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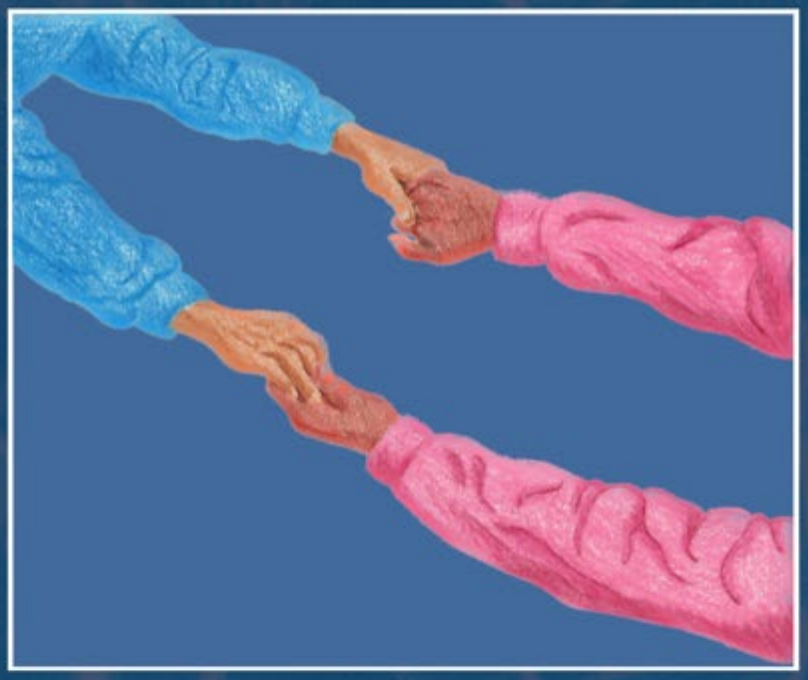
Growing and Strengthening the Behavioral Health Crisis Response Workforce



Connected and Strong

Third in a Series of Ten Technical Assistance Briefs to Foster Unity and Strengthen Continuity Across Crisis Response and Treatment Systems

SAMHSA
Substance Abuse and Mental Health Services Administration

Growing and Strengthening the Behavioral Health Crisis Response Workforce

Acknowledgments

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Abstract

The behavioral health workforce has been drastically impacted by the COVID-19 public health emergency. Providers, government entities, and policymakers around the country are seeking strategies to help build up staffing numbers and capacity at all levels. This paper provides employee- and organizational-level insights on barriers to employee recruitment, retention, and wellness among the crisis response and general behavioral health workforce. It highlights initiatives to grow and strengthen this workforce. To explore these initiatives, the authors reviewed national-level reporting on employee development initiatives and conducted semi-structured interviews with leaders of seven state mental health authorities. Findings suggest that several employee- and organizational-level initiatives exist to improve behavioral health workforce recruitment, retention, and wellness. The importance of workforce diversity (e.g., across gender, age, race and ethnicity, language, and sexual orientation) among crisis response providers and the value of bachelor's-level staff and peer support specialists are also reviewed. From an organizational improvement perspective, this report emphasizes the need to consider both the employee and organizational impact of workforce development to grow and strengthen the behavioral health crisis response workforce.

Highlights

- Workforce shortages exist among most behavioral health positions and across all crisis response service settings, including call centers, mobile crisis teams, and crisis centers (e.g., crisis stabilization, residential, and respite units).
- Low pay and funding barriers present the largest challenge to recruiting and retaining the behavioral health crisis workforce.
- Utilizing peer support professionals and bachelor's-level staff, with appropriate supervision, across crisis response components may improve access to care for individuals in crisis.
- Promoting the work of master's- and doctoral-level clinicians and psychiatrists to perform functions that require licensure and supporting multidisciplinary teamwork can help extend capacity.
- Diversity, equity, and inclusion in the workforce go beyond ideology in the workplace and should be implemented in organizational hiring and selection practices and policies. Diversity in the workforce is linked to positive outcomes for individuals served.

- Championing employee wellness—including reducing burnout, providing employees with flexible schedules, and reducing administrative burden—is critical to retaining a qualified workforce.
- Data can be leveraged to create a more diverse workforce and to understand community and sociodemographic characteristics.
- State-operated systems face unique barriers, including slower job posting and approval processes and lower and less competitive wages than private systems, which may hinder initiatives to grow and strengthen the behavioral health crisis response workforce.

Recommendations

1. **Work with the Centers for Medicare and Medicaid Services, state Medicaid offices, and private insurers to increase the reimbursement rate for behavioral health services.** Low reimbursement has been cited as a major barrier to recruitment and retention for behavioral health providers and provider organizations. Increasing reimbursement rates can facilitate higher wages, making Medicaid-credentialed provider organizations more competitive in the marketplace. Additionally, higher reimbursement rates may attract more providers to become enrolled with Medicare and Medicaid, which would in turn increase the number of in-network behavioral health providers available to low-income and older adults seeking services for behavioral health concerns.
2. **Leverage a broader spectrum of providers across the crisis continuum, including specialized behavioral health practitioners.** This entails legislation and policy that facilitates hiring and training of specialized behavioral health practitioners that may be underutilized in crisis response settings, including but not limited to psychiatrists, child and adolescent psychiatrists, substance use disorder specialists, psychologists, neuropsychologists, and other clinical mental health professionals, as well as nonclinical persons such as peer support specialists who have obtained specialized certification in crisis response and/or crisis counseling.
3. **Utilize existing data to make more informed organizational decisions and create data sources for more robust analyses of employees and individuals served.** For example, certain organizations have developed learning management systems to track employees' training. Other examples of data-leveraging strategies include using community data to inform organizational hiring and data reports and publications from behavioral health workforce centers to understand the community landscape.
4. **Apply an intersectionality lens to the organizational framework, including hiring candidates from diverse backgrounds and with unique lived experiences that reflect the communities of individuals served to improve supports for them.** Community and

organizational-level mapping (e.g., examining data on employee demographics from human resources) can be utilized to create a more equitable workforce that better represents the communities served by local crisis systems.

5. **Remove barriers to hiring peers in crisis settings. Peers, especially those looking to work within state-operated and state-contracted services, face challenges in the hiring process, including possible ineligibility due to legal history.** As peers offer invaluable insight into navigating behavioral health systems, organizational selection processes should be adapted to eliminate barriers to hiring peers into behavioral health, especially in crisis response settings.
6. **Establish programs that champion employee wellness, prevent burnout, and help employees navigate stressful workplace scenarios within crisis response work settings.** Providing behavioral health crisis care is emotionally laborious work that can require nontraditional work schedules. As such, addressing and preventing burnout is essential to recruiting, retaining, and maintaining the quality of the behavioral health crisis care workforce. Organizational leadership should explore strategies such as flexible work schedules and telehealth capabilities to support workers as services evolve, improving work–life balance as well as employee recruitment and retention.
7. **Leverage technology across the crisis continuum, including for crisis response.** Leveraging technology can extend the reach of the existing workforce across the crisis continuum and improve the efficiency and experience of on-site work. Examples of technology can include text services in crisis call centers and telehealth for mobile crisis teams and crisis centers.

Introduction

Recent studies document the current strain on the nation's mental health. According to one such study, approximately 90% of Americans believe there is a nationwide mental health crisis and more than 47% of people live in an area with a shortage of mental health professionals.[1,2] More than any other age group, young adults (ages 18–29) are reporting mental health concerns. These are vulnerable years that ironically overlap with growing independence and risk for emerging symptoms of serious mental illness (SMI), including first-episode psychosis.[3] There is therefore an increasing demand for behavioral health services, including treatment for mental health and substance use concerns. Recent efforts to expand behavioral health access—through initiatives such as school-based mental health, and especially through the implementation of the 988 Suicide & Crisis Lifeline and Certified Community Behavioral Health Clinics (CCBHCs) have further expanded the continuum and will require a growing behavioral health workforce.

The first of the 2024 Technical Assistance Briefs produced by the National Association of State Mental Health Program Directors (NASMHPD) on behalf of the Substance Abuse and Mental Health Services Administration (SAMHSA), *Connected and Strong: Strategies for Accessible and Effective Crisis and Mental Health Services,* provides an overview of President Biden's Unity Agenda as it relates to behavioral health, including the need to strengthen system capacity by addressing these very urgent workforce needs. As part of the ongoing effort to build a robust and comprehensive behavioral health continuum of care that prevents crises, addresses them, and links individuals to ongoing post-crisis care, workforce issues must be identified and addressed. In this paper, the third in the compendium of these 10 papers, the authors tackle complex workforce issues to help policymakers and practitioners understand the current landscape and develop strategies to address gaps and meet the goals set forth by President Biden.

Several providers and provider agencies, including state mental health authorities (SMHAs), have taken innovative steps to grow and strengthen the behavioral health crisis response workforce via recruitment, retention, wellness, and programmatic changes. Examples of how specific states are attempting to address workforce challenges can be found at the end of this paper. **Box 1** highlights some organizational strategies, obtained from a review of behavioral health workforce initiatives and case study interviews, to improve and/or enhance the crisis workforce.

