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COMMENTARY

Closing Behavioral Health Workforce Gaps: A HRSA Program Expanding Direct Mental Health Service Access in Underserved Areas

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It is estimated that 18.3% of the U.S. adult population —44.7 million people—suffered from any mental illness in the past year.[1] Beyond the direct toll on individuals and families, mental illness and substance use disorders are well-established drivers of disability, mortality, and healthcare costs.[2] Shortages and maldistribution of behavioral health providers further complicate the behavioral health landscape by constraining access to essential care and treatment for millions of individuals with mental illness or substance use disorders. A 2016 report by the Health Resources and Services Administration (HRSA) underscored this challenge as it released its first report on behavioral health practitioners, detailing the projected supply and demand of practitioners through 2025 at the national level.[3] The report indicated significant shortages of psychiatrists, psychologists, social workers, school counselors, and marriage and family therapists. The magnitude of provider shortages, however, are not the only issue when considering access to behavioral health services. Maldistribution is the other major concern, as certain areas of the country have few or no behavioral health providers available.[4] Access to mental health services is especially critical in areas besieged by poverty.[5]

As HRSA is the primary federal agency for improving health care to people who are underserved or live in underserved areas, its Behavioral Health Workforce Education and Training (BHWET) program is designed to help those in need of high quality behavioral health care by supporting the training of new behavioral health providers, both professionals and paraprofessionals. The BHWET program was initially funded through a partnership between HRSA and the Substance Abuse and Mental Health Services Administration (SAMHSA). By making grants to eligible entities, such as universities and other non-profit organizations, the BHWET program supports the development and expansion of the behavioral health workforce serving individuals across their life span, from early childhood to the end of life. The program focuses not only on supply of providers but also on their distribution as there is an emphasis on training and working in underserved communities where significant behavioral health disparities exist, particularly in terms of access to care. Research has shown that significant exposure to these communities during training is more likely to influence the future provider to practice in those areas during their career.[6] Additionally, this program emphasizes training in primary care and behavioral health integration. Integrated and interprofessional settings have the advantage of providing high-quality access to both primary and behavioral health care in a single setting with less stigma, which has traditionally been a known barrier to receiving needed care.[7]

The BHWET program has completed three full academic years of training to date. Each grant program is required to report performance data to HRSA at the end of each academic year to ensure achievement of programmatic as well as HRSA goals, strategies, and outcomes and as required by the Government Performance and Results Modernization Act of 2010. The U.S. Office of Management and Budget approved the performance data collection instruments and methods following public review and comment.[8] What follows is a descriptive summary of the cumulative achievements of the BHWET program based on the performance data awardees submitted to HRSA.

The number of training programs supported by BHWET has grown from 113 in the first year to 149 in the most recent academic year. Programs range from predoctoral internships in clinical psychology and master's-level practicums in social work to certificate programs for

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community health workers and peer paraprofessionals. The number of behavioral health students supported to date is 9,293—of which 6,868 have already graduated and prepared for entry into the behavioral health workforce. Of this total, 4,618 were new behavioral health professionals that included 120 new psychologists, 3,523 new social workers, 247 new mental health nurse practitioners, 152 new marriage and family therapists, and 576 new professional or mental health counselors. Additionally, 2,250 new paraprofessionals began work as community health workers, peer paraprofessionals, behavioral health technicians, and substance use/addictions workers. These new behavioral health providers represent a significant contribution to the overall supply of behavioral health practitioners and are already working to increase access to care.

An additional goal of the BHWET program is employment in underserved areas and provision of services to vulnerable populations. Upon graduation, nearly 40% of students indicated an intent to work in a rural or underserved area, and 72% indicated an intent to work with children, adolescents, and transitional-age youth, which is a particularly vulnerable population and at higher risk of developing behavioral health problems. Awardees also complete a 1-year follow-up of their graduates to inquire about employment setting. Of the graduates who responded to date (n=1,975), nearly all (97%) were employed in a clinical setting and providing behavioral health services, 47% were working in a medically underserved community or rural area, and nearly 60% were specifically working with children and transitional-aged youth. These high percentages may, at least in part, be attributed to the extensive training and exposure that students gained through their training experiences in BHWET-sponsored programs. During the most recently completed academic year, awardees utilized 2,348 training sites, more than 55% (n=1,307) of which were located in medically underserved communities. Additionally, a large number of the sites were community health centers (n=969), which not only provided students with exposure to underserved populations but also to integrated care services. During their training, behavioral health students spend a considerable amount of time at clinical training sites providing supervised services at reduced or no cost to clients and patients. BHWET supported students have cumulatively provided 1,816,529 hours of patient care in medically underserved communities and 686,823 hours of care in rural areas. Direct provision of behavioral healthcare services is a clear and significant benefit for underserved communities, but this type of service delivery also appears to increase students' interest in working with these populations in their future careers, thus meeting one of the primary objectives of this program. Programs such as BHWET are therefore providing critical access to needed behavioral health services, and at the same time are working to neutralize the projected future gaps in the nation's behavioral health workforce.

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