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Recruitment and Retention Recommendations for Oregon's Behavioral Health Workforce

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Table of Contents

Executive Summary

The behavioral health workforce provides prevention, treatment or recovery services for mental health or addiction disorders, including gambling and substance use disorders and is comprised of a variety of disciplines including licensed and unlicensed providers. This workforce is a critical factor in improving the quality of and access to behavioral health care where it is needed the most, and effectively providing care across various treatment settings. Despite the many types of licensed and unlicensed behavioral health providers, there is a universal shortage in supply across all provider types, leading to significant unmet need in behavioral health care, especially for the most underserved populations.

Oregon mirrors the national trends in workforce which identify significant shortages of psychiatrists, psychologists, social workers, school counselors, and marriage and family therapists.[1,2] Findings from a behavioral health workforce analysis completed by the Farley Health Policy Center in March 2019 point to both provider shortages and specific maldistributions across counties and regions in Oregon. Furthermore, the nature and distribution of the licensed and unlicensed behavioral health workforce in Oregon as it relates to population behavioral health needs indicates substantial insufficiencies and maldistributions of providers that may limit optimal behavioral health care delivery.[2]

The current behavioral health workforce recruitment and retention report is a companion resource to the workforce analysis and workforce mapping application developed by the Farley Health Policy Center (FHPC) for the Oregon Health Authority (OHA). Additionally, the FHPC worked with OHA and stakeholders to develop a set of core competencies for licensed behavioral health providers working in integrated ambulatory settings; OHA continues to work on these competencies, conducting a deeper dive on the cultural competence components.

Current efforts to implement recruitment and retention strategies in Oregon are underway; the intent of this report is to look outside of Oregon to provide recommendations, strategies, and evidence to support or enhance existing efforts and provide options for future recruitment and retention efforts. The report presents findings from a rapid review of the peer-reviewed and non-peer reviewed literature (state and local case studies, expert reports) to support the outlined recommendations. A workgroup of the Oregon Health Policy Board Healthcare Workforce Committee and key experts selected by Oregon Health Authority staff reviewed this report and shaped recommendations. Additionally, survey responses from a web-based survey sent to the full Healthcare Workforce Committee were incorporated.

Historical attempts to alleviate workforce shortages have focused on geographic distribution without consideration of other influential factors which contribute to provider shortages. The specific findings of the behavioral health workforce analysis provide an understanding of the contextual domains which influence provider supply and demand beyond geographic distribution. This recruitment and retention recommendations report is organized into key themes that align with the findings of the workforce analysis and delineates four specific domains for consideration when crafting policies and best practices to improve and expand the behavioral health workforce: geographic distribution; practice settings; provider types and; alignment of the workforce with the diverse patient characteristics of the population.

Due to the simultaneous maldistributions and shortages of behavioral health providers, the first recruitment and retention goal is to improve equitable geographic distribution of the behavioral health workforce across the state.[2] Strategic recommendations include the following: maximize rural educational pipelines; bolster incentive programs to attract the licensed and unlicensed behavioral health workforce to practice in rural and underserved areas; support and utilize telecommunication to improve specialty access as well as supervision for clinical learners; and improve access to housing for the behavioral health workforce. This will require effort from several implementors, including OHA, healthcare organizations and payers, educational institutions, and local community organizations.

Understanding provider distribution across clinical settings provides an opportunity to optimize patient care through the alignment of patient acuity with the most appropriate clinical setting in order to maximize the efficiency of the current workforce. The second recruitment and retention goal is to appropriately allocate the behavioral health workforce across different practice settings to efficiently and effectively meet population needs. This includes the advancement of integrated primary care settings, increased distribution of behavioral health providers in non-traditional settings, such as schools, and optimized distribution across acute settings, with supportive payment models and training opportunities.[2]

Thirdly, specific provider type should be considered when determining the appropriate focus for pipeline growth and recruitment efforts in order to boost supply with consideration of role designations and balance within the workforce. The variety of provider types required to deliver comprehensive and effective behavioral health services includes licensed prescribers, licensed providers, and unlicensed providers. In order to fill gaps in care due to provider shortages, expansion of behavioral health provider types can enable the behavioral health workforce to comprehensively address patients' needs. This can include the promotion of the roles of traditional health workers, qualified mental health associates, and unlicensed qualified mental health professionals; maximize the use of psychiatric advanced practice providers in balance with a supply of psychiatrists; and reduce administrative barriers for licensed providers applying for licensure from out of state.

Lastly, there are demographic disparities between the behavioral health workforce and the population of Oregon. Identification of patient characteristics and needs can inform interventions and incentives aimed to align Oregon's behavioral health providers with the population it serves.[2] Recommendations to be considered are: Implement multiple recruitment and retention strategies to increase the behavioral health workforce diversity and better address pediatric health needs and; increase diversity in the behavioral health profession through educational pipeline programs and career opportunities for individuals of cultural, ethnic, and linguistic diversity.

Increased attention on behavioral health and substance use services has caused a shift in the field of behavioral healthcare. Expanding the behavioral health workforce to improve quality and access to behavioral health care is of high priority within state and national changes. The current report aims to provide up-to-date, evidence-based recommendations based on current literature and national and state resources to inform the work of OHA in improving the behavioral health workforce in the state of Oregon.

Recommendations for Action

Oregon is reflective of the nation with behavioral health workforce insufficiencies resulting from both provider shortages and their maldistribution. Comprehensive workforce retention and recruitment strategies are necessary to increase access to high-quality behavioral health providers across the state and address challenges of insufficiency. Proposed recruitment and retention strategies are presented thematically to support solution-based planning efforts that address:

- Geographic distribution
- Practice setting
- Provider types
- Aligning provider-patient characteristics and needs

Goal	Strategies	Implementer
Improve equitable geographic distribution of the behavioral health workforce across the state. Rationale: Mental health conditions are reported with very little regional variation across Oregon; regional variations in the distribution of providers are the root cause for maldistributions and shortages.[2] Summary of recommendations: Establish educational pipelines, incentivize traditional and non-traditional behavioral health providers to practice in rural and underserved areas; support and utilize telecommunication; and improve access to housing for behavioral health workforce.	Recruit and train students from rural areas and other under-resourced communities to practice in behavioral health centers and medical centers in their home region	Educational institutions
	Increase the proportion of licensed and unlicensed behavioral health workforce that work in rural and underserved geographic areas: a Develop high-quality education and training programs for advanced practice provider behavioral health workers and traditional health workers that recruit from and train providers to serve in underserved rural and urban communities b Ensure that all counties have psychiatrists available to support advanced practice providers that are currently shouldering much of the rural care in Eastern Oregon c Incentivize redistribution of currently maldistributed concentrations among all provider types to Multnomah County d Maximize awareness and use of Oregon's Health Care Provider Incentive Program through marketing initiatives e Partner with education programs to expand the Health Care Provider Incentive Program to include scholarships and stipends for students in training f Maximize awareness and support use of HRSA National Health Service Corps program through marketing partnerships with rural pathway education systems g Make education and training opportunities easier to complete for rural community members through online education, local training opportunities with virtual supervision when appropriate	Educational institutions OHA, education institutions Educational institutions, community organizations
	Support telehealth and necessary infrastructure to facilitate consultation and co-management with the current workforce in rural geographic areas	Healthcare organizations, payers
	Convene multi-sector collaborative to develop roadmap for community development to support recruitment and retention of behavioral health workforce	Healthcare organizations, local and state government, business owners, community groups, faith-based organizations

Goal	Strategies	Implementer
Improve equitable geographic distribution of the behavioral health workforce across the state. (continued)	Improve access to housing: a Utilize deed restrictions (restrictive covenants) to ensure that housing (both rental and home ownership) remains affordable over time for use and occupancy by local employees. A deed restriction is a legal agreement that runs with the land and binds subsequent owners. Several types of deed restrictions are possible, including limiting the occupancy of a home to a local employee and may include resale, appreciation, and income caps as well as other restriction. b Develop a state program to incentivize employers to offer commuter/housing benefits such as a tax break or incentive	Local communities, support from state agencies State agencies
	Implement a thorough orientation process so that new hires are appropriately on-boarded and can adjust appropriately to the new work environment and policies a On-boarding and orientation should also include helping new employees adjust to the community, which may entail helping providers find housing, schools, and other services for their children and families, giving a map of the community or area of town, and involving outside community members in this process to allow the provider to meet other community members and start to form social networks outside of work b Schedule and implement regular follow up check-ins with all providers	Healthcare organizations
	Develop career ladders and opportunities, peer mentorship programs, specifically for individuals already in communities a Train new and current behavioral health workers to increase retention. Training can include pre-employment training, apprenticeship training, and post-employment training. b Voluntary credentialing, training programs, licensure and certification systems and the creation of additional, higher staff levels based on training or experience coupled with increased compensation from available funding sources can facilitate career advancement and workforce retention. c Development of additional curricula and training programs can help to address gaps in career ladders and provides an actionable step to helping the behavioral health workforce advance in their career.	Healthcare organizations, educational institutions
	Expand financial and non-monetary forms of incentives, such as training stipends, tuition assistance, and loan forgiveness, to increase recruitment and retention. Convene expert panels to propose and identify funding sources, priority areas, and recipients of federal and state initiatives. Examples include federal incentive programs, minority fellowship programs, and loan repayment programs (LRPs). Non-monetary forms of incentive and recognition can include press releases, plaques/certificates presented to clinicians, on clinic websites or newsletters and through announcements at staff or board meetings. a Events or accomplishments that could be recognized are years of service, publications, presentations or research, patient satisfaction or survey results, and teaching or advocating for students.	OHA, healthcare organizations
	Provide wage and benefits commensurate with education, experiences, and levels of responsibility and acuity of care. a Develop partnerships and collaborations with state and federal departments of labor in employment, wage, and benefit issues. Use data generated through collaborations to adjust wages and benefits appropriately.	OHA, CCOs, community mental health centers, state agencies, school districts

Goal	Strategies	Implementer
Allocate workforce across different practice settings to meet population needs (i.e., distribute workforce to match presenting need in school-based, primary care, and specialty community settings). Rationale: Understanding provider distribution across clinical settings provides an opportunity to optimize patient care through alignment of patient acuity with the most appropriate clinical setting in order to maximize the efficiency of the current workforce. Summary of recommendations: Advance integrated care settings, such as schools and primary care, with supportive payment models and training opportunities.[2]	Appropriately allocate workforce to practice setting, i.e., distribute clinicians to match patient need (severity and acuity), including efforts to integrate behavioral health clinicians into school-based and medical settings, to alleviate and reserve community mental health centers for severe mental illness	OHA, CCOs, community mental health centers, state agencies, school districts
	Improve delivery of behavioral health services in non-traditional health care and community settings a Integrate behavioral health providers into schools through CCO and community mental health centers partnerships (scaling efforts happening in southern Oregon) b Support school-based programs to destigmatize behavioral health prevention and treatment services to increase use among students c Utilize community service locations such as libraries, community and recreation centers, and Women Infants and Children (WIC) offices to offer behavioral health providers and services d Expand behavioral health services through increased staffing of providers in adult and youth correctional facilities	CCOs, community mental health centers, state agencies, school districts
	Increase support for behavioral health provider services practicing in physical health settings a Test payment models that support the expansion of behavioral health integration in primary care in order to treat mild and moderate behavioral health conditions in the outpatient primary care setting b Support efficient behavioral health provider supply for acute settings including patient care and emergency rooms for severe behavioral health conditions c Support implementation of the OHA Primary Care Office's Healthcare Workforce Retention Toolkit adapted for licensed and unlicensed behavioral health providers d Develop continuing education opportunities for providers to become competent in the *Core Competencies for Licensed Behavioral Health Providers Working in Ambulatory Integrated Settings* e Develop peer mentoring programs for organizations and agencies to reduce turnover	Oregon Health Plan; CCOs OHA OHA, professional organizations, healthcare organizations Healthcare organizations
	Support monthly meetings for multi-disciplinary learning and networking (example, local journal club meetings)	Healthcare organizations
	Compensate community-based settings that provide training for new BH providers in their first year of practice, incentivize and support the training sites	CCOs; Oregon Health Plan
	Expand telehealth reimbursement to include any site of origination	CCOs; Oregon Health Plan
	Increase integrated training opportunities.	Education institutions