Box 1: Highlights of employee recruitment, retention, and wellness strategies

Recruitment strategies

- Increase employee salaries and compensation.
- Offer recruitment bonuses.
- Offer scholarships, loan forgiveness, and loan repayment.
- Improve the education-to-employee pipeline through academic partnerships.
- Highlight competitive long-term benefits such as retirements and pensions offered to government employees in state-operated crisis settings.
- Partner with Department of Education to increase awareness and exposure to crisis and behavioral health careers to students in K-12.
- Use targeted strategies to improve the diversity of the workforce such as job fairs at Historically Black Colleges and Universities, minority serving institutions, Native American reservations, and older adult community activities.

*For additional employee recruitment strategies, see **Box 2** and the case studies.*

Retention strategies

- Increase Medicaid and private insurance reimbursement rates for providers and peer support specialists.
- Offer mentorship opportunities.
- Offer career advancement opportunities.
- Improve organizational culture centered around employee-specified needs and cultural competence.
- Provide employee training and development to increase knowledge, skills, and abilities surrounding working in a crisis response setting.
- Use learning management systems for tracking employee trainings and foster professional development.
- Utilize technology and telehealth to extend the reach of the workforce and increase the ability to hire providers with appropriate licensure across state lines.
- Connect with behavioral health workforce centers for resources and evidence-based approaches to workforce development specific to behavioral health.
- "Grow your own" programs to promote retention from people who grew up in the community and culture and are passionate about returning to serve their community.

*For additional employee retention strategies, see **Box 4** and the case studies.*

Box 1: Continued

Wellness strategies

- Build a planning and implementation taskforce dedicated to improving employee wellness.
- Conduct a needs assessment to highlight employee needs in the workplace and develop improvement strategies and interventions around the most salient needs.
- Complete interviews to identify the characteristics and mechanisms or tactics of employees currently excelling within the crisis response framework.
- When hiring, ensure a good person–environment fit at various levels including person–job, person–team, and person–organization.
- Address the risk factors for poor employee wellness such as decision latitude, low social support (including from leadership), and effort–reward imbalance as psychosocial risk factors of employee wellness.
- Use behavioral health mobile applications to reduce stress and improve coping mechanisms among the crisis response workforce.

*For additional employee wellness strategies, see **Box 7**.*

Programmatic strategies

- Implement and leverage the CCBHC service delivery model for crisis response at the community or state level to potentially increase employee compensation.
- Increase the use of telehealth and other technologies to increase reach and offer opportunities to address some workforce challenges.

The Current Behavioral Health Crisis Workforce Landscape

SAMHSA's *National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit* has established a No Wrong Door integrated crisis system of care that includes designations for (a) someone to talk to (i.e., call centers), (b) someone to respond (i.e., mobile crisis teams), and (c) somewhere to go (i.e., crisis stabilization centers).[4] For children's crisis services, the *National Guidelines for Children's Behavioral Health Crisis* specify the third designation as "a safe place to be," now "a safe place for help," as many crisis situations involving children can be managed at home.[5] Building a comprehensive crisis system of care that supports people of all ages requires enhancing the behavioral health workforce through additional hiring, training, and scheduling to provide 24/7 services.[6] Beyond the crisis system of care, emerging service delivery

models such as the CCBHC model and urgent care model provide immediate access to behavioral health services and seek to fill gaps in services, but they also create a need for additional workers to provide enhanced services.[7] The CCBHC framework addresses funding and compensation barriers.[8] See the case study, "Oklahoma—Leveraging the CCBHC Framework to Enhance the Crisis Workforce" for more information on how Oklahoma's Department of Mental Health and Substance Abuse Services has used CCBHCs to leverage a prospective payment system and fostered a team-based approach to crisis service delivery.

Settings

In crisis call centers, organizations often use bachelor's-level staff, peer support specialists, or volunteer staff to answer and triage calls. These individuals provide a unique value and can reduce the demand for licensed clinicians, though a licensed clinician typically supervises the work. In some states, peers are used to operate warmlines to provide support during difficult times for people with mental health challenges and/or substance use issues. In some call centers, staff can dispatch mobile crisis teams, coordinate care, and provide a warm handoff to licensed clinicians when appropriate.[9]

Organizations determine the composition of the mobile team that arrives on-site to assist an individual experiencing a mental health crisis. This is an evolving area, given the desire to leverage funding such as Medicaid reimbursement for these services, which entails particular staffing requirements. When licensed clinicians are not available to respond on site, telehealth can be used to connect an individual and/or the mobile crisis team to a licensed behavioral health professional. For example, although there is much more to be learned, various responders in Oklahoma now have iPads with software allowing them to connect with a licensed clinician who can provide additional behavioral health consultations and referral to the most appropriate level of care.[10]

In crisis stabilization centers, a variety of staff with different backgrounds (certified peer, bachelor's, master's levels) may be utilized to support the clinical staff and provide services based on the individual's needs at the time of arrival and length of stay necessary for stabilization. In certain cases, master's-level staff can provide stabilization and coordinate care (e.g., follow-up appointments with community-based providers and/or a follow-up call from a peer). Appropriately licensed clinical staff will be necessary for other instances to provide more extensive clinical services, including assessment and medication management. Although doctoral-level staff (e.g., psychologists and psychiatrists) may be employed in crisis stabilization and respite centers, master's-level staff are often utilized in crisis stabilization settings to allow individuals to return to their communities faster, in turn freeing up other staff to serve more individuals.[11] As crisis residential and respite centers serve as key points for both diversion from hospitalization and as step-down services upon release from hospitalization, maintaining a multidisciplinary workforce is essential to ensuring that individuals are diverted from hospitals.

Behavioral Health Teams

The workforce to serve individuals experiencing a behavioral health crisis consists of various behavioral health clinical and nonclinical teams. The knowledge, skills, and abilities for various team members is subjective to their lived experience, academic training, and workplace experiences. Both behavioral health clinical and non-clinical professionals are needed to create a comprehensive system of care that truly centers individuals receiving services. While behavioral health professionals provide direct clinical services, consultation, and supervision; non-clinical professionals such as peer support specialists are valuable in assisting those in care with navigating systems, scheduling follow-up appointments, and offering experiential insights that clinicians may not be privy to. Examples of non-clinical professionals include peer support and recovery specialists, community health workers, health navigators, and psychological and psychiatric technicians.[12]

Behavioral Health Professionals in the General Behavioral Health Workforce

Behavioral health professionals encompass a wide range of clinicians who provide behavioral health direct care services including psychiatrists, psychologists, various levels of nurses, social workers, licensed behavioral health counselors and therapists, and other professionals such as board-certified behavior analysts. In a report highlighting behavioral health supply and demand projections from 2017 to 2030, the Health Resources and Services Administration (HRSA) stated there is and will continue to be an inadequate supply of adult psychiatrists and substance use disorder counselors into 2030.[13] Shortages of psychiatrists and substance use disorder counselors present a grave concern as these job roles are critical in diagnosing and treating substance use disorders. As of January 2023, the Drug Addiction Treatment Act waiver, or X waiver, has been removed from the federal buprenorphine prescribing requirements for the treatment of opioid use disorder and any prescriber that is applying for or renewing their DEA license will be required to attest to a one-time eight hours of training specific to DEA-registered practitioners on the treatment and management of patients with opioid or other substance use disorders.[14] This could benefit the crisis response workforce, as it removes some barriers from practitioners who are able prescribe medications for opioid use disorder.[15]

Continued efforts to recruit and retain behavioral health professionals, including psychiatrists and social workers, will allow SMHAs and community organizations to mitigate workforce shortages across the crisis continuum. Although social work as a discipline has one of the highest projected growth rates from 2017 to 2032 (12% or 29,340 new clinicians),[16] many SMHAs report shortages of social workers in crisis settings.[17] Both nonclinical and clinical social workers play a unique role within behavioral health since they can occupy many roles and settings across the crisis services continuum, including call centers, mobile crisis teams, and crisis stabilization units. The greatest differences between nonclinical and clinical social workers are their state's regulatory purview of allowable services and supervisory requirements. Nonclinical social workers can generally work in crisis settings and function as counselors

providing crisis and case management, but they cannot provide direct clinical services. Licensed clinical social workers (LCSWs) and some other disciplines, depending on the state, can serve across all crisis service settings and have additional clinical training that allows them to diagnose, form treatment plans, and implement treatment plans with varying degrees of supervision, and many can practice independently. For this reason, shortages of licensed independent practitioners like LCSWs, licensed professional counselors, and other licensed mental health clinicians, greatly impact mobile crisis teams capabilities, as these teams often include a social worker.

Non-clinical professionals serve as an invaluable resource for individuals in care from underserved populations (e.g., forensic- or legal-involved individuals, youth, and minoritized individuals). For example, Mississippi's Department of Mental Health has used Transformation Transfer Initiative funds to expand the use of forensic-certified peer support specialists, which in turn has led to increases in the number of follow-up appointments scheduled for those reentering community settings and a reduction in the number of repeat incarcerations among legal-involved individuals living with an SMI.[18] Continued investment in the non-clinical behavioral health workforce will facilitate needed support for clinical teams and create opportunities for individuals served to access assistance navigating behavioral health systems. Non-clinical professionals can amplify the needs and voice of individuals in care through their lived experiences.

