THE ANNAPOLIS COALITION
ON THE BEHAVIORAL HEALTH WORKFORCE

Barriers to Behavioral Health Workforce Development: A Path Forward

An Annapolis Coalition Commentary

Introduction

There is a longstanding and widely recognized workforce crisis in behavioral health. Countless analyses have been completed of workforce shortages, worker burnout, high turnover rates, lack of diversity, and need for more training in evidence-based practices. There are innumerable calls to action and reports of recommendations for addressing the crisis, as well as behavioral health workforce plans that have been developed for the nation, individual states, organizations, and academic institutions. Except for a recent, brief surge in attention to this issue, which was precipitated by the pandemic and supported by federal pandemic-related funding, there has been relatively little effective and sustained action on the crisis.

The ideas regarding 'what needs to be done' are well documented. Drawing on the published literature and numerous reports, an AI chatbot can produce a cogent summary of recommendations in a matter of seconds. The critical question now facing the field is 'why has so little been done'?

This commentary examines that latter question. It is drawn from the observations of leaders within the *Annapolis Coalition on the Behavioral Health Workforce*, which has been addressing this crisis for twenty-five years (www.annapoliscoalition.org). It is based on discussions with thousands of federal, state, and local behavioral health leaders and staff, and the lessons learned from implementing a highly diverse set of workforce initiatives over the life of the *Coalition* (https://annapoliscoalition.org/about-us/milestones/). It is an analysis of the numerous and daunting barriers to action that have resulted in a workforce that is insufficient in size or preparation to address the unprecedented levels of mental health and substance use conditions in our nation. It is a call to shift attention to the root causes of the workforce crisis to overcome the barriers to change.

Barriers

Discrimination and Stigma

Negative, prejudicial attitudes and unfair treatment have for centuries been the hallmarks of discrimination experienced by persons with mental health and substance use conditions. It occurs at a societal level, within healthcare and educational systems, among employers, within families, and in the media. Negative attitudes and discriminatory treatment toward workers who care for persons with these problems have also been widespread, exemplified by lower wages for behavioral health workers, in contrast to those employed in other medical specialties. The siloed nature of behavioral health services, which have long been separated

from mainstream medical care, constitutes another form of discrimination that has minimized federal support, placed an undue burden on the states, and impeded the development of a strong behavioral healthcare system. Discrimination and stigma can be considered the root cause of failures to strengthen the behavioral health system and its workforce, leading to many of the barriers identified below.

Inadequate Financing

Discrimination and stigma have created a context within which behavioral health services have been funded and reimbursed at comparatively lower levels than most other forms of healthcare. Payers have frequently excluded behavioral health providers from insurance networks, implemented discriminatory exclusions of patients from healthcare coverage, placed excessive limits on coverage, and employed highly restrictive utilization management procedures to restrict care.

Because of these limitations and restrictions, the attractiveness and economic benefit to an individual of choosing a career in behavioral health has been declining. The financing systems constrain the resources available for behavioral health organizations to hire a workforce and provide it with wages and benefits that are commensurate with the level of education required and the level of responsibilities involved in the work. In the U.S., the high level of total healthcare costs as a percentage of Gross Domestic Product (GDP) is often cited as a reason for constraining behavioral healthcare costs, when evidence exists that coordinated general medical care and behavioral health care improves outcomes and can lower costs. The drive to contain these costs simply overlooks behavioral health needs nationally, the critical role of the workforce, and the financial discrimination against behavioral health in healthcare systems.

In response to low reimbursement rates and payer utilization management practices, many behavioral health providers now refuse to participate in managed care and other insurance networks, accepting only self-pay. This further diminishes public and corporate responsibility for this care and shifts the financial burden to individuals with behavioral health needs. Due to inadequate funding for positions and to income inequality in the U.S., much of the entry level, non-degreed direct care workforce in behavioral health does not receive a living wage, which results in extremely high position turnover and vacancy rates.

Another financial driver of the current workforce crisis has been the substantial decline in public funding for education in the United States. The behavioral health workforce has been specifically and significantly affected, as federal funding for training in this field has declined dramatically. The specter of student debt, which has been increasing rapidly, discourages job seekers from entering and remaining in the behavioral health workforce given the comparatively low levels of compensation in this field.

Absence of Outcome Measurement

There is ample evidence that the treatments of behavioral health conditions 'work' and reduce societal costs. Reliable and valid measurement of behavioral health outcomes are quite feasible. However, they are not measured or reported routinely. Performance metrics and reimbursement are typically tied to process measures such as the number and length of visits. Funding limitations result in weak administrative and data systems, and the absence of the technical workforce necessary to routinely and accurately collect and report treatment outcomes and workforce data. In the absence of reliable and valid outcomes measurement, it is impossible to demonstrate the impact and societal value of workforce size, retention, training, and competence. Without the data, leadership commitment and financial support to invest in the workforce are typically lacking.