Goal	Strategies	Implementer
Increase number of licensed and unlicensed behavioral health workforce providing direct services. Rationale: Shortages exist at every tier of the behavioral health service industry. The variety of provider types required to deliver comprehensive and effective behavioral health services includes prescribers, licensed providers, and unlicensed providers. Together, the behavioral health workforce works in concert to comprehensively address patients' needs, providing services for prevention and health promotion, treatment, and recovery.[2] Summary of recommendations: Promote roles of Traditional Health Workers, Qualified Mental Health Associates, and Qualified Mental Health Professionals; maximize use of psychiatric advanced practice providers; and reduce administrative barriers for licensed providers applying for licensure from out of state.	Increase Traditional Health Worker workforce a Create plans for integrating and utilizing THWs (as part of integrated healthcare teams, assertive community treatment teams, non-clinical care settings, etc.) b Establish alternative payment models with sustainable rates for THW services c Maximize use of peer workers – Standardization of the certification to become a peer worker would enhance peer provider status and ensure high quality of care among agencies and states. – Training of peer workers should also be streamlined across states, and can be done through resources such as the International Certification & Reciprocity Consortium – Reduce administrative barriers, including ongoing reforms for how background checks are used in hiring practices d Expand engagement of community health workers through certification, training, and reimbursement e Utilize expertise of the OHA Office of Consumer Activities and community partners to further explore issues related to the peer-delivered services workforce and develop strategies to address.	OHA, CCOs, OHP, Traditional Health Worker Commission, Healthcare organizations, community partners
	Further professionalize the role of Qualified Mental Health Associates and Qualified Mental Health Professionals through standardized training programs and development of manuals on billable services.	OHA, MHACBO
	Reduce administrative barriers for licensed providers applying for licensure from out of state.	OHA, licensure boards
	Maximize use of psychiatric advanced practice providers (NPs and PAs). a Recruit with appropriate job descriptions to ensure maximum scope of practice. b Clarify scope of practice and supervision requirements to full care team during onboarding process.	Healthcare organizations

Goal	Strategies	Implementer
Develop and support a behavioral health workforce that aligns provider and patient characteristics and needs. Rationale: There are demographic disparities between the behavioral health workforce and the population of Oregon. Identification of patient characteristics and needs can inform interventions and incentives aimed to align Oregon's BH providers with the population it serves.[2] Summary of recommendations: Implement multiple recruitment and retention strategies to increase the behavioral health workforce diversity and better address pediatric behavioral health needs. Grow interest in the behavioral health profession through marketing campaigns, educational programs, and career opportunities. Ensure recruitment efforts are reaching diverse populations.	Create workplace environments that are conducive to a diverse workforce a Ensure current workforce completes a cultural responsiveness training in accordance with House Bill 2611 b Support programs that attract providers from minority ethnic backgrounds including Hispanic, Asian, and Native American tribes, and African Americans to reflect local demographics c Incentivize clinics to employ hiring practices which result in a professional staff that mirrors their local community	Healthcare organizations, OHA
	Increase cultural competence of interpreters used in delivering services through the development of standards, training models, and reimbursement strategies	Healthcare organizations, OHA
	Implement comprehensive public relations campaigns to promote behavioral health as a career choice a Engage marketing firms to develop campaigns that promote and advertise behavioral health career options at a local and state level	OHA, healthcare organizations, professional organizations, educational institutions
	Establish and expand educational pipelines and partnerships with community colleges and universities to recruit and prepare students of diverse cultural and linguistic backgrounds and from underrepresented backgrounds for careers in behavioral health a Expand funding for educational capacity, stipends, scholarships, and internship opportunities b Encourage and support diversity courses, practicum placements, externships, and internships that provide mentoring, supervision, and direct clinical experiences with racial and ethnic minority populations for trainees going into behavioral health professions. c Recruit and support college students, including community college students, from underrepresented regions and backgrounds to pursue behavioral health careers. d Provide financial aid opportunities and organizational links with students at historical institutions of color. – Support scholarships for qualified students who pursue behavioral health profession and serve in underserved communities. – Expand funding for educational capacity, stipends, and scholarships to strengthen the size, distribution, and diversity of the behavioral health workforce. – Expand loan repayment programs (LRPs) for behavioral health clinicians practicing in underserved communities. e Conduct research to measure and track demographics of students training for behavioral health careers. f Involve existing minority faculty and minority students in recruitment efforts, establishing a critical mass of students of color, and having opportunities for students to engage in research on diversity issues with faculty are other recruitment and retention strategies.	Educational institutions, OHA, healthcare organizations
	Increase residency and fellowship opportunities for pediatric behavioral health providers (child and adolescent psychiatrists, developmental pediatricians, developmental psychologists)	Educational institutions
	Develop consortiums that involve multiple agencies to allow organizations to pool recruitment resources and candidates for behavioral health positions. Promote creative candidate searching to improve workforce diversity: a Partner with community organizations and chambers of commerce to host after-hours job fairs	Healthcare organizations, community organizations

Introduction

More than half of the population with mental health conditions does not receive treatment.[3] The behavioral health (BH) workforce includes all professionals who provide prevention, treatment or recovery services for mental health or substance use disorders. Recruitment and retention of providers who are a good fit for different models of care necessary to meet the demands of behavioral health practice. The behavioral health workforce is a critical factor in improving quality of behavioral health service delivery and facilitates training opportunities of behavioral health professionals. The behavioral health workforce consists of three basic categories of providers: licensed prescribers, licensed providers and unlicensed providers.

Licensed prescribers include individuals who provide prescription-based treatment for BH conditions. This generally includes physicians (MDs and DOs), and advanced practice providers (PAs, NPs, and CNSs). Licensed providers include individuals who administer psychotherapy-based services for BH conditions licensed by the Board of Psychologists, Board of Social Workers, and Board of Counselors and Therapists. This group also includes pre-licensees in training who will ultimately advance to licensed provider status. Unlicensed providers are comprised of a diverse group of individuals that focus on counseling-based and supportive services. They often specialize in addiction or mental health, and a smaller segment of the unlicensed workforce provide services that address both. Some unlicensed providers are baccalaureate-level professionals while others have more advanced degrees. A large segment of the unlicensed provider workforce is made up by certified addiction counselors and traditional health workers (THW).[2]

Despite the many types of licensed and unlicensed behavioral health workers, including ancillary support staff, there is a collective shortage in BH workforce supply, resulting in the inability to meet behavioral health demands, especially for populations in greatest need. A report by the Health Resources and Services Administration (HRSA) detailed a significant national shortage of psychiatrists, psychologists, social workers, school counselors, and marriage and family therapists. A substantial investment in human resources is needed to facilitate change and increase access to mental health treatment for those in need.[1]

To better understand the state of Oregon's behavioral health workforce and inform decision-making, the *Behavioral Health Collaborative, convened by the Oregon Health Authority, recommended an assessment of the licensed and unlicensed workforce*.[4] The workforce analysis conducted by the Farley Health Policy Center, *An Analysis of Oregon's Behavioral Health Workforce: Assessing Capacity of Licensed and Unlicensed Providers to Meet Population Needs*, describes the nature and distribution of the licensed and unlicensed behavioral health workforce in Oregon as it relates to population behavioral health needs and identifies insufficiencies and maldistributions of providers that may limit optimal behavioral health care delivery.[2]

Informed by findings of the workforce analysis, recent literature in recruitment and retention of the behavioral health workforce offers solutions for addressing workforce shortages and gaps and reduced capacity through policy development, state-wide agency collaboration, and specific action items that behavioral health agencies can take to increase recruitment and retention. Current efforts to focused on recruitment and retention in Oregon are underway;

the intent of this report is to look outside of Oregon to provide recommendations, strategies, and evidence to support or enhance existing efforts and provide options for future recruitment and retention efforts. The purpose of the current report is to provide recommendations for strategic recruitment and retention action items, aligned with the workforce analysis findings, and present the related evidence and background for these recommendations. This report may be used to support or enhance existing efforts in Oregon and provide options for future recruitment and retention efforts. The workforce analysis report presented thematic sections to inform recruitment and retention planning efforts to meet Oregon's behavioral health needs. This report is a companion resource to the workforce analysis and workforce mapping application. Additionally, the FHPC worked with OHA and stakeholders, including a workgroup of the Oregon Health Policy Board's Healthcare Workforce Committee members, Certified Community Behavioral Health Clinics stakeholder groups, and the executive directors of Trauma Informed Oregon and Patient-Centered Primary Care Home Program, to develop a set of core competencies for licensed behavioral health providers working in integrated ambulatory settings. OHA continues to work on these competencies, applying a deeper focus on culturally competencies.

Recruitment and retention recommendations and solutions provided in the report below are organized in solution-based themes to align with findings of the workforce analysis:

- Geographic distribution, including improving the rural behavioral health workforce and community-based strategies for workforce recruitment and retention to address regional variations in the distribution of providers resulting in shortages in the behavioral health workforce
- Practice settings, including school-based behavioral health workforce, integrated behavioral health in medical settings, and appropriate matching of patient severity and acuity to practice setting to maximize the efficiency of the current workforce
- Provider types, because of reported shortages among licensed prescribers and providers and underutilization for the unlicensed workforce
- Meeting the demand of diverse patient characteristics, including improving the alignment between demographics and characteristics of patients and providers, to address a significant underrepresentation of Hispanic providers and align characteristics of patients and providers through minority recruitment and retention strategies to increase ethnic, cultural, and linguistic diversity of the behavioral health workforce

Methods

A literature review was conducted as a rapid review, a methodology that streamlines the process for a systematic review to synthesize relevant evidence in a timely manner for decision-makers in policy and other sectors.[5] A search strategy and relevant search terms were developed, and both the peer-reviewed and non-peer reviewed literature (state and local case studies, expert reports) searched using PubMed, Ovid Medline, and Google Scholar. Four main recruitment and retention resources and reports were identified and used as a foundation for this report: the *SAMHSA-HRSA Center for Integrated Health Solutions Recruitment and Retention webpage, Objectives from An Action Plan for Behavioral Health*

Workforce Development by the Annapolis Coalition on the Behavioral Health Workforce, Oregon Health Authority (OHA) Primary Care Office Retention Handbook, and the Workforce Planning Recommendations, Resource: Community Living Exchange Collaborative at the Independent Living Research Utilization (ILRU) program.[6-9] Additional manuscripts, reports, and resources supplemented these recommendations.

A workgroup of the Oregon Health Policy Board, Healthcare Workforce Committee was assembled to provide input and suggestions to an initial set of recommendations through two work sessions (one virtual, one in-person). The full Healthcare Workforce Committee was invited to provide input via a web-based survey. Eight complete survey responses were received and informed finalization of the recruitment and retention recommendations.

Finally, key experts, selected by Oregon Health Authority staff reviewed the recommendations report.

A comprehensive study of current recruitment and retention efforts happening in Oregon was outside the scope of this report. However, initiatives or efforts that were highlighted throughout the review process are captured in call-out boxes in each section.