Availability of Psychiatrists and Other Medical Practitioners

Although psychiatrists are a critical piece of the workforce, the medical aspect of care for an individual in crisis is often provided by a broad array of appropriately licensed providers according to state by state practices. According to NASMHPD Research Institute's (NRI's) 2022 State Profiles report, *State Mental Health Agency Workforce Shortages*, 82% of reporting SMHAs use different types of providers for the delivery of behavioral health services.[19] In the same survey, the most common types of extenders utilized by SMHAs were certified registered nurse practitioners, advanced practice nurse practitioners, psychiatric nurse practitioners, physician assistants, and other non-psychiatrist physicians. In some states, some of these professionals must work under the supervision of or in a collaborative relationship with a psychiatrist or other type of physician. Adult and child and adolescent psychiatrists are among the most difficult provider types to attract and retain, and HRSA projected that the total number of practicing psychiatrists would decline between 2017 and 2030.[20] However, some studies are showing positive trends in recruiting child and adolescent psychiatry trainees.[21] In addition the National Resident Matching Program showed that in 2023 more first year residency positions were offered, with over half of the attributed growth due to increases in family medicine, internal medicine and psychiatry compared to 2022.[22] Either way, physician extenders and the incorporation of collaborative care models can supplement the limited supply of psychiatrists who work in community mental health and/or accept public insurance.

Growing and Strengthening the Behavioral Health Crisis Workforce

In 2021, a survey conducted by the National Council for Mental Wellbeing revealed that 97% of their membership organizations have experienced difficulties recruiting employees.[23] Public sector research also highlights the widening gap between the number of job openings and applicants in the general workforce, as the average number of applicants per job opening decreased from 56.1 in 2016 to 14.3 in 2022. The largest factors driving the increase in job openings include voluntary turnover, an inability to fill positions, and retirements.[24] This has left the remaining workforce to compensate for unfilled positions, often with negative outcomes for employees and organizations, including staff burnout, increased overtime, and limitations to the availability of services.[25] In behavioral health crisis care settings, this may result in slower responses from mobile crisis teams, and a decrease in capacity of stabilization supports. All of these factors may ultimately impact the quality and availability of services offered to individuals.[26]

Developing the behavioral health crisis response workforce entails a comprehensive personnel management strategy, from recruitment and selection, to retention, training, and ensuring employee well-being. According to NRI's *State Mental Health Agency Workforce Shortages* report, all 44 reporting SMHAs have at least one initiative to grow and strengthen the behavioral health crisis response workforce.[27,28] The most frequently reported initiative to improve workforce shortages was increasing funding for the workforce (61% of reporting SMHAs). Beyond financial incentives for recruitment, providers and provider organizations are engaging in several efforts to help shore up the gaps in workforce availability across the behavioral health system.

Recruitment and Early Career Development

Providers and provider organizations should invest in strategies to recruit top talent and establish early career pipelines so that future behavioral health professionals are eager to enter and stay in the workforce. In response to hiring challenges, SMHAs and provider organizations have enacted several strategies to improve the recruitment of the behavioral health workforce (see **Box 2**).

Box 2: Recruitment initiatives

Initiative	Additional information
Increasing salaries	Low pay and compensation have been cited as a leading cause of turnover among behavioral health professionals. In Massachusetts, inadequate compensation and benefits was cited as the top reason for behavioral health care staff leaving their organization.[a] According to the *State Mental Health Agency Workforce Shortages* report, 45% of reporting SMHAs are increasing salaries as a tactic to address workforce shortages.[b]
Offering recruitment bonuses or other financial incentives to attract behavioral health workers[c]	Recruitment bonuses provide a financial incentive to join the organization and allow employees to use additional funds to pay back student loans, relocate, or offset the increasing cost of living.
Offering scholarships, loan forgiveness, and loan repayment[d]	Many states and have initiated efforts related to financial incentives for workforce recruitment. There are federal loan repayment options as well. As a state example, Georgia's Department of Behavioral Health and Developmental Disabilities has begun offering loan forgiveness, paying for licensure fees, and providing no-cost continuing education credits as hiring incentives to grow and strengthen its behavioral health workforce. (For more information, see the case study "Georgia—Growing the Behavioral Health Crisis Workforce.")
Providing training with mental health providers or within a mental health program across a wide array of programs (e.g., psychiatry, crisis services, peer support, mental health first aid, trauma informed care, and evidence-based practices)[e]	Offering robust and informative training can be utilized as a recruitment tactic, especially since many new providers coming directly from academic settings may not feel fully equipped to handle the demands of crisis settings. Aspiring LCPC (Licensed Clinical Professional Counselor)/LCSWs look for supervised clinical hours. Providers offering those hours are at a competitive advantage over those who do not when recruiting these staff.

[a] **State Mental Health Agency Workforce Shortages.** ***NRI's 2022 State Profiles. Falls Church, VA, NRI, December 2022.***
nri-inc.org/media/hz2lygyh/workforce-shortages_final.pdf
[b] ***Ibid.***
[c] ***Ibid.***
[d] ***Ibid.***
[e] ***Ibid.***

Box 2: Continued

Initiative	Additional information
Utilizing technology to supplement the existing workforce and recruit behavioral health professionals into the workforce[f]	Through telehealth and contemporary practices, provider organizations have increased flexibility in employee scheduling, how the work is performed, and where employees need to live to perform services,[g] and developing additional efficiencies that may help prioritize time demands on the workforce to focus on other direct care duties. Due to expansions in telehealth policy, providers licensed to perform services in multiple states can now be hired across state lines, widening the geographic scope of hiring for human resources departments and hiring managers. This also allows hiring professionals to select top talent from a wider group of geographically dispersed applicants. In Oklahoma, the use of iPads that directly connect a user to a licensed clinician has resulted in increases in service utilization without requiring additional workforce.[h] In Nebraska, telehealth has been cited as the most effective strategy for navigating behavioral health workforce challenges.[i] Provider organizations should continue exploring technology to grow and strengthen the behavioral health crisis workforce. (See *Innovative Uses of Technology to Enhance Access to Services within the Crisis Continuum*)[j] Digital recruitment campaigns that include advertising positions on social media may attract younger candidates. Lastly, realistic job previews, videos, or testimonials from behavioral health professionals can be used as a tool to communicate the important aspects and benefits of the job before someone accepts or applies.
Connecting with behavioral health workforce centers for resources and evidence-based approaches to workforce development specific to behavioral health	HRSA manages eight major behavioral health workforce centers, housed at the Mullan Institute at George Washington University; University at Albany—State University of New York; University of California—San Francisco; University of Michigan; University of North Carolina—Chapel Hill, two programs at the University of Washington; and a technical assistance center through HRSA.[k] The goals of the centers are to grow and strengthen the capacity of the behavioral health workforce through workforce planning, development, and service delivery. To assist providers and provider organizations with workforce development, the centers have various resources including recent projects, publications, data, presentations, and training materials. These centers serve as a point of contact for technical assistance to improve the workforce.

[f] Ibid.

[g] New KFF/CNN Survey on Mental Health Finds Young Adults in Crisis. News release. KFF, October 6, 2022. www.kff.org/other/press-release/new-kff-cnn-survey-on-mental-health-finds-young-adults-in-crisis-more-than-a-third-say-their-mental-health-keeps-them-from-doing-normal-activities

[h] Bronson J, Washington, L: An Evaluation of the Grand Response Access Network on Demand Model (GRAND Model): Evidence of Effective Outcomes. Falls Church, VA, NRI, June 2022. nri-inc.org/media/qa2k0wdf/grand-model-evaluation_june2022_v2.pdf

[i] New KFF/CNN Survey on Mental Health Finds Young Adults in Crisis. News release. KFF, October 6, 2022. www.kff.org/other/press-release/new-kff-cnn-survey-on-mental-health-finds-young-adults-in-crisis-more-than-a-third-say-their-mental-health-keeps-them-from-doing-normal-activities

[j] Kazandjian M, Neylon K: Innovative Uses of Technology to Enhance Access to Services within the Crisis Continuum. Rockville, MD, Substance Abuse and Mental Health Services Administration, 2023

[k] Health Workforce Research Centers. Washington, DC, Fitzhugh Mullan Institute for Health Workforce Equity, 2023. www.gwhwi.org/hwrc.html

Opportunities to inspire younger professionals to pursue a behavioral health career track are also important to foster. Early career development refers to initiatives and programs that offer students connections, opportunities, and exposure to behavioral health care providers as career role models. To increase interest in behavioral health careers among high school and college students, providers and provider organizations have established or strengthened partnerships with local universities. Out of 44 reporting SMHAs, 36% are currently partnering with university-based services to recruit and train the future behavioral health workforce, including outreach to high school students, internships, and college funding to support students working to become certified peer recovery specialists.[29] In addition to improving the education-to-provider pipeline, partnerships between universities and provider organizations may allow minority students to learn about the benefits of working in behavioral health. The American Psychiatric Association Black Caucus, for example, developed a virtual recruiting event to help inspire diversity in psychiatry through a medical student recruitment effort.[30] SAMHSA's Historically Black Colleges and Universities Center of Excellence in Behavioral Health is another example of an exciting initiative aimed to recruit students into careers in behavioral health.[31] Observing professionals striving to improve the psychological and mental well-being of others can inspire young emerging professionals to take on this work and help improve the communities in which they live.

