018;54(6 suppl 3):S220–S229.
16. Chapman SA, Phoenix BJ, Hahn TE, Strod DC. Utilization and economic contribution of psychiatric mental health nurse practitioners in public behavioral health services. *Am J Prev Med*. 2018;54(6 suppl 3):S243–S249.
17. Gagne CA, Finch WL, Myrick KJ, Davis LM. Peer workers in the behavioral and integrated health workforce: opportunities and future directions. *Am J Prev Med*. 2018;54(6 suppl 3):S258–S266.
18. Au M, Kehn M, Ireys H, Blyler C, Brown J. Care coordinators in integrated care: burnout risk, perceived supports, and job satisfaction. *Am J Prev Med*. 2018;54(6 suppl 3):S250–S257.
19. Chapel MJ, Freese TE, Rutkowski BA, et al. Using ECHO clinics to promote capacity building in clinical supervision. *Am J Prev Med*. 2018;54(6 suppl 3):S275–S280.
20. Keeler H, Sjuts T, Miitsu K, Watanabe-Galloway S, Mackie PF-E, Liu H. Virtual mentorship network to address the rural shortage of mental health providers. *Am J Prev Med*. 2018;54(6 suppl 3):S290–S295.
21. Fraher EP, Richman EL, Zerden LdS, Lombardi B. Social work student and practitioner roles in integrated care settings. *Am J Prev Med*. 2018;54(6 suppl 3):S281–S289.
22. Chapman SA, Blash LK, Mayer K, Spetz J. Emerging roles for peer providers in mental health and substance use disorders. *Am J Prev Med*. 2018;54(6 suppl 3):S267–S274.
23. Kepley HO, Streeter RA. Closing behavioral health workforce gaps: a HRSA program expanding direct mental health service access in underserved areas. *Am J Prev Med*. 2018;54(6 suppl 3):S190–S191.