Composition of Behavioral Health Workforce

The behavioral health professional workforce comprises professionals who focus on understanding, preventing, intervening and promoting recovery to address mental, psychosocial and behavioral problems. Behavioral health professionals provide services to address the needs to individuals and families with psychiatric disorders and substance abuse, among other psychosocial challenges. The National Mental Health Act of 1946 identified four core types of mental health professionals: Psychiatry, Psychology, Social Work, and Nursing. Today, these disciplines are complemented by other clinically focused types of behavioral health providers, including counselors, non-psychiatric physicians and paraprofessionals, and the span of behavioral health provider types has broadened to include more diversity of providers who consider themselves part of the behavioral health workforce or who are likely to be perceived by consumers as such.[10] These types of providers can further be characterized by their scope of practice as defined by authority to prescribe psychiatric medication, and licensed versus non-licensed providers. In the accompanying workforce analysis report developed for the OHA, data on behavioral health providers are categorized and described inclusive of these provider types.[2]

Licensed Prescribers

Licensed prescribers include individuals who provide prescription-based treatment for BH conditions. This generally includes physicians (MDs and DOs), and advanced practice providers (PAs, NPs, and CNSs).

Psychiatry is a specialty of medicine oriented toward mental and behavioral health services. Psychiatrists tend to serve patients with more complex or severe mental health disorders, such as bipolar disorder or schizophrenia. Psychiatry emphasizes more biological and somatic approaches to intervention (e.g., psychotropic medications) rather than psychotherapy.

However, recent residency requirements have attempted to increase psychiatric residency training in psychotherapy to increase psychotherapeutic competence within this profession and enable psychiatrists to engage in behavioral health counseling and therapy.

Psychiatry Nursing or Psychiatric Mental Health (PMH) nursing is a specialization of the practice of nursing in which registered nurses work with individuals and families to assess behavioral health need. Psychiatric Mental Health Advanced Practice Registered Nurses (PMH-APRNs) are skilled in assessment, diagnosis and treatment of individuals and families with psychiatric disorders. PMH-APRNs can offer primary care services to individuals in need of mental and physical health care. APRNs earn master's or doctoral degrees in psychiatric-mental health nursing.[4]

Behavioral health physician assistants (PAs) or PAs in behavioral health provide health care services under the supervision of a physician. Behavioral health PAs may perform psychiatric evaluations and assessments, order and interpret diagnostic studies, counsel patients, develop and manage treatment plans, and order referrals. They may also prescribe psychotropic medication.

Licensed Providers

Licensed providers include individuals who administer psychotherapy-based services for BH conditions licensed by the Board of Psychologists, Board of Social Workers, and Board of Counselors and Therapists.

Psychology is the profession with the most extensive training in assessment (e.g., psychological testing), psychotherapy, and research. Most psychologists obtain a doctoral degree in psychology (Ph.D. or Psy.D.) or educational psychology (Ed.D.), complete a one-year internship, dissertation, postdoctoral supervised practice, and pass the Examination for the Professional Practice of Psychology (EPPP) required for licensure. Psychologists work in diverse settings (e.g., healthcare, academia, and industry) and roles (clinical, teaching, research, consultation, administration).

Social Work is a profession and academic discipline that addresses a broad range of societal problems, including mental health and physical health problems. Social workers have a variety of roles, including administrative and direct service roles in a number of settings (e.g., hospitals, governmental and non-profit agencies, schools, corporations, managed care organizations, prisons, nursing homes, mental health centers, etc.). Social workers are trained in psychotherapy, triage, referral, and facilitation or management of access to federal, state and local resources and programs. Social work aims to assist individuals to function more effectively in their environment by addressing issues related to individual, family, community and broader social barriers to mental and physical health.

Counseling professions may be distinguished by a set of developmental, educational, and preventative approaches to problem solving that focuses on individual functioning within environmental contexts. Counselors work in multiple settings, including in and outside of the health care system, and in schools, social service agencies, and industry.

Marriage and family therapy focuses on marital, couples, or family issues, with broad training in skills to improve relationships and address behavioral or emotional issues from a family systems perspective. Marriage and family therapists (MFTs) see patients individually, and in couple and family settings. Training in MFT is at the master's and doctoral level.

Unlicensed providers

Unlicensed providers are comprised of a diverse group of individuals that focus on counseling-based and supportive services. They often specialize in addiction or mental health, and a smaller segment of the unlicensed workforce provide services that address both.

Unlicensed providers have a range of education levels and highly varied clinical roles. Some are baccalaureate level professionals who provide supportive and educational services, while others are graduate level or may be enrolled in career advancing training programs for MH counseling. A large segment of the unlicensed provider workforce is made up of highly trained addiction counselors, certified by the state, while others provide supportive services as traditional health workers (THW) and lay community members who have completed job-specific training.

Peer workers in behavioral health include people in recovery and their family members to be considered members of the workforce through informal self-help and family caregiving or organized peer- and family-support services.[6] Peer workers are defined as individuals in recovery from mental illness or substance use disorders that have peer support competencies and can assist in behavioral health services.[11] Traditional Health Workers is an umbrella term for frontline workers who work in a community or clinic under a licensed health provider, focused on mental health, substance use, pre-natal and post-partum care, health care navigation, and more. In Oregon, traditional health workers focused on mental health and/or substance use are most commonly Peer Wellness Specialists and Peer Support Specialists, including both Family and Youth Support Specialists.

Within the subsequent groups of behavioral health professionals, substance use counselors and psychosocial rehabilitation service providers, both licensed and unlicensed providers may provide services.

Substance use counselors serve individuals with substance use problems and their families. The National Association of Alcoholism and Drug Abuse Counselors (NAADAC) is the largest organization of professionals serving individuals with substance use disorder and their families. The NAADAC approves and accredits a number of training and educational programs that provide training to associates, bachelors and master's level professionals.

Psychosocial rehabilitation services span a spectrum of behavioral health recovery services, including community housing, case management, crisis intervention, residential treatment, recreational and socialization, and other types of community services and support. Psychiatric rehabilitation practitioners providing rehabilitation services may have graduate degrees; peer workers, or individuals in their own recovery from mental illness or substance abuse supporting others, are also a portion of this workforce.

Recruitment and Retention: Findings and Recommendations

Recruitment and retention findings and recommendations are presented in four solution-based themes to align with findings of the workforce analyses: geographic distribution, practice setting, provider types, and aligning patient and provider characteristics and needs. While this organization lends itself to solution-based thinking, it does not capture the interdependencies or multiple impact recruitment and retention efforts may have across thematic area. For example, implementing strategies to improve recruitment of behavioral health providers to primary care settings may also help address geographic maldistribution, increase access to a needed behavioral health provider type for a community, and/or better match patient and provider demographics. Additionally, across sections, recommendations identified for specific settings or segments of the workforce may also be applied or adapted for broader use (for example, recruitment and retention principles within the integrated primary care section may be adapted for use in specialty mental health settings).

Geographic Distribution

While healthcare labor shortages are an ongoing problem, the magnitude of provider shortage in general is not the only issue when considering access to behavioral health services. Maldistribution across setting and geography is a major concern, as certain areas of the country have few or no behavioral health providers available. In addition to areas high in poverty, rural geographic locations have a maldistribution of behavioral health providers. Health Professional Shortage Area (HPSA) designations indicate shortages of healthcare professionals who provide services, including behavioral health services, and are designated by the Health Resources and Services Administration (HRSA). HPSAs may be geographic, population-specific, or facility based.[12] There is unequal distribution of behavioral health providers, including psychiatrists, psychologists, and psychiatric nurse practitioners, across geographic locations in the U.S. This unequal distribution can help to inform approaches to improving access to behavioral health services for underserved communities.[13]

Rural Workforce

Psychiatrists, psychologists, and social workers tend to be more heavily concentrated in population dense, metropolitan, higher-income counties. This may be due to these locations serving populations with greater average severity of illness and that these areas have a higher population density. Other contributing factors may include location of graduate programs for these professions, and history of these professions.[14]

In terms of training the behavioral health workforce, fewer than 1% of doctoral programs in psychology in the U.S. are located in rural areas. Expansion of high-quality, accredited training programs within rural areas will help to alleviate shortages of behavioral health providers in rural areas. Additional recruitment and retention strategies can include incentives such as additional funding or training awards for students recruited from rural areas and greater use of telehealth approaches to improve the availability of behavioral health services in rural areas.[15] For example, the University of North Carolina (UNC) School of Nursing has a Psychiatric-Mental Health Nurse Practitioner (PMHNP) curriculum specifically designed to educate and train PMHNPs recruited from rural areas to meet the needs of underserved, rural populations with mental illness and provide integrated behavioral health care.

Agencies and educational institutions can expand the use of "grow your own" recruitment and retention strategies focused on residents of rural areas, culturally diverse populations, and consumers and families. Development and distribution of technical assistance in existing initiatives can assist in recruitment of priority populations into entry-level positions and foster their continued professional development throughout their career.

In order to address gaps in the behavioral health workforce in rural geographic areas, it may be necessary to expand behavioral health provider types working in these areas. Increasing the proportion of psychiatric nurses choosing rural practice may help to address the shortage of behavioral health professionals in these areas. Recommendations to increase advance practice psychiatric nurses (APPNs) in rural areas include providing financial incentives, such as a reimbursement differential under Medicare and Medicaid for practices in designated behavioral health HPSAs and loan repayment programs under the National Health Service Corps or similar state programs.[16] Findings from the BH workforce analysis report show that 8 Oregon counties have no psychiatrists present. Six of these counties are supported by advance practice providers only, indicating that growth among psychiatrist trained licensed prescribers is also a priority for the state and could be utilized in conjunction with advanced practice providers who care for rural communities.[2] Some states require that advanced psychiatric nurse practitioners or psychiatric-mental health nurse practitioners have a collaborative relationship with a physician. This collaboration may be more difficult in rural areas, especially when the overseeing physician is a family practitioner and may not have sufficient psychiatric training. States that require this should consider Peer-to-peer clinical supervision can serve as an alternative for states challenged with a lack of appropriately trained overseeing physicians.

The supervision of the rural behavioral health workforce also poses challenges due to accessibility of supervisors and mentorship to train behavioral health workers in these areas. The use of ECHO (Project Extension for Community Healthcare Outcomes) demonstrates that virtual clinics applying telecommunication are feasible for the purpose of workforce development and clinical supervision.[17] Additionally, the Virtual Mentorship Network demonstrates that virtual or distance mentoring can provide a feasible option for the mentoring of high school and college students interested in behavioral health careers and further address the shortage of behavioral health providers in rural areas.[18]

The Behavioral Health Workforce Education and Training (BHWET) program funds grants to eligible entities such as university and non-profits to support the development and expansion of behavioral health workforce serving individuals across the lifespan. BHWET focuses on increasing the supply of providers and distribution, an important factor in addressing behavioral health disparities. One goal of the BHWET program is to employ behavioral health providers in underserved areas and provide services to vulnerable populations. To date, data show that many of these trained providers work within medically underserved communities (47%) or with children and transitional-aged youth (60%).[19]

Community Development to Promote Recruitment and Retention

Cross-sector connections between community development, housing, and workforce development are important considerations when addressing challenges to recruitment and retention. Housing, including access to affordable housing or available homes to purchase or rent, are barriers documented in the literature[20] as well as through anecdotal experiences. Additionally, understanding place, as a means of accessing housing, education, transportation and other components necessary to thrive in a community, are essential community development considerations for recruiting and retaining behavioral health workforce to currently underserved communities.[20,21] Efforts to build employment opportunities with

sufficient income potential for partners and spouses, quality public schools, access to shopping and other services, such as broadband, are overlooked, but essential components to recruitment and retention.[6] Often thought of as just a "healthcare problem," multi-sector community development collaborative have the capacity to solve systemic problems by tapping into diverse expertise and resources.