Realizing the Potential of the Peer Support Workforce

Peer support specialists are a type of behavioral health professional who have personal experience with mental health challenges, substance use issues, trauma, legal involvement, and/or houselessness who have special training to help others engage in the recovery process. Using their unique experience of being a service recipient, peers build rapport with individuals seeking services and offer invaluable insights to help individuals in care to navigate systems.[32] Some peers, especially those with justice-involved backgrounds, may face barriers in the hiring process.[33]

Several SMHAs have peer-specific recruitment initiatives in place, including using grant funding to recruit more peers, providing training for individuals who want to become peers, and financing certification for peers.[34] Other strategies for recruiting peers include targeted recruiting from peer provider training lists (a limited directory of certified peer support specialists) and using specific language such as "this position requires experience as a former or current user of mental health services" or "must have personal experience with recovery."[35]

One of the main benefits of hiring peers as part of the workforce is improvements in outcomes for individuals served, including improved quality of life, increased engagement with behavioral health services, decreased hospitalization and inpatient days, and reductions in the overall costs of services.[36,37] Other outcomes highlighting the effectiveness of peers include increased empowerment and hope, social functioning, and community engagement.[38,39,40] Peer recovery coaching has also been linked to greater housing stability and decreased criminal justice

involvement.[41,42] (For more information on peer support specialists see the 2024 Technical Assistance Brief no. 2, *Peers Across the Crisis Continuum*.)[43]

Building a Representative Workforce That Can Support All Populations

Providers and provider organizations should work to recruit and retain professionals and non-clinical professionals who share aspects of their identities such as language spoken, race, sexual orientation and gender identity, and/or ethnicity with the individuals they serve, as concordance with community demographics can improve community engagement and decrease health disparities. It is helpful to consider an individual's self-identification and multiple identities to recruit individuals with unique intersectionality. Additionally, providers of all backgrounds should be knowledgeable of the culture of those they treat and be offered training specific to awareness, skills, and humility surrounding the needs and contexts of cultures outside their own. According to NRI's *State Mental Health Agency Workforce Shortages* report, 66% of reporting SMHAs do not have cultural standards or expectations that staff have demonstrated capacity to serve diverse populations.[44] This demonstrates the need to attend to diversity in the workforce and training to best meet the needs of diverse populations.

Many federal and state behavioral health organizations have a goal to address the health needs of historically underserved populations. SAMHSA's 2020 *National Guidelines for Behavioral Health Crisis Care—A Best Practice Toolkit* states that crisis service organizations need to be prepared to care for anyone who needs behavioral health services.[45] Growing a behavioral health crisis workforce that considers the needs of individuals outside of dominant majority populations is especially important as the demographics of the US change and equitable access to care is increasingly prioritized. **Box 3** includes an overview of some current initiatives used by provider organizations to recruit a more representative workforce.

Box 3. Diversity, equity, and inclusion recruitment strategies

Selected current initiatives by SMHAs and other organizations to guide recruitment:

- **Collaboration with the Office of Diversity, Equity, and Inclusion (ODEI) to develop a DEI strategic plan** to improve the concordance between the diversity in the workforce and the demographics of the communities served
- **Seeking out diverse candidates to fill open job positions, implementing inclusive recruitment practices, investing in trainee success, and building the education-to-provider pipeline:**[a] SAMHSA's Minority Fellowship Program is designed to reduce health disparities and improve behavioral health outcomes within minoritized populations by supporting students who are pursuing behavioral health degrees or specialty training. The program aims to increase the number of behavioral health providers serving minorities. The University of California (UC) Postbaccalaureate Consortium (health.ucdavis.edu/postbacc-consortium) aims to increase the number of medical students from disadvantaged backgrounds accepted into UC schools by assisting students with Medical College Admission Test (MCAT) preparation, applications, and one-year academic enhancement programs. To increase the likelihood of hiring individuals from racially and ethnically diverse backgrounds, provider organizations should use targeted recruitment methods such as job fairs and markets at Historically Black Colleges and Universities or Colleges for Deaf/Hard Hearing students. Recruitment initiatives should also include provisions for hiring from rural and more remote populations, which face unique workforce challenges that local candidates may be more familiar with. Another option for national recruitment of candidates is to disseminate job openings through national minority associations such as the Society for Advancement of Chicanos/Hispanics and Native Americans in Science, National Association of Hispanic Nurses, National Black Nurses Association, American Association of People with Disabilities, National Hispanic Medical Association, Out to Innovate (formerly known as the National Organization of Gay and Lesbian Scientists and Technical Professionals), Health Professionals Advancing LGBTQ Equality, OutCare Health, the Association of Lesbian, Gay, Bisexual, Transgender Addiction Professionals and their Allies, and through minority professional caucuses and committees such as those in the American Psychiatric Association. The American Psychiatric Association has also taken positions for the need to support diversity in the workforce, which can be helpful in advocating for better outcomes in this arena.[b]

[a]Gonzaga AMR, Appiah-Pippim J, Onumah CM, et al: A framework for inclusive graduate medical education recruitment strategies: Meeting the ACGME standard for a diverse and inclusive workforce. Acad Med 2020; 95(5):710–716

[b]Position Statement on Diversity and Inclusion in the Physician Workforce. Washington, DC, American Pscyhiatric Association, 2019. https://www.psychiatry.org/File%20Library/About-APA/Organization-Documents-Policies/Policies/Position-Diversity-and-Inclusion-in-the-Physician-Workforce.pdf

Currently, there is an underrepresentation of gender, cultural, and ethnic diversity in health care, especially in leadership positions.[46] Only 6% of psychologists, 6% of advanced practice psychiatric nurses, and 13% of social workers come from diverse backgrounds.[47] A representative behavioral health workforce includes professionals and paraprofessionals that encompass the vast range of personal identities found within US communities. In *Crisis*

Services: Addressing Unique Needs of Diverse Populations, Pinals and Edwards highlight several populations that may not be well represented within the crisis workforce, including special age cohorts, racial and ethnically diverse populations, immigrant populations, linguistically diverse individuals, sexual orientation and gender identity minorities, persons with neurodevelopmental disorders, and legal-involved individuals.[48] In the sections that follow, the needs of the cohorts described by Pinals and Edwards are further discussed in the context of relevant workforce issues.

Age Diversity

Both youth and older adults are special populations that need to be considered when providing crisis services and building a representative workforce. In 2021, a study of youth mental health during the COVID-19 pandemic by the Centers for Disease Control and Prevention highlighted that 44% of high school students felt persistently sad or hopeless within the past year and 37% reported poor mental health.[49] When considering the mental health of older adults, recent data suggests that approximately 20% of older adults (ages 55 and older) have experienced or are experiencing some type of mental health concern.[50] Additionally, according to data from the CDC, there were significant increases in deaths by suicide among older adults from 2021 to 2022.[51] With our rapidly aging population, researchers anticipate increases in the number of older adults needing treatment for behavioral health concerns. These data showcase the need for a crisis workforce that is equipped to handle the mental health needs of both youth and older adults. Targeted recruiting tactics may assist in hiring more youth and older adult peer support specialists. To create a more specialized crisis response workforce, providers and provider organizations should consider working and/or consulting with clinicians who have special training in child or older adult mental health. Enhancing training opportunities for the general workforce to improve their capacity to support people across the lifespan will also be important.

Racial and Ethnic Diversity

Racially and ethnically minoritized individuals are less likely to seek behavioral health services, often underutilizing mental health services in the United States.[52,53] A behavioral health workforce that is insufficient in numbers and is not racially and ethnically diverse is a barrier to care. Racial and ethnic concordance increases the likelihood that members of specific BIPOC groups will seek preventative care for health concerns. Additionally, racial and ethnic concordance increases the likelihood members of minoritized groups receiving services will continue to visit their providers for ongoing health issues.[54] Increasing the prevalence of racial and ethnically diverse professionals within the behavioral health crisis workforce has great potential to improve health outcomes.

Immigrant Populations

In 2018, approximately 44.8 million foreign-born individuals were living in the United States, reflecting about 13.7% of the total US population.[55] Recent global events have increased the prevalence of traumatic experiences among immigrants and refugees.[56,57] Since crisis services should be designed for anyone seeking services, crisis providers should be prepared to treat

immigrants, including refugees and asylees. Additionally, SAMHSA has highlighted that the health insurance marketplace has made it easier for refugees and other qualified noncitizens (i.e., asylees, victims of trafficking, American Indians born in Canada, and battered noncitizens) to get insurance through the Affordable Care Act.[58] Although 18% (2.6 million) of the 14.7 million workers employed in the health care field are foreign-born,[59] the extent to which these individuals work in crisis response settings is unknown. Providers and provider organizations should strive to make the crisis response workforce representative of the populations served, including naturalized citizens, legal permanent residents, and temporary workers.[60]

Linguistic Diversity

Services along the crisis continuum should be accessible to every individual. The behavioral health workforce must be able to provide services for linguistically diverse populations. Pinals and Edwards highlight that certain states and jurisdictions have enacted policies mandating the use of translation services for threshold languages, including but not limited to Spanish, Russian, and Vietnamese.[61] Provider organization leaders should utilize various data sources including individual-level, facility-level, and census data to better understand the demographics of individuals served by the organization. Recruiting and retaining crisis staff that is diverse in linguistic capabilities creates a more equitable workforce and may improve the experience for individuals in care moving throughout the crisis continuum. For example, research suggests that native Spanish speakers receiving services may have a strong preference for bilingual providers.[62] The benefits of linguistic concordance between provider and individual receiving services include improved accuracy of communication, sense of trust, and privacy.[63] Language and insurance barriers have been cited as structural barriers to mental health services for immigrants from Asia, Latin America, and Africa.[64] Therefore, improving the linguistic concordance between providers and individuals served may improve utilization and ultimately have a positive impact on behavioral health outcomes for this population. At the very least, access to proper interpreter services and knowledge of how to work with interpreters should be available and integrated into staff training.