Quality Improvement Failure

The methods for quality improvement in healthcare are well-developed and relevant to behavioral health. However, most behavioral health provider organizations lack the managerial workforce and data systems necessary to systematically and continuously improve care and the quality of the workforce. As federal and state governments issue and demand an ever-changing list of 'best practices', provider organizations struggle to effectively adopt them and, if achieved, struggle to find the financial and human resources to sustain those gains. Many efforts at improvement are undermined by high rates of staff turnover among the very managers responsible for the quality initiatives, and by the departure of workers who have been trained in the latest best practices. Often overlooked in the sporadic and ineffective efforts to implement evidence-based practices is an essential and more achievable goal of instilling and maintaining 'basic' practices throughout the workforce.

Complexity of the Workforce

Behavioral health has, arguably, the most complex workforce in all of healthcare. Between the mental health and substance use sectors, there is an enormous service and workforce divide. At the professional level, there is a plethora of guild-like disciplines, each with its own history, traditions, and unique competencies. The distinctions between the disciplines have eroded as all have positioned themselves as 'healthcare providers' eligible for third-party payments to 'diagnose and treat' mental illness and substance use. The disciplines often compete in the legislative and regulatory arena, viewing the behavioral health field as a zero-sum game in which a gain for one discipline represents a loss for the others. Without cause, the federal government, through health policy and entitlement programs, has discriminated against selected disciplines in terms of eligibility for reimbursement in public entitlement programs. Policymakers, payers, grantmakers, and foundations are often confused and exasperated by the divisions, differences, and competition between workforce sectors and disciplines in behavioral health.

Unlike many healthcare fields, a large percentage of the positions in behavioral health organizations are 'employer defined'. There are comparatively few widely recognized and accepted 'industry defined' positions and position titles. This creates a major barrier to effective position advertising and recruitment of qualified workers. It further limits the field's access to federal and state workforce development funds, which are generally restricted to initiatives that train workers for widely recognized, industry-defined jobs for which there is critical demonstrated need for workers. Peer specialist and family advocacy positions have been a positive addition to the field, while adding further complexity surrounding their workforce roles and responsibilities. There has been a confusing blend of mission driven and financially driven motives behind their creation and such positions often lack both a living wage and opportunities for career advancement.

Scarcity of Workforce Development Experts and Expertise

There has been relatively little public or private funding to support research and evaluation on workforce development in behavioral health. Many workforce initiatives are never fully implemented, and few are evaluated, documented, disseminated, or sustained.
Some knowledge on this topic has emerged from research demonstrations of evidenced-based mental health and substance use treatments. Best practices in behavioral health workforce development have often simply been adopted from other fields such as medicine, human resource management, and computer-based learning.

While 'training positions' in behavioral health are common, there are few dedicated 'workforce development' positions in federal agencies, state governments, or at the local level within county agencies and provider organizations. There is no career path for the development of workforce experts. Given the complexity and challenges surrounding this workforce, the task of fostering its development is confusing and overwhelming to professionals who have no education, training, or mentored experience on the topic.

Little is taught in the typical medical, graduate, or professional school about management and leadership, including workforce development. Many of the smallest behavioral health organizations lack even a single Human Resource (HR) manager. In many behavioral health organizations, HR is not treated as a profession, and its staff are not afforded continuing education in HR best practices or membership in professional HR societies that promote continuous workforce quality improvement. Once again, it is the financial constraints within these organizations that limit building an HR and training staff of sufficient size and competence to continuously find, develop, and retain qualified mental health and substance use providers.

Ineffective Training

The term 'workforce development' is often narrowly used to mean only 'training'. The predominant approaches to initial training and continuing education of behavioral health professionals involve lectures, webinars, and conferences. Research has demonstrated that these generally have no impact on worker professional behaviors or patient outcomes.

Intensive, multi-modal initiatives to develop workers' skills have been shown to be effective in changing professional behaviors and impacting outcomes. However, these are used much less frequently because behavioral health organizations seldom have the financial resources to fund them or to provide the release time for workers to participate in them. When intensive approaches are implemented, their impact is routinely undermined by worker turnover during or shortly after participation in the skill development training. With respect to paraprofessional, direct support workers, ineffective training is the predominant approach and is typically provided in very minimal quantities.

Lack of Integration

Historical forces led to the separation that exists between mental health and substance use services, and to the siloed approach to training workers to specialize in one or the other of these sectors. Despite decades of national, state, and local efforts to foster 'co-occurring' services and competent workers, the legacy of the mental health/substance use divide still haunts the organization and delivery of services and limits the competence of the workforce.

The stark separation of behavioral health services from general health care has been another devastating divide, leaving mental health and substance use services segregated from mainstream health care, relegated largely to the poorly funded public sector. As such, behavioral health lacks much of the infrastructure, revenue, leadership, managerial talent, electronic medical records, and quality improvement systems found in mainstream health systems. Integration of behavioral health into general healthcare has been touted as an ideal by experts, but gains on this goal have been minimal.