Agencies can promote recruitment and retention of behavioral health providers by assessing community needs and fit of providers during the hiring process. Agencies should describe the patient population of the clinic and any associated strengths and difficulties with the patient population or community served and ask the following questions:[7]

- Have they lived or worked in a community similar to yours? If so, did they leave because they were dissatisfied with this type of community?
- If they're currently working, are they planning on transitioning to a new position because they are unhappy with things related to the community or clinic? What are those things?
- What things do they value? Values may include:
  - A small community to raise their children
  - Excellent school system
  - Outdoor recreation opportunities
  - Access to shopping and other services
  - Proximity to a large metropolitan area
  - Diversity community
  - Employment opportunities for their spouse
  - Religious preferences and places of worship
  - Cultural events

Implementation of a thorough orientation process may also help new hires adjust appropriately to not only a new work environment, but a new community. Orientation processes can benefit from input of current staff, and may include efforts to:

- Welcome new provider and partner/family to clinic and community
- Arrange opportunities for provider and family to give a clinic administrator feedback and ask questions
- Help the new providers find housing, schools and other services for their children and families
- Give new providers a map of the area and involve community members outside of the organization to allow the provider to meet other members of the community and begin to form social networks outside of work
- Partner new provider with mentor (fellow employee) during first year of employment
- Address concerns or issues as soon as possible that may cause provider or family to leave the clinic or community
- Recognize provider for accomplishments
- Support provider's compensations, education, and benefit needs as much as possible
- Creating a written plan and checklist to guarantee streamlined orientation process that can be followed after every new employee can be helpful. The OHA Primary Care "Retention Handbook" has an example checklist for reference

OREGON EFFORTS

- Oregon's Health Care Provider Incentive Program
- George Fox University interprofessional training program

Recommendations for Action

GOAL: Improve equitable geographic distribution of the behavioral health workforce across the state.

RATIONALE: Behavioral health conditions are reported with very little regional variation across Oregon; regional variations in the distribution of providers are the root cause for maldistributions and shortages.

SUMMARY OF RECOMMENDATIONS: Establish educational pipelines, incentivize traditional and non-traditional behavioral health providers to practice in rural and underserved areas; support and utilize telecommunication; and improve access to housing for behavioral health workforce.

1. Recruit and train students from rural areas and other under resourced communities to practice in behavioral health centers and medical centers in their home region
   Implementer: Educational institutions
2. Increase the proportion of licensed and unlicensed behavioral health workforce that work in rural and underserved geographic areas
   a. Develop high-quality education and training programs for advanced practice providers and traditional health workers that recruit from and train providers to serve in underserved rural and urban communities
   b. Ensure that all counties have psychiatrists available to support advanced practice providers that are currently shouldering much of the rural care in Eastern Oregon
   c. Incentivize redistribution of currently maldistributed concentrations among all provider types to Multnomah County
   d. Create financial incentives such as reimbursement and LRPs for the workforce in these areas, as well as scholarships for the workforce in training
      - Maximize awareness and use of Oregon's Health Care Provider Incentive Program through marketing initiatives
      - Partner with education programs to expand the Health Care Provider Incentive Program to include more scholarships and stipends for students in training
      - Maximize awareness and support use of HRSA National Health Service Corps program through marketing partnerships with rural pathway education systems
   e. Make education and training opportunities easier to complete for rural community members through online education and local training opportunities with virtual supervision when appropriate
      Implementer: Educational institutions, OHA, community organizations

3. Support telehealth and necessary infrastructure to facilitate consultation and co-management with the current workforce in rural geographic areas
   Implementer: Healthcare organizations, payers
4. Convene multi-sector collaborative to develop roadmap for community development to support recruitment and retention of behavioral health workforce
   Implementer: Healthcare organizations, local and state government, business owners, community groups, faith-based organizations
5. Improve access to housing
   a. Utilize deed restrictions (restrictive covenants) to ensure that housing (both rental and home ownership) remains affordable over time for use and occupancy by local employees. A deed restriction is a legal agreement that runs with the land and binds subsequent owners. Several types of deed restrictions are possible, including limiting the occupancy of a home to a local employee and may include resale, appreciation, and income caps as well as other restrictions.
   b. Develop a state program to incentivize employers to offer commuter/housing benefits such as tax breaks or incentives
      Implementer: Local communities, state agencies
6. Implement a thorough orientation process so that new hires are appropriately on-boarded and can adjust appropriately to the new work environment and policies
   a. On-boarding and orientation should also include helping new employees adjust to the community, which may entail helping providers find housing, schools, and other services for their children and families, giving a map of the community or area of town, and involving outside community members in this process to allow the provider to meet other community members and start to form social networks outside of work
   b. Schedule and implement regular follow up check-ins with all providers

   Implementer: Healthcare organizations
7. Develop career ladders and opportunities, peer mentorship programs, specifically for individuals already in communities
   a. Train new and current behavioral health workers to increase retention. Training can include pre-employment training, apprenticeship training, and post-employment training.
   b. Voluntary credentialing, training programs, licensure and certification systems and the creation of additional, higher staff levels based on training or experience coupled with increased compensation from available funding sources can facilitate career advancement and workforce retention.
   c. Development of additional curricula and training programs can help to address gaps in career ladders and provides an actionable step to helping the behavioral health workforce advance in their career.

   Implementer: Healthcare organizations, educational institutions

8 Expand financial and non-monetary forms of incentives, such as training stipends, tuition assistance, and loan forgiveness, to increase recruitment and retention. Convene expert panels to propose and identify funding sources, priority areas, and recipients of federal and state initiatives. Examples include federal incentive programs, minority fellowship programs, and loan repayment programs (LRPs). Non-monetary forms of incentive and recognition can include press releases, plaques/certificates presented to clinicians, on clinic websites or newsletters and through announcements at staff or board meetings.

   a Events or accomplishments that could be recognized are years of service, publications, presentations or research, patient satisfaction or survey results, and teaching or advocating for students.

   Implementer: OHA, healthcare organizations

9 Provide wage and benefits commensurate with education, experiences, and levels of responsibility.

   a Develop partnerships and collaborations with state and federal departments of labor in employment, wage, and benefit issues. Use data generated through collaborations to adjust wages and benefits appropriately.

   Implementer: OHA, healthcare organizations, department of labor

Practice Settings (Matching Patient Acuity and Severity to Practice Setting)

It is widely accepted that patients whom are ready to engage in treatment for mental health or addiction conditions often present at a window of opportunity, with the potential to lose momentum, interest, and patience when care is delayed or inefficient. The optimal distribution of providers across a spectrum of healthcare and non-healthcare settings allows for providers to be available when and where patients present, increasing access, and reducing bottle necks, and long wait times. Effective distribution of providers across settings maximizes provider efficiency and improves BH service delivery. When addressing healthcare settings, optimization and expansion of integrated primary care settings should be an early priority. Oregon is recognized as a national leader for system efforts to integrate behavioral and physical health and continues to implement and set high standards for the Coordinated Care Organizations to advance behavioral health integration.[22]

Twenty percent of primary care office visits are related to mental health.[23] Nearly half of all lifetime mental health disorders start by mid-adolescence, and almost 1 in 5 youth meet criteria for a diagnosable mental health condition.[24-26] Of the youth that do receive needed services, the majority obtain behavioral health services in school settings.[27,28] The specialty mental health system does not have the capacity to meet the behavioral health needs of the entire population or demand for behavioral health care. This presents an opportunity to improve access, compliance, and efficiency for meeting mild-moderate behavioral health needs of a population where they are living, working, and learning, leaving the specialty mental health system to serve populations of acute and severe mental illness (SMI).

There is evidence for improved outcomes of integrated behavioral health and primary care, as well as integrated behavioral health in school-based settings.[29,30] School-based services provide critical screening, assessment, and treatment children may otherwise not receive. Children and adolescents with access to behavioral health services in school (through school-based health centers) are 10 times more likely to seek care for mental health or substance use than those who do not.[31] Integration into a multitude of settings including primary care settings, community-based settings such as libraries and community centers as well as correctional facilities for adults and youth should be optimized. These efforts will allow patients with high acuity and SMI to be referred for treatment in specialty mental health centers where more intensive services can be administered.

To recruit and retain the behavioral health workforce across settings to meet population needs, attention must be given to strategies that may need to be adapted from "traditional" or specialty mental health settings to integrated care settings. Strategic goals of recruitment and retention of the behavioral health workforce across settings can be to: accurately describe the organizations' model of care and the behavioral health job and role; attract interested providers who will have the best fit in team settings; standardize performance assessment to ensure providers have the necessary skill set to achieve desired health outcomes; and promote job satisfaction of individuals delivering care through payment incentives (e.g., reimbursement, wages and benefits, and loan repayment programs).[9]

Schools

Schools provide a unique opportunity for the behavioral health workforce to meet the behavioral health needs of children and transition-aged youth. Members of the behavioral health workforce that can be utilized in schools include school counselors, school psychologists, school social workers and school nurses. In order to address behavioral health workforce needs in school settings, district-level staffing policies can help to increase the quantity and quality of counseling, psychological, and social services staff in schools. As a result of meeting the patient in a setting where they are present and in which emotional and behavioral disruptions are most likely to occur, integrated behavioral health in schools settings leads to improved mental and behavioral health outcomes for students and reduce the load on other behavioral health professionals in the community.[32]

One consideration is improving staffing ratios to allow for the delivery of a full range of services and effective school-community partnerships. School professional associations (e.g., American School Counselors Association, National Association of School Psychologists, and School Social Work Association of America) recommend specific staffing rations in schools: School counselor-to student ratio- 1:250.[33]

Additionally, schools can require school-level counseling, psychological and social services (CPSS) coordinators that organize quality and delivery of mental and behavioral health services to youth. These coordinators can provide management of providers within and outside of schools (such as coordination with other healthcare or social service agencies within the community) to ensure students' behavioral health needs are met. Coordination of services can include delineating a clear mission, goal, and objectives to promote integration of behavioral health procedures and programs into schools. CPSS staff are typically employed by the school district which highlights the importance of district-level coordination of behavioral health services in order to assign CPSS staff to schools. At the school level, integration and promotion of behavioral health services in schools can help secure resources, ensure confidential policies and help minimize lost class times for students seeking behavioral health services.[32]

The Multi-Tiered System of Support (MTSS)

The MTSS is an established framework that facilitates the integration of behavioral health in schools and can expand CPSS services in school-based settings through integrated services and strong community partnerships for referrals. The MTSS is a school prevention-based framework that incorporates CPSS services into schools to improve learning for all students through a layered continuum of evidence-based practices and systems.[34] The nationwide school-based framework starts with shared family, school, and community partnerships and is tiered into three sections that are layered to align systems necessary for every student's academic, behavioral, and social success. The tiered approach spans from universal screening (tier 1) to targeted intervention (tier 3) with evidence-based practices as well as opportunities for partnering with healthcare and community groups throughout the tiers.

Tier 1 is universal for all students, focusing on positive behavioral supports for all youth.[35] Tier 1 services address the entire student body and include programming such as universal screening, evidence-based social and emotional learning curricula, and an established referral process for identified concerns. Tier 2 is targeted intervention for some students who need additional behavioral health support services through either individual or small-group interventions. Psychological testing in schools is an example of a tier 2 strategy that CPSS professionals can provide before referring students out for additional testing or services. Tier 3 is intensive intervention for the few students with high severity and acuity that need individualized treatment. Critical components of this tier include a strong referral process with community agencies, such as specialty mental health clinics, and re-entry assistance for students transitioning back from treatment in the community (e.g., hospitalization or residential treatment).[36] Since community partnership and referral are important aspects of the MTSS framework and providing behavioral health services in schools, strategic steps can be taken to facilitate a smooth partnership. Building systemic channels for communication between school and healthcare and community agencies encourages collaboration and cross-disciplinary conversations. This can be done in a number of ways:[35]

- Establishing Memorandums of Understanding (MOU) and training teachers and school personnel to identify and screen students at risk for behavioral health concerns and in need of early intervention
- Formalize referral process for students in need of additional behavioral health supports in school and community healthcare settings
  - Create a Release of Information (ROI) for parents to authorize sharing of their child's health and academic information to promote timely referrals and permit bidirectional flow of information
- Consider designating a school-health care liaison, who can effectively communicate and translate health information between the medical community, family, and school. Liaisons can be a school nurse, school psychologist, counselor, or administrator
- Create partnerships with universities or local department of public health to assist in program evaluation, data collection, and management. Data sharing to evaluate outcomes of programs, partnerships or clinical services is critical to sustaining a long-lasting partnership[37,38]

Primary Care

Primary care clinics with integrated behavioral services maximize behavioral health service delivery to patients where they are most likely to present. As health systems and individual practices attempt to initiate, maintain, or expand an integrated model, successful recruitment and retention of behavioral health providers becomes a priority. General principles in recruitment and retention efforts specific to integrated primary care clinical models include several core concepts. Although these principles are highlighted as they relate to integrated models, they are applicable to most if not all aspects of behavioral health workforce recruitment and retention strategies across settings, geographies, and provider types.