Sexual Orientation and Gender Identity Minorities

Sexual orientation and gender identity minorities refer to groups of individuals who's sexual and/or gender identity differ from majority groups. Examples include LGBTQI+ (lesbian, gay, bisexual, transgender, queer, and questioning, intersex, asexual, and other sexual orientation/gender identity minority) populations. Discrimination from health care providers and feelings of being misunderstood continue to serve as a barrier for LGBTQI+ people seeking behavioral health services.[65] When compared to their peers, lesbian, gay and bisexual youth are more than four times as likely to attempt suicide.[66] According to 2021 and 2022 data from SAMHSA, lesbian, gay and bisexual adults are more likely to use substances, experience mental health issues including major depressive episodes and suicidal ideation compared to their peers.[67] Additionally, in 2016, 48% of transgender adults considered suicide, compared to 4% of the overall United States population.[68] In a study assessing providers' competency in treating

LGBT individuals, only 51% of care physicians felt that they were competent in providing care, and a mere 29% stated that their previous medical training prepared them to provide competent care to LGBT+ individuals.[69] However, 98% of providers in the study acknowledged that providers should be knowledgeable about the unique issues experienced by LGBT individuals in care.[70] Provider organizations should therefore specifically recruit LGBTQI+ providers and make ongoing cultural competency training covering the unique needs of LGBTQI+ populations available to all staff.

Neurodevelopmental Disorders

Individuals with intellectual and developmental disability disorders are three times more likely to have a co-occurring behavioral health condition compared to the general population.[71] Kalb et al. found that approximately 40% of individuals with an intellectual disability may also have a mental health condition. Recent federal funding from the Administration for Community Living has been allocated to the National Association of Directors of Developmental Disability Services to work in in collaboration with partners such as the National Association for the Dually Diagnosed and NASMHPD to develop a technical assistance resource center to enhance technical knowledge for working with these populations. Several types of providers—including neuropsychologists, behavioral pediatricians, child and adolescent psychiatrists, and behavior analysts—have training in behavioral health, developmental disabilities, and co-occurring behavioral health and neurodevelopmental disorders. Some of these providers can assess, diagnose, and treat this unique population in various settings across the crisis continuum. Several SMHAs have established partnerships with colleges and universities to form an education-to-provider pipeline with schools that offer programs in neuropsychology, which may increase the representation of these providers in the crisis workforce.[72]

Veterans and Military Families

Veterans continue to have one of the highest rates of death by suicide. When compared to nonveterans, veterans are 1.5 times more likely to die by suicide.[73] Additionally, female veterans are almost twice as likely to die by suicide when compared to nonveteran females.[74] Reasons for these high rates include high levels of exposure to stress and trauma, easy access to and familiarity with firearms, loneliness, and trouble reintegrating into civilian settings.[75] Although the Veterans Health Administration is the largest health care organization in the United States, most veterans receive services outside of the agency. This means that community providers need to be prepared to treat veterans, who may have complex trauma histories that can differ from nonveterans, such as for those exposed to combat or military conflict zones. Military family members also often experience high rates of trauma and mental health problems.[76] The behavioral health crisis workforce should include veterans and workers who are familiar with the unique health and psychosocial needs of veterans, including persons with histories of military service, service members, and members of their families. As veterans face higher rates of unemployment than nonveterans, careers in crisis services may provide an opportunity for

veteran peers to use their lived experience to improve the mental health and well-being of both veterans and nonveterans.

Retention, Training, and Support

An organization's retention capability refers to its ability to keep its current employees to help ensure the sustainability of the organization. In community mental health settings, turnover rates can exceed 50% among all job positions and up to 25% among those in leadership positions.[77] In addition to increasing the work burden among the remaining staff, turnover is costly to organizations. Before quitting, employees may show signs of demotivation in the workplace, including the intention to quit, absenteeism (e.g., calling in sick when not sick), and counterproductive workplace behaviors (e.g., engaging in harmful gossip about coworkers/leadership/the organization, production deviance, or holding back productivity).[78]

Funding has been identified as a major component of organizations struggling to maintain their staff and ensure organizational sustainability.[79,80] Innovative funding and payment mechanisms, such as a prospective payment system within the CCBHC model, may ameliorate workforce shortages since these models have more liberty in the allocation of funding outside of direct service delivery (e.g., using funding to offer higher salaries to employees).[81,82] **Box 4** identifies select strategies to retain the behavioral health workforce.

Box 4: Employee retention initiatives

Retention initiative	Additional information
Increasing Medicaid rates for providers, especially for provider types with traditionally low reimbursement rates	Gaps in provider pay continue to serve as barriers for behavioral health providers to enroll in Medicaid. As of March 2023, approximately 93.9 million individuals were enrolled in the Medicaid Children's Health Insurance Program.[a] Among 44 reporting SMHAs, 50% are increasing Medicaid reimbursement rates.[b]
Reducing administrative burden on providers[c]	Currently, administrative duties such as completing lengthy forms and documents, electronic health records systems with excessive documentation requirements, and navigating long credentialing processes are examples of administrative burdens with negative employee- and organizational level outcomes.[d] Employee burnout and medical errors are commonly cited negative outcomes related to administrative burden.[e,f]
Increasing the number of mentoring relationships	On-the-job mentor–mentee relationships provide a strong dyadic bond between seasoned and new professionals in the workplace. These relationships allow new professionals to inherit individual and organizational knowledge that is not always available in traditional training programs. From a selection and hiring standpoint, increasing the availability of mentorship may allow organizations to reduce the minimum application requirements since employees are learning more directly on the job. Reducing minimum application requirements has been highlighted as an effective strategy for attracting and hiring more candidates.[g]
Improving organizational culture to foster a positive environment, prioritizing the needs of employees as well as individuals served	Conducting a robust needs assessment can provide insights into the top areas of organizational culture that employees feel the organization needs to improve. A poor organizational culture in health care can result in poor work–life balance, decreased job satisfaction, and increases in errors.[h, i, j] Organizations with a constructive organizational culture have been shown to have better employee retention and adoption of evidence-based practices.[k] Additionally, organizational culture has direct links to service quality level.[l]

[a]March 2023 Medicaid & CHIP Enrollment Data Highlights. Medicaid, April 2023. www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

[b]State Mental Health Agency Workforce Shortages. NRI's 2022 State Profiles. Falls Church, VA, NRI, December 2022. nri-inc.org/media/hz2lygyh/workforce-shortages_final.pdf

[c]Saunders H, Guth M, Eckart G: A Look at Strategies to Address Behavioral Health Workforce Shortages: Findings from a Survey of State Medicaid Programs. KFF, January 10, 2023. www.kff.org/medicaid/issue-brief/a-look-at-strategies-to-address-behavioral-health-workforce-shortages-findings-from-a-survey-of-state-medicaid-programs

[d]Behavioral Health Workforce is a National Crisis: Immediate Policy Actions for States. Issue brief. Lansing, MI, Health Management Associates, October 2021. www.healthmanagement.com/wp-content/uploads/HMA-NCMW-Issue-Brief-10-27-21.pdf

[e]Vanderhook S, Abraham J: Unintended consequences of EHR systems: A narrative review. Proc Int Symp Hum Factors Ergon Healthc 2017; 6(1), 218–225

[f]Yan Q, Jiang Z, Harbin Z, et al: Exploring the relationship between electronic health records and provider burnout: A systematic review. J Am Med Inform Assoc 2021; 28(5):1009–1021

[g]The Quiet Crisis in the Public Sector. NeoGov, 2022. http://www.neogov.com/hubfs/Content/NEOGOV-2022-Quiet-Crisis.pdf. Accessed July 16, 2023

[h]Garcia CDL, Abreu LCD, Ramos JLS, et al: Influence of burnout on patient safety: Systematic review and meta-analysis. Medicina (Kaunas) 2019; 55(9):553

[i]Levine KJ, Carmody M, Silk KJ: The influence of organizational culture, climate, and commitment on speaking up about medical errors. 2020., J Nurs Manag 2020; 28(1):130–138

[j]Stefanovska-Petkovska M, Petrovska I, Bojadziev M, et al: The effects of organizational culture and dimensions on job satisfaction and work–life balance. Montenegrin Journal of Economics 2019; 15(1):99–112.