Dispersion of Responsibility

A barrier unrelated to inadequate financing is the number and diversity of groups, organizations, and agencies that have a role in behavioral health workforce development. These include, but are not limited to, federal, state, county, and local governments; academic institutions; accrediting bodies; licensing agencies; provider agencies/employers; professional associations; and technical assistance and training organizations. There is a dispersion of responsibility for workforce development across these stakeholders, which fosters among each an attitude that addressing the workforce crisis is not their responsibility. The result is inaction. At the federal level, responsibility for issues related to this workforce are dispersed across the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), Centers for Medicare and Medicaid Services (CMS), and the Agency for Healthcare Research and Quality (AHRQ), among others. This has led to a lack of clear federal leadership, concerted action, and coordinated efforts at the federal level despite the potential financial influence and leverage that these agencies could exert.

The fact that the concept of "workforce development" is poorly understood by many leaders makes it easier for them to dismiss it as their responsibility. Effective workforce development requires intermediate and long-term strategies within a framework of continuous workforce

improvement to address the many challenges. The frequent turnover in leaders and administrations within political, governmental, and service organizations reduces their incentive to invest their current and limited resources to address this crisis. Further, there are few mechanisms to hold stakeholders accountable for their actions on workforce development, or lack thereof, such as academia's failure to train students to treat individuals across the age range or the reluctance of provider accreditation bodies to hold service agencies accountable to provide effective supervision of their workforce. In the absence of mandates or incentives that force attention to workforce development, it is the vision and actions of a *small* number of individual political, governmental, academic, and service leaders that have driven isolated efforts at workforce improvement.

The Path Forward

The recent increase in attention to this workforce crisis, which was stimulated by the pandemic, has been heartening. However, the barriers described above remain. The acute social, psychological, and financial impact of the pandemic has subsided. However significant behavioral health needs persist. As federal pandemic-related funds are exhausted and the current federal administration moves to shrink government, there are reasons to believe that the heightened focus on this workforce will wane.

It is no longer rational to assume that simply articulating the workforce challenges and the practical solutions to address them will bring about major change. While short-term efforts to strengthen the workforce continue, it is imperative to dramatically increase the focus on barriers to large scale change and on strategies to overcome those obstacles. This is a daunting challenge, but one that must be embraced if a workforce of sufficient size and effectiveness is to be developed and the nation's behavioral health needs are to be met.

Comprehensive nationwide efforts to address stigmatizing attitudes and wide scale discrimination are essential. Advocacy, legislative action, and legal challenges are necessary to ensure sufficient funding of behavioral health services. Strengthened state enforcement of parity laws and regulations offers a major opportunity to improve financial support. Outcome measurement must be implemented as a standard element of behavioral health services to assess and demonstrate both their treatment effectiveness and the impact of workforce variables on access to quality care. Successful and sustained quality improvement within behavioral health organizations will require the provision of more evidence-based, comprehensive, and longitudinal technical assistance from federal and state agencies and technical assistance providers.

With respect to the workforce, a national and collaborative effort among stakeholders is necessary to replace the myriad of 'employer-defined' position titles with universally recognized 'industry-defined' titles for professional, para-professional, and peer/family roles. Intensified advocacy is required to ensure the eligibility of all qualified providers for public and private reimbursement of services. Public and private sector collaboration is similarly needed to develop a pipeline of workforce experts in behavioral health and to enhance the competence of

leaders, managers, and human resource staff on workforce recruitment, skill building, and retention.

All providers of training and technical assistance should immediately reduce the use of non-evidenced based techniques, such as lectures and workshops, to no more than 20% of their efforts and redirect resources to evidence-supported, sustained, multi-component interventions to build worker competencies. Integration of services and systems within behavioral health (i.e., mental health and substance use) and across sectors (i.e., behavioral health and general healthcare) must be an imperative, not just to improve the quality of direct care, but as a strategy to eliminate the segregation of degradation of mental health and substance use services.

Lastly, achieving both short-term and long-term goals to strengthen the workforce will require specific strategies to hold all involved organizations and individuals accountable for addressing workforce development within their scope of responsibilities. Congress can and should require federal agencies to focus on this agenda. These agencies can, in turn, use their political and financial influence to require an intensive focus on workforce development among states, professional associations, and other organizations that receive federal funding. States can exert the same leverage on provider organizations, licensing boards, and professional associations within their borders. So, too, can the leaders of behavioral health organizations mandate and support efforts by their managers and supervisors to make workforce recruitment, development, and retention among the highest of priorities.

Looking back, there has been an intensive focus at certain times in history on issues such as discrimination, stigma, parity, outcomes, quality improvement, evidence-based training, and integration. The path forward involves re-examining and learning from those efforts, while launching a renewed surge of activity to overcome the barriers that prevent the access to effective care from a strengthened behavioral health workforce.

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