General principles in recruiting:

- One size does not fit all - adapt marketing strategies to the provider type you seek to recruit[39]
- Be willing to bypass potential employees if the fit is not right or if there is a sense that they are unwilling to stay
- Partner with state and local governments to facilitate cost of living adjustments[40]
- Be open to non-traditional demographics; approach recruits of various ages and career stages such as empty nest adults returning to the workforce[39]
- Partner with diverse community leadership organizations to pull from specific segments of the population[40]
- Hold job fairs during non-business hours to reach candidates that may be currently working but looking to switch fields[39]
- Give referral bonuses to staff who recruit new employees paced as the new employee stays on board, such as at the 6 month, 12 month, and 24 month mark[40]

General principles in retention:

- Create realistic Job Previews, do not undersell the magnitude of the work - videos, internships, volunteer programs, web-based presentations, meetings with current employees[40]
- Provide wellness activities as a long-term strategy in retention - ideas include lunch-hour yoga, local coffee shop drop-off, and guided meditation during staff meetings[39]
- Provide room for career growth; ask providers “if you were going to spend your career here what would that look like?”[39]

Learning from former providers:

- To maximize the learning potential in exit interviews, consider the following questions:[40]
  - When you began this job, how long did you plan to stay?
  - Why are you leaving?
  - Probe about salary, benefits, stress, career ladders, educational attainment, interpersonal issues, child care, transportation, paperwork
  - Are you planning to continue working in the mental health field?
  - What could our organization do to improve job conditions or hold on to employees?

Case examples of states with unique and effective approaches to recruitment and retention of behavioral health providers to integrated primary care settings are included in Appendix A.

As it relates to adequate allocation of providers across settings, risk stratification as a means to streamline access for consumers and aid in retention of workforce should be considered. That is to say, when the workforce distribution is more in line with clinical presentations based on severity, opportunities exist to increase work satisfaction and avoid burnout. More clinicians in primary care and school-based settings are able to see more patients of lower severity due to limited numbers of encounters, briefer episodes of care, and the chance to encounter high functioning individuals that demonstrate little to no need for behavioral health care. Such encounters can go a long way in retention, preserving providers' vulnerability to work stress, vicarious trauma, and burnout. Conversely, when providers have greater to ability to focus on fewer patients of higher severity, more intentional services to those fewer individuals allow providers to be less burdened with intake sessions, back-to-back therapy sessions and can utilize group psychotherapy to maximize clinical service hours. This, too, promotes retention due to less likely burnout.

Integrated Behavioral Health across the lifespan: Pediatric and Geriatric Needs

Limited access to pediatric behavioral health care is of significant concern. There are multiple barriers to accessing high-quality, evidence-based behavioral health care for children and adolescents, including stigma, family beliefs, significant shortages of child and adult behavioral health providers, and the separation of physical and behavioral health care in medical settings and schools, where children most often present. Behavioral health integration emphasizes pediatric behavioral health promotion, prevention, treatment and recovery, and includes parents and family in the education and continuum of care. The American Academy of Pediatrics (AAP) and the American Academy of Child and Adolescent Psychiatry (AACAP) reports multiple benefits of integrated behavioral health care in pediatric primary care settings, including the importance of behavioral health promotion, screening, assessment, and evidence-based treatment in pediatric medical homes. Models of pediatric integrated behavioral health that can be adopted include: consultation, allowing primary care physicians to access behavioral health resources (see Appendix A for case study); care coordination, that can serve a geographically broad and diverse population of children in need; collocated, and integrated, both which facilitate collaboration between primary care and behavioral health providers.[41,42] Integrated behavioral health in pediatric settings has been found to result in increased accessibility and family engagement in evidence-based interventions, reductions in barriers to care, and increased opportunities to reach a greater number of children and families in need of behavioral health services.[42]

Additionally, behavioral health is a significant healthcare problem for older adults.[43] There is also a need to identify and improve the use of evidence-based practices and other resources for serving older adults in integrated care. Evidence-based practices for older adults includes integrated behavioral health in primary care; behavioral health outreach services; mental health consultation and treatment teams in long-term care settings; the use of screening, brief intervention and referral to treatment (SBIRT) for the misuse of alcohol and prescription

medications; family and caregiver support interventions; and psychopharmacologic treatments. Improvements in access to and quality of behavioral health care for older adults in primary care settings can be achieved through the combination of physician and patient education, care management, and improved care coordination among behavioral health and primary care providers. Specific interventions shown to be effective in geriatric behavioral health care include monitoring of patients' progress (e.g., the use of standardized measures such as the Patient Health Questionnaire to assess depression) and system scheduling of routine follow-ups. In addition to primary care, models of service delivery include long-term care and specialty services in the community.[43]

OREGON EFFORTS:

- Collaborations between Coordinated Care Organizations, community mental health centers, and school-based health centers to integrate providers in schools
- Collaborations between school districts and behavioral health providers to develop agreements that allow sharing behavioral health resources or piloting telehealth programs
- CCO 2.0 policy recommendations to use metrics to incentivize behavioral health integration
- Local meetings, get-togethers, or journal clubs to promote interdisciplinary and interprofessional networking and learning
- Organizational efforts to overcome barriers to transformation and organizational stress

Recommendations for Action

GOAL: Allocate workforce across different practice settings to meet population needs (i.e., distribute workforce to match presenting need in school-based, primary care, and specialty community settings).

RATIONALE: Understanding provider distribution across clinical settings provides an opportunity to optimize patient care through alignment of patient acuity with the most appropriate clinical setting in order to maximize the efficiency of the current workforce.

SUMMARY OF RECOMMENDATIONS: Advance integrated care settings, such as schools and primary care, with supportive payment models and training opportunities.

1 Appropriately allocate workforce to practice setting, i.e., distribute clinicians to match patient need (severity and acuity), including efforts to integrate behavioral health clinicians into school-based and medical settings, to alleviate and reserve community mental health centers for severe mental illness
Implementer: OHA, CCOs, community mental health centers, state agencies, school districts

2 Improve delivery of behavioral health services in non-traditional health care and community settings

   a Integrate behavioral health providers into schools through CCO and community mental health center partnerships (scaling efforts happening in southern Oregon)

   b Improve staffing ratios to allow for the successful delivery of behavioral health services in schools. School professional associations recommend specific staffing ratios in schools, such as 1 school counselor to every 250 students

   c Support school-based programs to destigmatize behavioral health prevention and treatment services to increase use among students

   d Utilize community service locations such as libraries, community and recreation centers, and WIC officies to offer behavioral health providers and services

   e Utilize the Multi-Tiered System of Support (MTSS) to integrate behavioral health services into schools and establish community partnerships for referral services

   f Expand behavioral health services through increased staffing of providers in adult and youth correctional facilities
   Implementer: CCOs, community mental health centers, state agencies, school districts

3 Increase support for behavioral health provider services from physical health settings

   a Test payment models that support the expansion behavioral health integration into primary care in order to treat mild and moderate behavioral health conditions in the outpatient primary care setting

   b Support efficient behavioral health provider supply for acute settings including patient care and emergency rooms for severe behavioral health conditions

   c Support implementation of the OHA Primary Care Office's Healthcare Workforce Retention Toolkit adapted for licensed and unlicensed behavioral health providers

   d Develop continuing education opportunities for providers to become competent in the Core Competencies for Licensed Behavioral Health Providers Working in Ambulatory Integrated Settings

   e Develop peer mentoring programs for organizations and agencies to reduce turnover
   Implementer: Oregon Health Plan, CCOs, OHA, professional organizations, healthcare organizations

4 Support monthly meetings for multi-disciplinary learning and networking

   a Local journal club meetings are an example of multi-disciplinary networking and support
   Implementer: Healthcare organizations

5 Increase integrated training opportunities
Implementer: Education institutions

6 Compensate community-based settings that provide training for new behavioral health providers in their first year of practice, incentivize and support training sites
Implementer: CCOs, Oregon Health Plan

7 Expand telehealth reimbursement to include any site of origination
Implementer: CCOs, Oregon Health Plan

Provider Types

As the demand for behavioral health increases, with significant gaps in care among demographic groups and geographic locations, non-traditional behavioral health provider types are filling gaps in care across the country. This workforce is composed of peer workers, nurse practitioners, advanced practice registered nurses (APRNs), behavioral health physician assistants (PAs), advanced practice registered nurses (APRNs) and community health workers.

Development of career ladders to promote accessible programs to students and trainees of advanced practice providers in behavioral health is a strong recommendation in improving recruitment. Development of additional curricula, training programs, and certification or licensure procedures to address gaps in career ladders is an action item for this objective. Reviews of career pathways through educational, certification and licensing systems can help to facilitate this. The Alaska Behavioral Health Workforce Initiative can serve as a model for collaboration between behavioral and educational systems within states. Examples of such actions include creating distance-education programs accessible to residents of remote areas of the state and establishing a bachelor's-level social work program and a doctoral program in clinical psychology within the University of Alaska system.

Peer Workforce

Peer workers in behavioral health provide additional services and supports for organizations that serve individuals with mental health and addiction disorders. People in recovery and their family members should be recognized as pivotal members of the workforce whether through informal self-help and family caregiving or organized peer- and family-support services.[6] Peer Support Specialists and Peer Wellness Specialists outreach and build personal relationships with people experience behavioral health challenges; support people to become socially involved with others and build community; help navigate systems and plan for appointments; and promote recovery and resiliency and model a healthy recovery lifestyle.[44]

The peer workforce works across settings, including traditional behavioral and physical health care settings and community-based settings (examples include on Crisis Service Teams, either serving on mobile crisis teams or crisis stabilization units; in Medication-Assisted Treatment (MAT) for People with OUDs in which peer workers can provide support with ongoing services during MAT and help link people to services in the community; in criminal justice settings; supporting employment programs and; on Assertive Community Treatment (ACT) teams.[11]

Peer support has demonstrated effectiveness in supporting people with behavioral health conditions to across a continuum of care: promotion, prevention, treatment and recovery. Peer interventions have been found to increase the use of primary care over emergency services, reduce psychiatric rehospitalizations, and support patients to be active participants in their treatment plan in their treatment.[11,45-47]

Job growth for the peer workforce can be enhanced by strong consumer advocacy groups, increased insurance through Medicaid expansion, SAMHSA administrative grant programs, hiring mandates, as has been shown through various case studies.48 Additionally, better tracking of employment rates of peer providers would assist in workforce planning across states. Streamlining of training and certification standards across states (such as through the International Certification & Reciprocity Consortium) will support peer providers in being certified across states and enhance peer provider status and quality of care.[48]

Strategies to improve retention and job satisfaction of peer workers can include:[11]

- Organizational values indicating readiness to hire peer workers and commitment to hiring diverse individuals
  - Recovery-oriented mission of the organization
  - Defined peer roles and clear job descriptions for peer workers
  - Equitable wages and benefits packages for peer workers
- Incorporate recovery-oriented values across organization policies such as organizations:
  - Confidentiality policies and practices
  - Inclusive hiring policies and practices
  - Policies that ensure routine performance evaluations that reflect peer worker's role
- Staff knowledge and attitudes about recovery
  - Recovery is possible
  - Knowledge about the benefits of peer support
  - Continued development of understanding of peer support
  - Addressing staff prejudice about people with behavioral health conditions
- Supervision and support of peer workers
  - Recovery-oriented and trauma informed supervision and support

See Appendix B for specific recovery-oriented values and key ingredients published by SAMHSA during their National Summit on Recovery. Refer to case study on the integration of BRSS-TACS development by Massachusetts' Interagency Council on Substance Abuse and Prevention for how to build these values into a recovery-oriented system (Appendix A).