[k]Aarons GA, Sawitzky AC: Organizational culture and climate and mental health provider attitudes toward evidence-based practice. Psychol Serv 2006; 3(1):61–72

[l]Gantsho Y, Sukdeo N: Impact of organizational culture on service quality; in Proceedings of the International Conference on Industrial Engineering and Operations Management. Southfield, MI, IEOM Society International, 2018

Training and development are critical avenues for improving the knowledge, skills, and abilities of the behavioral health crisis workforce. **Box 5** details selected training initiatives to support the workforce. Research suggests that well-trained employees with supportive leadership are less likely to leave the workforce.[83] The Annapolis Framework, developed by The Annapolis Coalition on the Behavioral Health Workforce to guide hospitals and health systems to modify

Box 5: Workforce training initiatives

Recent initiatives by SMHAs and provider organizations related to training and supporting the training of the behavioral health crisis workforce	
Providing training across a wide array of programs including psychiatry, crisis services, peer support, mental health first aid, trauma informed care, and evidence-based practices[a]	Training opportunities need to exist for the various types of behavioral health professionals and peer support specialists working across all levels of the crisis continuum
Supporting licensing/certification of behavioral health workers, including providing training that supports licensure and licensure supervision[b]	Providing funding for the licensure and certification process removes financial barriers for individuals seeking additional training and professional development.
Standardizing the employee onboarding process to improve retention and productivity	Setting employees up for success with proper onboarding is key. The onboarding period is a sensitive and vulnerable time for new employees. This may be especially true for new graduates entering the workforce for the first time. Some studies have shown that a positive employee onboarding experience can improve employee retention by 50% to 82%.[c] Employee onboarding should not only focus on technical skills and abilities but also encompass the organizational and social aspects of the job. Standardizing the employee onboarding experience can also increase new employee productivity by 62%.[d] Training and support can be used as tools for employee retention by giving the employee confidence and knowledge. Overall, employees who feel more nurtured and connected upfront are more likely to stay within the organization.[e]

[a]State Mental Health Agency Workforce Shortages. NRI's 2022 State Profiles. Falls Church, VA, NRI, December 2022. nri-inc.org/media/hz2lygyh/workforce-shortages_final.pdf
[b]Ibid.
[c]Ginger N, Dunlap, B: Effective Onboarding to Improve Employee Retention. Berry Dunn, September 7, 2022. www.berrydunn.com/news-detail/effective-onboarding-to-improve-employee-retention
[d]Carucci R: To Retain New Hires, Spend More Time Onboarding Them. Harvard Business Review, December 3, 2018. hbr.org/2018/12/to-retain-new-hires-spend-more-time-onboarding-them
[e]Vance, RJ: Employee Engagement and Commitment: A Guide to Understanding, Measuring, and Increasing Engagement in Your Organization. Alexandria, VA, Society for Human Resources Management, 2006.

their approaches to addressing their behavioral health workforce needs, suggests that increasing the relevance, effectiveness, and accessibility of training directly strengthens the workforce.[84] In crisis care settings, topics of workforce trainings may include trauma-informed care to better relate to individuals from diverse backgrounds with various traumatic experiences, conflict de-escalation to prevent escalation into violence or worsening mental health conditions, and motivational interviewing to make individuals in care feel more heard and better understood. In higher education institutions, crisis-specific programs and degrees have been developed that may better train individuals to work across settings. For example, Wayland Baptist University (catalog.wbu.edu) offers a master's degree in human services with a crisis response specialization, and Walden University (www.waldenu.edu) has established a trauma and crisis counseling specialization program that teaches students how to address health-related school and mental health crises including intervention with suicidal individuals.

Championing Employee Wellness

Workplace well-being has been seen as a key priority in many ways, as recognized by the U.S. Surgeon General, who released a framework for mental well-being in the workplace.[85] The COVID-19 pandemic has led organizational leadership to increasingly prioritize the health and well-being of employees. Studies have estimated annual costs of $2.6 billion to $6.3 billion associated with turnover and lost clinical hours related to employee burnout.[86,87] Beyond increasing retention in the workplace, employee wellness remains important for improving the mental health of behavioral health workers while minimizing negative outcomes. Individual-level negative outcomes associated with poor employee wellness within behavioral health include secondary trauma and stress from negative encounters with people in care and emotional laborious work, intention to quit, and most concerningly, suicidal thoughts.[88] At the organizational level, poor employee wellness has been linked to turnover and poor brand marketing since burned-out employees are less likely to recommend their organization as a place to work.

Because of the structural challenges associated with hiring and retaining staff, leadership should focus on creating and fostering positive work environments. Strategies to improve employee wellness include implementing flexible schedules, promoting open communication with management about employee well-being, and investing in anti-burnout and resiliency programs.[89] Increasing the flexibility of work schedules allows employees to have more freedom in managing their work–life balance and, ultimately, their stress levels, throughout their employment. Positive organizational cultures where employees feel comfortable discussing workplace stressors improve the dyadic relationship between employees and supervisors while also alerting management to issues within the workplace. Efforts to decrease employee burnout should be funded and sustained within crisis settings.[90] **Box 6** provides an overview of anti-burnout strategies recommended by SAMHSA in the comprehensive workbook *Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies*.[91]

Other factors to improve employee wellness in the workplace are described in **Box 7**.

Box 6: Employee anti-burnout strategies

To address burnout among the behavioral health workforce through organizational strategies, SAMHSA has suggested the following tactics in its comprehensive workbook:

- Build a planning and implementation taskforce focused on improving employee well-being.
- Conduct a needs assessment to determine the drivers of burnout and better understand the contextual factors further exacerbating the burnout experience among employees.
- Identify resources and strategies such as an implementation framework or model that is relevant to the organization and may be adopted by employees. A framework that is well aligned with the organization also helps to ensure that leadership feels supported in assisting employees experiencing burnout.

Source: Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies. SAMHSA Publication no. PEP22-06-02-005. Rockville, MD, National Mental Health and Substance Use Policy Laboratory, SAMHSA, 2022.
store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/pep22-06-02-005.pdf

Box 7: Employee wellness initiatives

Initiative	Additional information
Ensuring a good person–environment fit between new job applicants and the crisis setting	Working in a crisis setting may not be an optimal environment for everyone, including some behavioral health professionals, but hiring the candidate who is the best fit can improve employee well-being. The candidate's fit should be analyzed at various levels—between the person and the job, team, and organization—since misbalance at any of these levels can negatively impact employees' wellness.
Appropriately distributing workloads among staff	Workloads in health care settings can be very polarizing, with administrative and clinical workers taking on a large portion of the work. Creating a team-based approach through professional development, wherein employees at various levels are cross-trained to distribute the burden of heavy workloads more equally, can reduce burnout levels among high-stress job positions. Providing extensive behavioral health training and empowering bachelor's-level staff and peers within mobile crisis teams, may reduce the burden on clinical staff at higher tiers of the organization.
Implementing employee assistance programs (EAPs) that include components for employee mental health and well-being	EAPs can include free confidential counseling for employees, resiliency training, and mental health applications focused on improving mental health and well-being in the workplace.

Box 7: Continued

Initiative	Additional information
Addressing the risk factors for poor employee wellness	SAMHSA has identified high psychological demands, low decision latitude, low social support (including from leadership), and effort–reward imbalance as psychosocial risk factors for poor employee wellness.[a] Other risk factors include poor working environments (i.e., discrimination and inequality, excessive workloads, low job control, and job insecurity), a poor organizational culture that enables negative behaviors, long and inflexible hours, job insecurity, poor investment in career development, and underused skills. In crisis settings, special considerations should be made to ensure that clinicians are utilizing their clinical skills and the organization is not overburdening these highly trained individuals for administrative and operational work.
Using behavioral health mobile applications to reduce stress and improve coping mechanisms among the crisis response workforce[b]	In recent years, compassion fatigue (a combination of burnout and secondary traumatic stress) has led to high levels of exhaustion among providers and turnover within organizations.[c,d] An example of how an app can help alleviate burnout among providers is the Provider Resilience App, which SAMHSA promotes as a way for health care professionals to access "tools to guard against burnout and compassion fatigue." The app allows users to take self-assessments, access support, and resources to help providers manage their mood and mental health.
Reduce compassion fatigue among employees[e]	Behavioral health professionals are at high risk of experiencing compassion fatigue, or reduced capacity for empathy toward those in need due to the decreased capacity to manage the emotional burden created by trauma. To reduce compassion fatigue, organizational leadership should ensure that employees are a good fit for their job positions and the emotional demands of the job, provide self-care options including EAPs that offer free counseling for employees and vacation time to recover from the emotional demands of the job, and promote self-care in the workplace. Examples of workplace self-care could include time set aside for meditation, mindful movement including yoga or tai chi, and breaks that offer time for breath work.

[a] Addressing Burnout in the Behavioral Health Workforce Through Organizational Strategies. SAMHSA Publication no. PEP22-06-02-005. Rockville, MD, National Mental Health and Substance Use Policy Laboratory, SAMHSA, 2022. https://store.samhsa.gov/sites/default/files/pep22-06-02-005.pdf

[b] Washington L, Neylon K: Resources to Help: Select Behavioral Health And Wellness Mobile Applications. Lansing, MI, Michigan Health Endowment Fund; and Falls Church, VA, NRI, May 2022. www.nri-inc.org/media/s54kcijm/2022bh_appsreport_20220616.pdf

[c] Sheppard K: Compassion fatigue among registered nurses: Connecting theory and research. Appl Nurs Res 2015; 28(1):57–59

[d] Labrague LJ, de Los Santos JAA: Resilience as a mediator between compassion fatigue, nurses' work outcomes, and quality of care during the COVID-19 pandemic. Appl Nurs Res 2021; 61:151476

[e] Tips for Healthcare Professionals: Coping With Stress And Compassion Fatigue, Rockville, MD, SAMHSA. https://store.samhsa.gov/sites/default/files/PEP20-01-01-016_508.pdf. Accessed April 12, 2023

Case Studies

To spotlight state-specific strategies focused on growing and strengthening the behavioral health crisis workforce, NRI selected and interviewed seven SMHAs: Arizona, Delaware, Georgia, Ohio, Oklahoma, South Carolina, and Utah. Each of these SMHAs has a unique program or organizational structure that other states might consider implementing and learning from regarding addressing workforce challenges. See **Box 8** for a highlight of the workforce programs and initiatives among the selected case studies.

