



A Critical Need for Mental (and Behavioral) Health Workforce Training

In 1992 Congress created the Substance Abuse/Mental Health Services Administration (SAMHSA) to focus on service delivery and training, as well as three new National Institutes of Health – the National Institute on Mental Health (NIMH), the National Institute on Drug Abuse (NIDA), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) – to focus on research and training. However, except for a few small programs (e.g., Minority Fellowship Program and HIV/AIDS training), and despite a serious shortage of qualified mental (and behavioral) health professionals, there is very little mental (and behavioral) health workforce development at SAMHSA. Yet, the Health Resources and Services Administration (HRSA) Office of Shortage Designation reports that currently there are over 2600 Mental Health Professional Shortage Areas (MHPSA) in the United States.

- *Individuals with major mental illness die 25 years younger than the general population (Colton and Manderscheid, Preventing Chronic Illness, April 2006).*
- *Seriously mentally ill persons are less likely to receive care for their chronic illnesses, even though they have higher rates of physical illnesses (Harvard Mental Health Letter, 2003).*
- *Serious mental illness can also lead to increased risk for suicide (President's New Freedom Commission, 2003).*

The Overall Need – In general, there is a need for an adequate mental (and behavioral) health workforce to address the needs of underserved persons with chronic illnesses (e.g., cancer, heart disease, diabetes). Mental health professionals are not only needed to treat chronically ill persons who suffer with psychological disorders, such as depression, but also to promote behavior changes that can positively impact the course of their illness and affect their longevity. Mental (and behavioral) health professionals address a variety of health care needs, including focusing on changing behaviors among children and youth who are violent or accident prone, among persons who engage in smoking, substance abuse, or risky sexual behavior, as well as older adults who need help with medication compliance. In fact all fifteen leading causes of death (CDC, 2005) have a behavioral component either with prevention, diagnosis and/or treatment. The economic costs are staggering. Mental illnesses and disorders cost approximately \$216 billion annually and the cost of the most common chronic illnesses in terms of treatment and lost productivity is about \$1 trillion a year (Milken Institute, 2007). Moreover, there is a particular shortage of mental (and behavioral) health professionals who specialize in the needs of children and youth and older adults—our Nation's two most vulnerable populations. The need for an adequate supply of mental (and behavioral) health professionals is especially acute in underserved rural communities where access issues are complicated by the long distance that individuals must travel to reach healthcare facilities.

Annapolis Coalition Workforce Plan – In 2002 the Annapolis Coalition was commissioned by SAMHSA to develop a strategic plan for developing a mental and behavioral health workforce. In early 2007, after five years of work, the Coalition publicized its action plan for behavioral workforce development. The report states:

“There is substantial and alarming evidence that the current workforce lacks adequate support to function effectively and is largely unable to deliver care of proven effectiveness. There is equally compelling evidence of an anemic pipeline of new recruits to meet the complex behavioral health needs

of the growing and increasingly diverse population... The improvement of care and the transformation of systems of care depend entirely on a workforce that is adequate in size and effectively trained and supported."

The Annapolis report highlights several key areas that need to be addressed:

- A notable lack of racial and cultural diversity among mental health disciplines.
- Concerns about workforce size in general and the geographic distribution of these professionals, especially in rural communities.
- A critical shortage of those trained to meet the needs of children and youth and older adults.
- Training among disciplines occurs in isolation, not in an interdisciplinary model, which is necessary for primary care service delivery that is affordable, cost-effective and comprehensive.

A key recommendation of the Annapolis Coalition is to improve training for mental (and behavioral) health professionals. They specifically recommend: the use of evidence-based practices in initial clinical training and continuing education; the initiation of widespread leadership training; and training in critical topics including integration with primary care and focusing on high need populations.

IOM Reports – Two other key reports have called attention to the widespread problems in health care delivery. The ground breaking report by the Institute of Medicine (IOM) released in 2001, *Crossing the Quality Chasm: A New Health System for the 21st Century*, identified the pervasive problems of health care today. This led to another report in 2006, *Improving the Quality of Health Care for Mental and Substance Use Conditions*, which identified the inadequacy of mental and substance use health care and recommended both building and assuring the competency of the workforce.

A strategic plan for transforming mental health care commissioned by SAMSHA (Daniels and Adams, February 2006) used these reports, along with the President's New Freedom Commission and SAMSHA's Federal Action Agenda, to develop a framework for a more coherent, coordinated, and effective national response to improve the quality of mental health care that includes building and ensuring the competency and capacity of the mental health care workforce.

The Need for Data Collection, Analysis and Dissemination – In the last few years, the University of North Carolina Shep Research Center under contract with HRSA has identified variables that can be used in the revision of the Mental Health HPSA (Health Professional Shortage Area). It was concluded that, unlike Medical HPSAs, it is not possible to determine need, only demand, for Mental Health HPSAs and that there are no accurate records of availability of mental health professionals by state or community (i.e., the state licensing boards have some information, but available data is incomplete). *The result is a significant undercounting of shortage areas.*

The Shep Center findings demonstrate the need for a continued and expanded capability to conduct workforce analyses. This is essential to ensure the presence of an adequate and qualified mental health workforce to address our nation's mental and behavioral needs. Armed with these data and subsequent analyses, policy makers will be able to make informed decisions on the need and demand of addressing mental and behavioral health.

Conclusion – The need for federal support of mental health workforce development and training is substantial. The findings from reports commissioned by the federal government all point to the need for an investment in mental (and behavioral) workforce training. Moreover, there is a critical shortage of qualified mental health professionals, as evidenced by the growing number of Mental Health Professional Shortage Areas nationwide. *Workforce issues must be considered in order to ensure that federal programs are cost effective, comprehensive and sufficient to meet the mental health care needs of underserved populations.*

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