Addressing systemic barriers to entry into the workforce: Background checks

The existence of a criminal record and criminal background check procedures creates long-lasting barriers to employment, particularly for individuals of color. Although employers have a perceived need for criminal background checks, employers may have difficulty understanding and interpreting criminal records as they are laden with technical language and abbreviations. Examples include differences between arrests and convictions and arrest-only records.[49] Additionally, employers and agencies may be uninformed about the laws protecting applicants from discrimination.[50] Since arrests that often do not lead to a conviction are known to disproportionately involve persons of color, this poses a significant continuation of racial disparities in the U.S. by impacting employment and housing opportunities for persons of color.[51]

Criminal background checks are considered a challenge and barrier that negatively impact the peer workforce in behavioral health. Criminal background checks serve as an entry barrier into the workforce that eliminates some qualified peer staff. Some individuals in recovery who are qualified to be peer providers may fail background checks for a number of reasons (arrest-only records, criminal history with drugs or alcohol) and are ultimately not hired.[52,53]

It is recommended that more information is needed regarding criminal background checks or instances in which a prospective peer provider fails a background check (e.g., the individual may have been arrested but not convicted, convicted by not incarcerated, or convicted or a non-violent crime). Oregon led the west coast's adoption of "Ban the Box" legislation, prohibiting employers from asking about arrests and convictions on job applications. Portland's ordinance also prohibits employers from asking during the interview process and prevents certain information from being considered once a background check is conducted after a conditional offer is made. Portland employers are prevented from considering: 1) an arrest not leading to a conviction, except where a crime is unresolved or charges are pending; 2) convictions that have been judicially voided or expunged; or 3) charges not involving physical harm or attempted physical harm that have been resolved through the completion of a diversion or deferral of judgement program. Local ordinances such as these may be studied for workforce implications and decisions to scale state-wide.

Agencies can work with human resources (HR) to review procedures on background checks to see if it will exclude peers from being hired based on their criminal history. Agencies and behavioral health organizations may also look into state requirements or appeals processes that can be filed so that the individual can be hired despite information uncovered in a criminal background check. Rather than only considering whether or not the individual has a criminal history, arrests without convictions, conviction without a term of incarceration, or conviction of a non-violent crime may warrant alternative best practices related to criminal background checks. Policies and procedures that can tailored to the essential requirements of the job and the circumstances under which the job will be performed should be adjusted to reduce this barrier. It should be noted that adjustments to policies on criminal background checks should be job-related for the position and consistent with agency or organization necessity.[52] Agencies can use the U.S. Equal Employment Opportunity Commission (EEOC) Enforcement Guidance to determine and guide adjustments to criminal background procedure policies.[50]

Community Workers

The increased use of "promotores de salud" (community health promotors) or community health workers has been seen in the medical field to help meet the increasing demand for behavioral health care. According to the American Public Health Association, promotores are "frontline public health workers who are trusted members of and/or have a close understanding of the community served. This trusting relationship enables community health workers to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. Community health workers also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support, and advocacy." Community health workers, or promotores can draw on lived experience and experiential knowledge to support better health outcomes and promote recovery for individuals in the community with mental illness and substance use disorder.[54,5555]

Community health workers are local residents trained in a variety of tasks, including conducting outreach, basic health care, health promotion groups, and interpretive services. Training of entry level workers requires strategies such as mentoring, in-service training, additional education, tuition assistance, loan forgiveness, and apprenticeship opportunities. Supports such as these enable workers to progress up a career ladder.

The provision of the Prevention and Early Intervention component of the Mental Health Services Act (MHSA) in California allows for funding opportunities for supporting and expanding the use of promotores in the behavioral health workforce. See Appendix A for a case study on the use of promotores in California.

Behavioral Health Advanced Practice Providers

Nurse Practitioners

A focus on underutilization of psychiatric mental health nurse practitioners (PMHNPs) and behavioral health nurse practitioners, that deliver behavioral health care in the workforce has occurred in the literature, indicating this can be addressed as a component in improving workforce.[56] Behavioral health nurse practitioners diagnose and treat acute, episodic, or chronic behavioral health-related illness, either independently or as a part of a broader health care team. PMHNPs or behavioral health nurse practitioners can help address behavioral health workforce shortages as they receive graduate mental health training in diagnostic assessment, psychotherapeutic and pharmacologic management of psychiatric disorders, and evaluation of physical health conditions. Several studies have found that behavioral health care provided by PMHNPs is high quality and leads to positive behavioral health outcomes.[57-59] Barriers to full utilization of psychiatric mental health nurse practitioners include system-level barriers to hiring PMHNPs, lack of role-appropriate job descriptions, confusion related to scope of practice/ supervision requirements, and challenges in recruitment and retention.

Behavioral Health PAs

Behavioral health PAs provide health care services under the supervision of a physician. Behavioral health PAs may perform psychiatric evaluations and assessments, order and interpret diagnostic studies, counsel patients, develop and manage treatment plans, and order referrals. They may also prescribe psychotropic medication. Behavioral health PAs in psychiatry and mental health can help to improve access to behavioral health services in areas in which physician shortages exist. Training PAs to become more comfortable in psychiatric and mental health settings can increase access to behavioral health treatment for individuals with gaps in access. The integration of behavioral health PAs into psychiatric teams can help to improve the quality and access to primary and psychiatric care.[60] Additionally, behavioral health PAs may help to improve continuity of care by extending psychiatric services by working with psychiatrists, leading to better patient care.[61] States have begun to enact laws that allow for the delegation of behavioral health and psychiatric services to PAs in efforts to address the significant gaps in care that exist due to the shortage and geographic maldistribution of the behavioral health workforce. This delegation imposes certain risks and responsibilities on psychiatrists who chose to supervise PAs with behavioral health caseloads, requiring psychiatrists to understand regulatory responsibilities of supervision.[62] See Appendix A for state case studies and recommendations regarding responsibilities when states allow for this delegation.

OREGON EFFORTS:

- Certification for peer delivered services for billing purposes
- Clinics and CCOs employing Traditional Health Workers (e.g., Yamhill CCO)
- Training programs for non-physician students in rural and underserved areas

Recommendations for Action

GOAL: Increase number of licensed and unlicensed behavioral health workforce providing direct services.

RATIONALE: Shortages exist at every tier of the behavioral health service industry. The variety of provider types required to deliver comprehensive and effective behavioral health services includes prescribers, licensed providers, and unlicensed providers. Together, the behavioral health workforce works in concert to comprehensively address patients' needs, providing services for prevention and health promotion, treatment, and recovery.

SUMMARY OF RECOMMENDATIONS: Promote roles of Traditional Health Workers, Qualified Mental Health Associates, and Qualified Mental Health Professionals; maximize use of psychiatric advanced practice providers; and reduce administrative barriers for licensed providers applying for licensure from out of state.

1. Increase Traditional Health Worker workforce
   a. Create plans for integrating and utilizing THWs (as part of integrated healthcare teams, assertive community treatment teams, non-clinical care settings, etc.)
   b. Establish alternative payment models with sustainable rates for THW services

   Implementer: CCOs, OHP, Traditional Health Worker Commission
2. Further professionalize the role of Qualified Mental Health Associates and Qualified Mental Health Professionals through standardized training programs and development of manuals on billable services

   Implementers: OHA, MHACBO
3. Maximize the use of psychiatric advanced practice providers (NPs and PAs)
   a. Recruit with appropriate job descriptions to ensure maximum scope of practice
   b. Clarify scope of practice and supervision requirements to full care team during onboarding processes

   Implementers: Healthcare organizations
4. Maximize the use of peer workers
   a. Standardization of the certification to become a peer worker would enhance peer provider status and ensure high quality of care among agencies and states.
   b. Training of peer workers should also be streamlined across states, and can be done through resources such as the International Certification & Reciprocity Consortium
   c. Reduce administrative barriers, including ongoing reforms for how background checks are used in hiring practices

d Expand engagement of community health workers through certification, training, and reimbursement

e Utilize expertise of the OHA Office of Consumer Activities and community partners to further explore issues related to the peer-delivered services workforce and develop strategies to address.
Implementers: OHA, CCOs, OHP, Traditional Health Worker Commission, Healthcare organizations, community partners

5 Reduce administrative barriers for licensed providers applying for licensure from out of state
Implementers: OHA, licensure boards

Aligning Patient and Provider Characteristics and Needs

Minority Recruitment and Retention

Racial and ethnic disparities in unmet need and access to behavioral health services currently exists and has not improved over time. Findings of recent literature point to workforce planning that may improve availability of behavioral health for underserved populations.

Geographic contexts are part of explanatory variables that limit access to behavioral health services for minority groups, but other factors also contribute in a cumulative manner such as: patient literacy and health literacy, health insurance coverage, greater language needs, differential referral practices to specialty care, and other cultural barriers.[63,64] Therefore, diversifying the behavioral health workforce could ameliorate some of the root causes of health disparities, such as greater diversity in language ability to address patient need.

Health care delivery systems need to ensure a sufficient workforce of behavioral health care specialists and diverse providers within communities.[64] The current behavioral health workforce contributes to current disparities in mental health and substance use treatment and services because of its lack in diversity.[65] For example, substance abuse disorder treatment workforce is primarily female, older, Caucasian, differing from their predominately young, male, and minority clientele.[65] Minority populations are significantly underrepresented in health care professions (e.g., there is a substantial shortage of Latino professionals working in behavioral health) and this disparity is even more prevalent in rural, border and frontier areas of the nation.[66-68] The key to delivery of culturally and linguistically competent services is a diverse workforce.

"Understanding the cultural and historical experiences of various groups and examining how patient characteristics such as socioeconomic status, ethnicity, health beliefs, and language influence service are essential to the treatment of mental and general medical disorders." (p.2)[67]

Cultural and Linguistic Competency

Cultural and linguistic competency in the delivery of behavioral health services for racial and ethnic minorities is a crucial aspect in access and quality of patient care. Language significantly affects accurate screening, diagnosis and treatment of mental and medical disorders. Limited English proficiency (LEP) is associated with lower mental health service use and is particularly concentrated among Latino and Asian populations.[33,69] Having a health provider that does not speak the patient's primary language significantly contributes to lack of patient satisfaction, poor patient education and poor understanding of their disorders. Additionally, patient-provider language barriers may lead the patient to perceive that the provider lacks respect and interest.

Furthermore, as in Oregon, the demographic composition of the United States behavioral health workforce does not match the demographic composition of the general population. Pairing ethnic minority clients seeking behavioral health treatment with therapists that share the same ethnic background can increase treatment utilization, lower rates of drop out, and facilitate the discussion of sensitive and private issues more so than when there is not a patient-provider match.[70] Patients seem to have a preference for bilingual providers over the use of interpreters, whom may impede the therapeutic alliance. The benefits of bilingual providers include greater privacy, a sense of trust, and accuracy of communication. However, interpreters increase access to services and facilitate communication with providers in the absence of bilingual providers.[7]

Findings are mixed in the literature regarding patient outcomes of provider-patient racial and ethnic match in behavioral health services. Although enhancing client-therapist cultural similarity may strengthen the therapeutic relationship and improve therapeutic outcomes, data from several meta-analyses indicates mixed findings.[71-74] These findings may be related to lower access and less utilization of behavioral health services among patients who prefer linguistically- or culturally-similar providers making this phenomena more difficult to study.