Arizona—Utilizing Academic Partnerships and Training to Enhance the Crisis Workforce

Approximately 1 million adults in Arizona have a mental health condition, and nearly 2.9 million Arizonians live in a community with a shortage of mental health professionals.[92] An interview with the Arizona Health Care Cost Containment System (AHCCCS) leadership revealed that nurses were the hardest to retain in crisis settings during the COVID-19 pandemic because hospital systems could offer higher pay and compensation. Additionally, high rates of burnout across various job types exacerbated existing workforce shortages in crisis service settings.

The AHCCCS has engaged in various efforts to strengthen the education-to-practice pipeline and increase competencies among the crisis workforce. Some efforts are centered around partnerships with community college systems to provide tuition assistance for potential employees and existing providers. A portion of ARPA funds has been dedicated to expanding initial and ongoing in-service training programs for all behavioral health personnel. These training programs are being developed in collaboration with faculty and staff from Arizona's 10 community college districts and providers of behavioral health services. One result of this training program development will be the creation of a training curriculum

Box 8: Common themes among the case studies

- Providing crisis-specific training to better prepare employees to work in crisis settings
- Increasing salaries to improve the recruitment and retention of the crisis response workforce
- Improving the education-to-provider pipeline through partnerships with academic partners such as local community colleges and universities
- Improving the organizational and team culture surrounding employee wellness, diversity, and cultural competence
- Utilizing American Rescue Plan Act (ARPA) funds to invest in the training and development of the crisis response workforce
- Using learning management systems to track training and development
- Highlighting the benefits of working within a government system, including a competitive retirement benefit, where available

focused on practical knowledge and skills to prepare employees to work in crisis settings. AHCCCS leaders have realized that providing training to the crisis workforce is important because employees' feelings of unpreparedness are often drivers for burnout and turnover. Arizona currently uses a single learning management system to disseminate training and track professional development and goal achievement among all behavioral health personnel including crisis staff. Beyond the use of ARPA funds to expand the reach and substance of job-specific training programs, the AHCCCS SMHA is creating a comprehensive workforce database and decision support system. The hope is that the data will allow AHCCCS leadership to make data-driven decisions to improve recruitment and retention.

Delaware—Benefits and Barriers of an SMHA-Operated Crisis Continuum

Delaware's Division of Substance Abuse and Mental Health (DSAMH) provides adult crisis services in the state's three counties. Currently, the DSAMH operates two crisis call centers that cover the northern and southern parts of the state. Both call centers house mobile response units, wherein mobile crisis teams are deployed from the call center. Unlike most SMHAs, which rely on contractors to provide behavioral health services, Delaware's crisis workforce is employed by the state. When considering crisis workforce needs since the onset of the COVID-19 pandemic, one DSAMH leader said that the division "has been struggling to maintain a workforce," though it is easier to attract out-of-state talent to the more urban and populated northern region.

Having crisis staff employed by the DSAMH creates several benefits and barriers to employee recruitment and retention. The major benefits of a state-operated crisis continuum include the ability to offer pension and retirement benefits superior to the private sector, less reliance on private providers in the community, and a greater influence on the organizational culture surrounding the behavioral health workforce. Public retirement plans generally include a pension, in which the employer assumes the fund investment risk rather than the employee. Since all crisis staff in Delaware are employees of the state, the DSAMH can offer competitive retirement benefits despite potentially lower salaries. From a leadership standpoint, a state-operated system provides a clear framework for decision-making, conflict resolution, and team building across the organization. An organizational chart that only includes state employees may provide greater clarity in reporting relationships and job roles. Even in states where a state employee program is not feasible, some of the advantages (such as clear organizational charts and improved benefit packages) may be feasible strategies to help the workforce.

Challenges with a state-operated system include slower job posting and approval processes, lower and less competitive wages than those in the private sector, and difficulties hiring people to work nontraditional work hours (e.g., nights, weekends, and holidays). Increasing salaries has been useful for retaining employees in Delaware, but not necessarily recruiting new employees from a competitive job market. Additionally, crisis leadership stated that the SMHA has

difficulties staffing positions with nontraditional working hours that require the employee to work nights, weekends, and some holidays. This is a salient challenge in the crisis services space, which operates 24/7.

Delaware's DSAMH is in the process of reclassifying salaries, offering overtime compensation to cross-divisional staff seeking extra hours, and providing free trainings to state employees. Salary reclassification involves assigning higher pay grades to existing job positions to hopefully build a more qualified and equitably compensated crisis workforce. Employees working in other divisions can work additional overtime hours in crisis settings for extra compensation (i.e., time and a half). Lastly, the SMHA provides regular and ongoing training, such as certified drug and alcohol counselor (CADC) classes, for providers. The CADC training is free to state employees and helps the crisis workforce to feel more comfortable working with individuals with substance use needs.

Georgia—Growing the Behavioral Health Crisis Workforce

An estimated 1.4 million people in Georgia are living with a mental health condition, and 4.9 million Georgians live in an area with a shortage of mental health professionals.[93] As Georgia's Department of Behavioral Health and Developmental Disabilities (DBHDD) is responsible for services for individuals with mental health concerns, substance use challenges, and intellectual and developmental disabilities, state workforce shortages greatly impact the accessibility of treatment for a variety of mental and behavioral health conditions. The DBHDD outsources its community-based behavioral health workforce through contracts with local providers and provider organizations, meaning that the crisis system staff work for private provider agencies and are not state employees. The DBHDD works closely with providers, or vendors, to design services and foster a culture at a systems level that accommodates the needs of individuals served and the provider workforce.

When interviewed about shortages among crisis job positions, DBHDD leadership stated that "it is especially difficult to find those disciplines who are experienced in providing behavioral health crisis care and are willing to work in this area." Additionally, Georgia's DBHDD leadership stated that it is difficult to both recruit and retain qualified employees to work across the crisis continuum. These challenges are exacerbated by ongoing efforts to increase access to crisis health care, because the "current capacity is manageable, but projections for growth outstrip the current funding and behavioral health workforce capacity."

As a result of behavioral health workforce shortages, Georgia utilizes credentialed and noncredentialled providers and paraprofessionals (i.e., highly trained bachelor's-level staff and certified peer specialists) on crisis teams. The DBHDD has enacted several strategies to enhance and better leverage the existing crisis workforce. One strategy is offering recruitment and retention bonuses. Examples of retention bonuses include offering loan forgiveness, paying licensure fees, and providing no-cost continuing education credits. In 2022, a loan forgiveness

law was enacted that forgives up to $10,000 per year. In crisis call centers, leadership relies heavily on a bachelor's-level workforce that is trained in de-escalation and crisis prevention. Additionally, the DBHDD works closely with vendors to ensure their staff is competent, feels supported at the state level, and is empowered to change culture when needed. The DBHDD places high value on employee voice, meeting quarterly with their community partners, including peers and representatives of racial and ethnic minorities, members of the LGBTQI+ community, veterans, and the deaf and hard of hearing community. The state Office of Deaf/Hard of Hearing Services also works with the DBHDD and their community groups to help develop best practices to work with populations with hearing challenges. Lastly, the DBHDD leadership stated that compensation and organizational culture have been the drivers of successful recruitment and retention.

Ohio—Supporting Recruitment, Retention, and Contemporary Practice

An estimated 1.9 million adults in Ohio have a mental health condition, and approximately 2.4 million Ohioans live in a community with mental health workforce shortages.[94] As Ohio's Department of Mental Health and Addiction Services (DMHAS) does not directly hire crisis staff, leadership must work closely with contracted local mental health agencies to ensure that crisis hiring and staffing needs are adequately met.

To address overall workforce shortages, the DMHAS is dedicating $85 million to behavioral health workforce initiatives, including pipeline recruitment through partnerships with colleges and universities, incentivizing retention, and supporting contemporary practice utilizing evidence-based and/or skill-based instruction and training. The DMHAS collaborates with colleges and universities to enhance internships and scholarship opportunities for college students working on behavioral health degrees. Additionally, stipends are available for early career practitioners to offset educational expenses. Other funding is allocated to cover costs associated with obtaining licensure and certifications, such as exam-related fees.

To increase retention, the DMHAS has implemented bonuses for students and employees who commit to working at the state's community mental health and substance use disorder centers. These bonuses consist of an initial $2,000 signing bonus and payments of $1,500 for each of their first two years of employment, up to $5,000.

Within Ohio, contemporary practice has been instrumental in increasing employees' independence and competence. As of January 2023, the DMHAS has provided training to 16,000 professional staff on topics related to crisis centers, call centers, and mobile crisis response.

