The Behavioral Health Workforce

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- 55% of US counties have no behavioral health provider
- 77% have unmet behavioral health needs
- Plagued with shortages and maldistribution
• **CALL TO ACTION – 2007**

• Mental health, addictions, treatment & prevention

• Identified a core set of strategic goals & objectives and priority action items by stakeholder

• A planning resource with levers of change

1000 points of “NO”

**WHO, WHAT, WHERE** of the Behavioral Health Workforce and Policy Recommendations
1) **WHO** is our Workforce?
Behavioral Health Workforce

Behavioral Health and Other Related Providers, by Field

- Counselors: 37%
- Social Workers: 29%
- Other Mental Health Related Professionals: 2%
- Marriage and Family Therapists: 7%
- Psychiatrists: 9%
- Psychologists: 16%

Source: Centers for Medicare and Medicaid Services, National Provider Identifier (NPI) Database (2014)
We Need to *Redefine* the Workforce

- 100,000 nurses working in mental health settings
- Over 275,000 primary care clinicians
- 3.8 million general nurses
- Police
- Peers, consumers, people in recovery
- Community health workers
- Families and friends
We Need a Planning *Data Base*

- Nationally adopt a minimum data set of all specialty and generalist behavioral health care providers: Michigan: Behavioral Health Workforce Research Center funded by SAMHSA and HRSA

- Exemplar: New Mexico passed legislation to provide the state with behavioral health workforce data
We Need to *Recruit* our Future Workforce and then *Retain* Them

- Expand federal programs:
  - Loan forgiveness
  - Training programs (BHWET)
- Allow for full scope of practice for all licensed/credentialed clinicians
- Reimbursement for all licensed/credentialed clinicians
- Fully utilize and reimburse non-behavioral health providers as core behavioral health service providers – nurses, other clinicians, peers, community health workers
2) **WHAT** type of care is provided?
We Need to Rethink our Treatments

- Reimburse only Evidence-Based treatments inclusive of “non-traditional” care – trauma-informed, recovery support, care coordination
- Expand fee-for-service limitations in primary care from 10-15 minute appointments
- Eliminate prohibiting same-day and two-generation services
- Reimburse specialty trainees for care provided
We Need to Rethink our Treatments

- Move beyond medications into psychosocial interventions
- Implement new processes of care – simple, standardized, automated screening tools
- Triage patients to most appropriate care-giver based on symptom severity and type and intensity of service needed
We Need to Rethink our *Treatments*

- Opioid Crisis – 47% US counties and 60% rural counties have no MAT prescriber
  - Eliminate the waiver process for MAT prescribers by including it in training programs
  - Eliminate waiver requirements for those who can prescribe controlled substances
  - Make MAT an essential health benefit
  - Ensure insurance parity
3) **WHERE** is Care Provided?

- Hospitals
- Clinics – siloed and/or integrated
- Outpatient offices
- Medical Homes
- Sometimes Mobile Crisis Units
- Sometimes Crisis Stabilization and/or Detox Units

- Most settings are 9-5 on weekdays

- And so the ER is now a primary point of behavioral health care
We Need to Rethink our Settings

- Churches
- Community Center
- Work places
- Prisons
- Schools
- Homes

And coming NOW is “anytime, anywhere” behavioral health care with eHealth, mHealth, telehealth and telesupervision.
So, at the End of the Day.....

We need the **right workers**
with the **right skills**
in the **right place**
doing the **right thing**

**Thank you!**