Training approaches to build cultural competence of the behavioral health workforce can include: diversity courses, practicum placements, and externships and internships that provide mentoring, supervision, and direct clinical experiences with racial and ethnic minority populations. Financial aid, organizational links with historical institutions of color, involvement of existing minority faculty and minority students in recruitment efforts, establishing a critical mass of students of color, and having opportunities for students to engage in research on diversity issues with faculty are other recruitment and retention strategies. Recommendations to increase cultural competency of the current behavioral health workforce may include: dissemination of standards and tools for culturally competent practice; increase in cultural competence of interpreters used in delivering services through the development of standards, training models, reimbursement strategies, and workplace environments that are conducive to a diverse workforce.

Another strategy for diversifying the behavioral health workforce is to ensure that a diverse population of students are enrolling in and graduating from behavioral health training programs, which is currently not the case. Across the U.S., the student body of psychologists in training is predominately white (64.5%) and female (77.3%). About one third of students are underrepresented minorities.[75,76] Expanding educational pipelines for culturally and linguistically competent professionals entering the behavioral health field can increase the diversity of the future workforce. Within existing graduate programs, factors for improving student body diversity include measuring and tracking student demographics, recruiting diverse students, and retaining those students until they complete the training program. Graduate programs in behavioral health can attract students from diverse backgrounds by establishing educational pipelines to recruit and provide resources for aspiring students in behavioral health careers. The use of workshops, lectures or internship opportunities can help to facilitate this and target both graduate and undergraduate students of minority populations. Targeting undergraduate programs with higher-than-average minority populations (such as universities and Hispanic serving institutions) for these pipeline partnerships can help to increase the rate of students with diverse backgrounds applying for partnered doctoral programs. Retention of students from diverse backgrounds in education

programs is a crucial component of diversifying the behavioral health workforce. Barriers to retention include the cost of these programs, financial competition from other programs, and lack of support services they can offer students. To better support these programs, states can increase resources of universities by allocating more taxes towards higher education within the state (contingent on these programs expanding their support services, or offering grants tied to the expansion of student support services). Financial aid incentives (e.g., stipends and offering students health care) can be used as a method of recruitment and retention of diverse students to assist in any cost of living adjustments. Programs can also assist and support students in applying for scholarship and fellowship programs (e.g., SAMHSA's Minority Fellowship Program seeks to increase the number of minorities working in healthcare to better match that of representative populations served by health care). Efforts to diversify faculty and staff of graduate programs in behavioral health will also help to retain students, promote success in graduate school and ultimately increase diversity in the workforce, as lack of ethnic diversity within faculty, staff and student body are cited as barriers to recruitment of diverse students into these training programs. Programs can also facilitate networking and connections between diverse doctoral students and employers in the field.

OREGON EFFORTS:

- CCO collaborations with local hospital to hire a recruiter
- George Fox University cultural competency program

Recommendations for Action

GOAL: Develop and support a behavioral health workforce that aligns with patient characteristics and needs.

RATIONALE: There are demographic disparities between the behavioral health workforce and the population of Oregon. Identification of patient characteristics and needs can inform interventions and incentives aimed to align Oregon's BH providers with the population it serves.

SUMMARY OF RECOMMENDATIONS: Implement multiple recruitment and retention strategies to increase the behavioral health workforce diversity and better address pediatric behavioral health needs. Grow interest in the behavioral health profession through marketing campaigns, educational programs, and career opportunities. Ensure recruitment efforts are reaching diverse populations.

1. Create workplace environments that are conducive to a diverse workforce
    a. Ensure current workforce completes a cultural responsiveness training in accordance with House Bill 2611
    b. Support programs that attract providers from minority ethnic backgrounds including Hispanic, Asian, and Native American tribes, and African Americans to reflect local demographics

c Incentivize clinics to employ hiring practices which result in a professional staff that mirrors their local community

Implementer: Healthcare organizations, OHA

2 Increase cultural competence of interpreters used in delivering services through the development of standards, training models, and reimbursement strategies
Implementer: Healthcare organizations, OHA

3 Establish and expand educational pipelines and partnerships with community colleges and universities to recruit and prepare students of diverse cultural and linguistic backgrounds and from underrepresented backgrounds for careers in behavioral health

a Expand funding for educational capacity, stipends, scholarships, and internship opportunities

b Encourage and support diversity courses, practicum placements, externships, and internships that provide mentoring, supervision, and direct clinical experiences with racial and ethnic minority populations for trainees going into behavioral health professions.

c Recruit and support college students, including community college students, from underrepresented regions and backgrounds to pursue behavioral health careers.

d Provide financial aid opportunities and organizational links with students at historical institutions of color.

- Support scholarships for qualified students who pursue behavioral health profession and serve in underserved communities.
- Expand funding for educational capacity, stipends, and scholarships to strengthen the size, distribution, and diversity of the behavioral health workforce.
- Expand loan repayment programs (LRPs) for behavioral health clinicians practicing in underserved communities.

e Conduct research to measure and track demographics of students training for behavioral health careers.

f Involve existing minority faculty and minority students in recruitment efforts, establishing a critical mass of students of color, and having opportunities for students to engage in research on diversity issues with faculty are other recruitment and retention strategies.

Implementer: Educational institutions, OHA, healthcare organizations

4 Increase residency and postdoctoral fellowship opportunities for pediatric behavioral health providers (child and adolescent psychiatrists, developmental pediatricians, developmental and child psychologists)

Implementer: Educational institutions

5 Develop consortiums that involve multiple agencies to allow organizations to pool recruitment resources and candidates for behavioral health positions. Promote creative candidate searching to improve workforce diversity:

a Partner with community organizations and chambers of commerce to host after-hours job fairs

Conclusion

These recommendations can be used to influence and direct decision-making of key implementors and partners, including OHA and other organizations across the state. The recommendations laid out in the current report will assist in meeting the common goals of behavioral health service providers at state and local levels, including improving equitable diversity and geographic distribution of the behavioral health workforce across the state, better alignment with population characteristics, allocating appropriate workforce across practice settings to meet population needs, and expanding licensed and unlicensed professionals within the behavioral health workforce.

In combination with the workforce analysis, Oregon has the ability to significantly impact the delivery of behavioral health services by expanding, adapting, and diversifying the behavioral health workforce.[2] The workforce analysis indicates a significant need for more equitable distribution of behavioral health providers across rural geographic regions of the state and among underserved populations. In order to improve access to quality behavioral health services for these populations, expansion of the current behavioral health workforce to include a greater number of licensed and unlicensed provider types among community-based practice settings is necessary.

Application of the findings of the workforce analysis as well as recruitment and retention efforts are already underway in Oregon. Oregon's current efforts include utilization of creative financial incentives, such as the Healthcare Provider Incentive Program and training programs at George Fox University to create an interprofessional workforce and promote cultural competency. Collaborations between Coordinated Care Organizations, community mental health programs, school-based health centers and school districts help to efficiently utilize and integrate the behavioral health workforce into community-based practice settings. Additional efforts to support the behavioral health workforce that are ongoing include encouragement of local get-togethers, meetings, or journal clubs to promote interdisciplinary networking and support, and the use of training programs and employment of traditional health workers to utilize the current behavioral health workforce more efficiently.

Oregon has already taken steps to meet the challenges of increasing access to and quality of care for their populations in need of behavioral health services; the evidence-based and outcome-oriented recommendations delineated in this report provide strategies to advance and support continuation of recruitment and retention efforts. By doing so, behavioral health organizations and providers in Oregon will be better able to meet the needs of underserved populations.

Appendix A. Case Studies

New Mexico Workforce Plan

Data obtained from the Health Care Work Force Data Collection, Analysis, and Policy Act enacted in 2011 in New Mexico (NM), combined with discussions with Behavioral Health Workforce Workgroup, has allowed NM to begin strategic planning to address behavioral health shortages.[77]

Findings from the analysis included: a need for behavioral health workforce planning at the state level; a need to integrate behavioral health into primary care to follow national trends; a scarcity of social workers and counselors in rural areas and; a need to address shortages through both improved recruitment and retention of behavioral health professionals.[77]

Corresponding action items based on findings from the analysis include:

- The creation of an 18-month strategic plan to address workforce issues. The Behavioral Health Workforce Workgroup included statewide stakeholders through a new expansion of the workgroup
- Enhancement of behavioral health services by several state federally qualified health centers and piloting of integrated behavioral health in Health Homes for individuals with serious mental illness (SMI)
- The Behavioral Health Services Division initiated a pilot of telehealth supervision to rural clinicians by adjusting clinical supervision requirements by professional licensing boards
- NM's state legislature passed NM 2016 Senate Bill 105 that expedites licensure of applicants who are licensed in good standing in other jurisdictions in the country, resulting in the reduction of administrative barriers for qualified clinicians applying from other states
- In order to increase retention of providers in rural areas, NM House Bill 54 was passed in 2016 that adds professions, such as social workers and counselors, to the list of eligible providers who receive state tax credits when providing behavioral health care in rural communities

NM Medicaid also increased reimbursement rates by 12.5% in fiscal year 2015 in an effort to reduce administrative burden due to the high level of documentation required when providing services to individuals through state-regulated agencies, such as community mental health centers.[77]

NM is also one of five states where prescribing psychology is currently approved. Prescribing psychology or medical psychology allows psychologists who complete additional training in prescribing medications may prescribe to patients. Prescribing or medical psychology is a postdoctoral specialty that integrated evidence-based psychological principles with medical science to diagnose and treat mental disorders.[78] The State Psychologist Association (SPA) of New Mexico is the professional association for NM's Medical/Prescribing Psychologists and reports that there currently 64 New Mexico licensed or conditional prescribing psychologists located around the state. NM requires a minimum of 450 hours of didactic instruction along with a 400-hour supervised practicum as eligibility criteria to become a

prescribing psychologist. Prescribing psychologists can help meet the need and demand for psychiatrists in areas where psychiatry is limited or oversaturated; they may also be able to better support under-served communities by allowing patients to receive both psychotherapeutic and psychopharmacological treatment through one professional.

NM also displays effective recruitment and retention of behavioral health providers into integrated primary care settings by utilizing the following strategies:

- Adjusting clinical supervision requirements to allow for long-distance and tele-supervision to pre-licensees who are providing clinical support already. This facilitates career promotion from their current location and shows administrative support for their individual career advancement goals
- Telehealth supervision is also providing intentional support to providers in rural locations to combat professional isolation and support when navigating multiple interpersonal and professional roles with patients in a small-town setting
- Passed a house bill to make social workers and counselors eligible for rural practice state tax credits

Integrated Behavioral Health in Primary Care

In addition to NM, case examples of states with effective approaches to recruitment and retention of BH providers to integrated primary care settings include the following states:

Kansas

- Used “life style” recruiting approach- advertising in outdoor and bicycling magazines to reach individuals who might be interested in specific lifestyle activities commonly practiced in the region for which they were recruiting[39]

Washington[79]

- Working to expand the professions whom are eligible to bill as behavioral health providers within integrated primary care settings
- Training and deploying entry level providers in primary care and BH to support health team efforts in community health settings
- Compensate community-based settings that provide training for new BH providers in their first year of practice, incentivize and support the training sites

North Carolina

- Monthly blog written by local providers to dispel myths, and answer a milieu of questions about their region including the following questions[80]
  - What are the best cultural events in your state?
  - Are healthcare professionals valued in your state? Do you have any examples?
  - Why do people travel to your state?