Finally, the DMHAS has also established a technical assistance center to help students find federal and state funding opportunities and to work with local agencies on general workforce development issues such as retention, recruitment, and continuing education opportunities.

Overall, these opportunities play a critical role in allowing students to gain behavioral health experience, especially in nontraditional work environments such as crisis service settings.

Oklahoma—Leveraging the CCBHC Framework to Enhance the Crisis Workforce

The CCBHC model is unique in that it utilizes a prospective payment system that allows for payment based on estimates of true costs rather than fee-for-service payments based on quantity of services provided.[95] Oklahoma is an example of a state that has adopted the CCBHC model as an alternative to the traditional Community Mental Health Center model of service delivery. This change in funding mechanism has allowed CCBHCs in Oklahoma to offer higher employee salaries, which in turn makes the CCBHCs more competitive in the health care market. As low wages have been cited as a nationwide issue driving health care employees to leave their organizations or the field entirely, CCBHCs offer a useful framework for improving employee recruitment and retention through increased pay and compensation.

CCBHCs require that crisis services are made available 24/7, forcing a change in traditional behavioral health care staffing models to accommodate the new boundless crisis services delivery schedule. In NRI's 2022 State Profiles, *State Mental Health Agency Workforce Shortages*, Oklahoma's Department of Mental Health and Substance Abuse Services (DMHSAS) reported workforce shortages among psychiatrists, nurses, licensed behavioral health counselors, peer specialists, and mental health aids and technicians across their crisis service continuum. Specific to mobile crisis teams, Oklahoma's CCBHCs have reexamined the composition of teams to better accommodate the needs of individuals receiving services. In addition to existing licensed clinicians, case managers or peer recovery support specialists were added to mobile crisis teams. Teams that do not include a licensed clinician can use a DMHSAS-sponsored iPad to connect directly to a licensed clinician for crisis support, consultation, and potential triage.

According to DMHSAS leaders, CCBHCs foster a team-based care model that allows them to rely on staff and clinicians of varying levels and types, especially peers and wellness coaches. Because licensed clinicians are often the hardest staff to hire, a team-based approach decreases the burden on clinicians by training and empowering employees to thrive in various positions across the crisis continuum. The DMHSAS offers free online courses, including training specifically for mobile crisis staff, and has statewide partnerships with colleges and universities to provide internship and licensure supervision opportunities. Local partnerships play a critical role in the education-to-workforce pipeline by ensuring that trainees are representative of the communities that they serve or will serve.

South Carolina—Benefits and Barriers of an SMHA-Operated Crisis Continuum

An estimated 706,000 adults in South Carolina are living with a mental health condition, and 2.3 million South Carolinians live in an area with a shortage of mental health professionals. In 2022, South Carolina's Department of Mental Health (DMH) reported workforce shortages of nurses, social workers, licensed behavioral health counselors, and mental health aides and technicians across their crisis service continuum. South Carolina's crisis workforce are all state employees. Having crisis staff employed by the DMH creates several benefits and barriers to employee recruitment, retention, and workforce development.

An interview with the DMH highlighted major benefits of an SMHA-operated crisis continuum, including an increased ability to provide services to diverse populations (i.e., deaf and Spanish-speaking individuals), increased control in decision-making processes, and greater sustainability of workforce and services when compared to private organizations. The DMH has hired employees who are proficient in American Sign Language and Spanish, which allows these clinicians to connect with non-English speakers in a more meaningful manner and provide higher-quality services. Since the crisis workforce is comprised of state employees, the DMH has greater decision-making power in rulemaking, credentialing requirements, and establishing a standardized framework of quality as compared to their private counterparts. Additionally, since the SMHA has access to multiple revenue streams (e.g., general funds, ARPA, and Community Mental Health Block Grants), leadership is confident that state-operated models for behavioral health service delivery are more sustainable than private models. Lastly, the DMH leadership pointed out that their workforce can operate in more rural areas of the state where private behavioral health providers do not exist.

Challenges within the DMH-operated crisis continuum included pay and compensation restrictions established by South Carolina's statewide Human Resources (HR) department and low availability of master's-level clinicians to work crisis shifts. The biggest barrier to crisis workforce development is the inability to offer competitive pay and compensation to crisis employees. The DMH is "competing with other agencies in and outside of South Carolina that are able to offer higher wages and allow remote work opportunities." It is particularly difficult to recruit and retain staff in populated areas, such as Charleston, because salaries offered do not reflect the cost of living (i.e., $43,000/year starting salary for master's-level clinicians). The state's HR department determined that salaries were 40% under market value and needed to be raised to attract employees, but the state agency has not been allocated the funds by the state legislature to offer market-rate salaries. Another challenge is recruiting and retaining master's-level clinicians that are willing to work outside of traditional office hours (i.e., 24/7 services including nights, weekends, and holiday shifts). Finally, although increased use of telehealth has allowed for more remote work, competition with telehealth can at times limit the availability of in-person assistance.

In recognition of the barriers associated with recruiting and retaining state employees, DMH leaders have proposed several solutions. The DMH has partnered with local colleges and universities to create training programs and improve the diversity of the workforce pipeline. Additionally, the DMH supports certification and provides trainings in support of certification in various disciplines. From a pay and compensation standpoint, the DMH has increased baseline salaries by 15% and offered bonuses for recruitment and retention. Although there is more work to be done to increase salaries, the generous pensions packages are a long-term benefit that is often highlighted for recruitment purposes. The DMH has heavily invested in advertising job positions on social media, billboards, television, and radio. Finally, the SMHA has begun conducting interviews with employees to better understand what drives high performance and how the agency can improve.

Utah—Crisis Worker Certification Programs to Improve Employee-Level Outcomes

Approximately 550,000 Utahns have a mental health condition, and 2.7 million Utahans live in a community with a shortage of mental health professionals. As of 2021, Utah would need more than 70 psychiatrists to remove its Health Professional Shortage Area designation established by HRSA. In NRI's 2022 State Profiles report, *State Mental Health Agency Workforce Shortages*, Utah's Office of Substance Use and Mental Health (SUMH) reported a shortage of social workers, licensed mental health counselors, certified crisis workers, and peer specialists in its crisis workforce. SMHA leadership stated that the greatest turnover has been among crisis call center staff, and the largest complaint among staff had been low compensation. Utah requires community-based crisis workers to be certified, creating an additional barrier to employment but allowing the SUMH to have increased control over the quality of crisis-related trainings.

Utah created a 40-hour crisis worker certification program to address the need for a standardized, basic level of service available at all crisis service providers in the state. The program works in collaboration with schools of social work at universities in Utah to bridge the gap between academic and practical experience, allowing providers just out of school to have the tools necessary to provide crisis services at the minimum level required by Utah. The program aims to provide the least experienced staff with a basic core level of knowledge, including attitudinal outcomes (understanding of the needs and concerns of the people they will serve); knowledge (a basic understanding of the field); and skills (a minimum set of skills necessary to provide services to people in crisis).

As of January 2023, more than 300 crisis workers have received certification through the program. Utah's SUMH is currently working toward establishing more robust data reporting metrics for the certification program, allowing them to improve the program via an outcome-based approach. For example, the SMHA conducted a community-based study showing that crisis services were not culturally responsive, identifying the need for additional cultural

competency training. Findings from the study are being used to inform changes to the current curriculum. In the future, leadership seeks to collect information on the efficacy of the program, especially improvements of core competencies, through post-training data.

In addition, the program has allowed Utah's crisis call center to use the certification to create a job code specifier for an increased rate, incentivizing crisis work and alleviating crisis worker's concerns about compensation.

Overall, Utah's SUMH has discovered that the development and implementation of a crisis certification program needs to be dynamic. Increased flexibility would allow the training curriculum to be easily augmented to meet the needs of providers and ultimately those of individuals receiving crisis response services across the continuum. Additionally, partnerships with colleges and universities strengthen the education-to-workforce pipeline within Utah.

Conclusion

State agencies and provider organizations looking to grow and strengthen their behavioral health workforce face both barriers and opportunities, with recent influxes of state and federal funding and increased demand for services. State leaders are increasingly understanding the need to expand the entire behavioral health workforce, including a recognition of the value of peer support as part of the overall workforce need. Through enhancements toward a robust and expanded workforce, improved outcomes can be realized. In strengthening the infrastructure of behavioral health systems, the crisis response workforce will need particular attention. The crisis setting has unique barriers to recruitment (e.g., nontraditional working hours including nights and weekends), retention (e.g., low pay and high administrative burden), and employee wellness (e.g., high stress and secondary trauma). Understanding employees' needs within crisis settings may provide valuable insights into the specific factors impacting workforce development and sustainability. Improving reimbursement and financial incentives, providing allowances for telehealth, diversifying the workforce to match community needs, fostering positive organizational-level factors such as improving clarity of organizational structure, nurturing a trauma-informed organizational culture across crisis components (i.e., call centers, mobile crisis teams, and crisis centers), offering employee leadership training, and increasing the availability of services to support employee wellness are key strategies to strengthen the behavioral health crisis workforce across the country. Connections to academic centers could also nurture staff while developing new workers. Although these efforts will need to be sustained for years to come, the strategies highlighted in this paper offer approaches that have the potential to foster a strengthened system with promising direction.

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