  - What is the biggest misconception about your state?
- Website from the state's central placement agency to circulate positive feedback from successful placements on their website encouraging clinics to advertise their vacancies[81]

Massachusetts' Model of Pediatric Integrated Behavioral Health

The Massachusetts Child Psychiatry Access Project (MCPAP) is a prominent model of consultation to integrate behavioral health into pediatric health care settings. Once enrolled with MCPAP, primary care pediatricians can access behavioral health resources when they have a behavioral health concern. An initial phone consultation with a child psychiatrist is followed by an in-person clinical assessment, brief therapy, or facilitated referral to specialty mental health within the community. MCPAP has regional teams of child psychiatrists, licensed therapists, care coordinators, and administrative support throughout Massachusetts.[41]

Massachusetts' Bridging Recovery Supports to Scale (BRSS-MASS)

Collaboration between behavioral health peer workforce, state agencies and provider agencies through BRSS-MASS resulted in five recommendations within the following categories to initiate and maintain recovery oriented behavioral health services within developing and new models of integrated care delivery: 1) Person- and Community-Level Integration, 2) Systems-level integration, 3) Provider-level integration. Selected examples are included below.[82]

1 Recognize the peer workforce as essential elements of healthcare delivery.

   a Person-community level:

      – Continue to host and support leadership meetings that include representatives from peer communities, Department of Public Health, Department of Mental Health, the Office of Medicaid, primary health providers, behavioral health providers, and academic partners.

   b Provide-level:

      – Peer workers should be meaningful members of treatment teams and care coordination efforts responsible for caring of people with behavioral health conditions.

      – Training on the role of peer workers should involve entire treatment teams, not just specific professions.

   c Systems-level:

      – Host workshops on the roles and benefits of peer recovery workers in healthcare models. Workshops should invite individuals from care organizations, state agencies, behavioral health providers, community health centers, mental and health home providers, systems leaders, and any other necessary stakeholder or individual.

2 Through new models of integrated care, develop a comprehensive, recovery-focused system of care for people with co-morbid mental health and substance use disorders.

   a Person-community level:

      – Educate stakeholders on the prevalence of comorbid mental health and substance use disorders and associated barriers to receiving effective treatment.

b Provider-level:

- Provide specific guidance on providing effective co-occurring services that are reflective of recovery principles.
- Develop provider training protocols that are reflective of evidence-based recovery practices.

c Systems level:

- Identify strong practices within state (Massachusetts) that can be replicated and scaled for widespread practice.

3 Sustain and improve the quality of peer recovery supports within the state, including peer-run recovery centers and communities.

a Person-community level:

- Address the need for universal access, inclusion, and cultural competence through the development, training, and implementation of peer workforce.

b Provider level:

- Require that every peer specialist interact regularly with a Certified Peer Specialist or Recovery coach supervisor and peer colleagues, as well as receive regular supervision (See full report for definitions of types of Peer Recovery Workers).

c Systems-level:

- Clarify and promote standards for Certified Peer Specialist and Recovery Coaches, including expectations for supervision and best practices.
- Provide opportunities for recovery centers and communities to collaborate.

4 Establish policies for the successful integration of peer workers and recovery coaches in all healthcare delivery models.

a Person-community level: Through Steering Committee, develop and support best practices around culture change amongst providers; access to information and technical assistance of peer workers (e.g., sample job descriptions, supervisor orientation); understand and emphasize the importance of consumer choice in receiving and peer worker during treatment; and hiring processes, such as use of benefits and accommodations in regards to work goals of organization, with appropriate utilization of Human Resources to support employment success.

b Provider and Systems Levels:

- Share information with diverse stakeholders within different models of care, such as Primary Care Providers, Health Home Providers, Accountable Care Organizations, and Behavioral Health Providers.
- Create opportunities for collaboration between peer workers and community health workers.

5 Develop a culturally competent peer workforce that represents the community it is serving.

   a Work with individuals from diverse communities to test values involved in development and training efforts.

   b Actively seek planning partners from groups and communities that are underrepresented in the community to address barriers to access to behavioral health treatment and recovery.

Promotores de Salud in Califorina[83]

Promotores de salud (health promoters) are particularly effective in reaching underserved individuals and families in their community. In California, promotores have been indicated to play a significant role in the Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA). Through this initiative, funding opportunities can expand and support the use of promotores in behavioral health. The PEI component specifically provides a niche for promotores to have a significant role in the community, including serving the mission of the PEI component of MHSA of transforming the public mental health system to support people before they become devastated by the effects of mental illness. Hispanics in California are one underserved population that face unique challenges that promotores can assist with, such as problems with housing, problems with immigration and acculturation, linguistic barriers, and lack of culturally competent care. Additional barriers to accessing services for Hispanic individuals may include not knowing how to navigate systems, not having the necessary documentation required to access services, and scarcity of services. In an effort to increase the proportion of Hispanics in the behavioral health workforce, promotores in Hispanic communities can address some of these systematic barriers and integrate behavioral health services into the community. As a result of MHSA requirements, counties in California have begun to integrate promotores services within different departments in order to fund this workforce, such as through Community Services and Supports. Opportunities and involvement of promotores in Prevention and Early Intervention include:

- Provide emotional support to individuals and families
- Facilitate support groups
- Provide mental health and substance use education to address challenges members of their community face
- Provide self-help training
- Identify and refer people in need of additional services
- Offer support for accessing resources and navigating systems

Recommendations for the implementation of promotores integration into public mental health from this California report include:

- Collaborate and contract with organizations that have historical ties and are trusted by communities in order to ensure community access to promotores will be met
  - Partnering with an organization that has experience supporting promotores can help with identification and selection of local organizations that could support a promotores program, instead of building a new promotores program from the ground up with
  - Conduct a community assessment of existing organizations that integrate promotores in their services (e.g., behavioral health, primary care, social services) to learn about existing programs and how they connect with the community
- Provide sufficient, inclusive, and flexible funding to support the ongoing training, supervision, evaluation, and time spent by promotores in the program
  - Allow for funding to cover costs of providing services, including transportation, communication, educational materials, and meeting supplies
- Fund and support capacity building in any new program that incorporates promotores or community workers

Creative Candidate Searching: Virginia and Kansas

In order to improvement recruitment efforts in mental health and disabilities workers, the state of Virginia connected with the Hispanic community through the Hispanic Chamber of Commerce. They held a Hispanic job fair that included translation of recruitment materials into Spanish and made announcements at local Catholic churches. Virginia also scheduled job fairs after hours (4-9pm) to reach individuals currently working but intending to switch jobs or fields.

Kansas adopted a “lifestyle recruiting” approach by advertising in outdoor and bicycling magazines to find potential candidates that may be attracted to lifestyle benefits of working in Kansas City.

The Maryland Training Consortium

The Maryland Training Consortium on Mental Illness is a coalition that includes family advocates, consumers, mental health service providers, and academic representatives from the community college and university levels. The consortium meets to share information about mental health education and resulted in the development of new graduate and undergraduate courses on treating persons with severe mental illnesses to better prepare the future workforce.

Vermont’s PAL/HRD Initiative

The Public-Academic Linkage/Human Resource Development (PAL/HRD) initiative merged the expertise of the Mental Health Division of the Vermont Department of Mental Health and Developmental Disability and the University of Vermont. This consortium resulted in working groups development new courses at community college, university and graduate levels, as well as creating public mental health internships for graduate students.

State Delegation of Mental Health Services by Behavioral Health PAs: Case Examples[62]

Kentucky

In Kentucky, psychiatrists may actively supervise up to four PAs at any one time. PAs are allowed to practice in separate locations as long as the supervising psychiatrist is able to communication with the PA, which can be done through telecommunication. The state medical board requires a written request by the PA in the separate location, with information about the distance between the primary office and separate location and the means of availability of continuous direct communication between the supervising psychiatrist and the PA. Supervising psychiatrists are required to review and co-sign at least 10% of the medical notes written by the PA every 30 days. The supervising psychologist must also reevaluate the PA every two years for approval or disapproval of PA licensure renewal to the state medical board. Supervising psychiatrists are also responsible for the monitoring of the scope of practice of the PA and ensuring that PAs limit their practice to what as submitted and approved by the state medical board of Kentucky. Supervising psychiatrists are responsible for prohibiting the prescribing of controlled substance by PAs. Supervising psychiatrists also have notifying responsibilities, such as notifying patients that they are being treated by a PA.

Alabama

In Alabama there is no limit on the number of PAs that a psychiatrist can supervise, but there is a limit on the cumulative number of hours that the physician assistants supervised by one psychiatrist may work. The cumulative weekly work time for all PAs supervised by a supervising psychiatrist may not exceed 120 hours. The supervising psychiatrist must provide direct, continuous and close supervision of the PA, and may be available by telephone or telecommunication. Supervising psychiatrists do not need to be onsite to supervise PAs, although off-site supervision is subject to additional requirements (e.g., receipt of “daily status reports”; visit the site 10% of the time during regular business hours that the PA is present, not less than quarterly; etc.). Supervising psychiatrists must also be available for consultation or referrals of patients from the PA. When the supervising psychiatrist is unavailable, the PA may practice only if an alternate supervising psychiatrist can supervise.

Appendix B. Recovery-Oriented Values and Key Ingredients

Essential elements of a recovery-oriented system identified at the National Summit on Recovery:[84]

1. Person-centered
2. Family and other ally involvement
3. Individualized and comprehensive services across the lifespan
4. Systems anchored in the community
5. Continuity of care (pretreatment, treatment, continuing care, and recovery support)
6. Partnership/consultant relationship, focusing more on collaboration and less on hierarchy
7. Strengths-based (emphasis on individual strengths, assets, and resilience)
8. Culturally responsive
9. Responsive to personal belief systems
10. Commitment to peer recovery support services
11. Inclusion of the voices of individuals in recovery and their families
12. Integrated services
13. System-wide education and training
14. Ongoing monitoring and research
15. Outcomes-driven
16. Based on research
17. Adequately and flexibly financed

Key ingredients to recovery-oriented systems:[84]

1. There are many pathways to recovery
2. Recovery is self-directed and empowering
3. Recovery involves a personal recognition of the need for change and transformation
4. Recovery is holistic
5. Recovery has cultural dimensions
6. Recovery exists on a continuum of improved health and wellness
7. Recovery emerges from hope and gratitude
8. Recovery involves a process of healing and self-redefinition
9. Recovery involves addressing discrimination and transcending shame and stigma
10. Recovery is supported by peers and allies
11. Recovery involves (re)joining and (re)building a life in the community
12. Recovery is a reality

References

1. Beck AJ, Manderscheid RW, Buerhaus P. The Future of the Behavioral Health Workforce: Optimism and Opportunity. In: Elsevier; 2018.
2. Hemeida S, Brou L, Petterson S, et al. *An Analysis of Oregon's Behavioral Health Workforce: Assessing Capacity of Licensed and Unlicensed Providers to Meet Population Needs.* Farley Health Policy Center March 2019 2019.
3. *The State of Mental Health in America.* Alexandria, Virginia: Mental Health America;2018.
4. Oregon Health Authority. *Behavioral Health Collaborative Report.* Avaliable at: https://www.oregon.gov/oha/HSD/BHP/Documents/Behavioral-Health-Collaborative-Report.pdf: Oregon Health Authority;2016.
5. Abou-Setta Aea. Methods for developing evidence reviews in short periods of time: a scoping review.
6. Hoge MA, Morris JA, Daniels AS, Gail SW, Leighton HY, Adams N. *An Action Plan for Behavioral Health Workforce Development: A Framework for Discussion.* The Annapolis Coalition on the Behavioral Health Workforce;2007.
7. Villalobos BT, Bridges AJ, Anastasia EA, Ojeda CA, Hernandez Rodriguez J, Gomez DJPS. Effects of language concordance and interpreter use on therapeutic alliance in Spanish-speaking integrated behavioral health care patients. 2016;13(1):49.
8. Kadis J. Workforce planning: how to recruit and retain mental health workers.
9. Recruitment & Retention. https://www.integration.samhsa.gov/workforce/recruitment-retention. Accessed.
10. Robiner WN. The mental health professions: Workforce supply and demand, issues, and challenges. *Clin Psychol Rev.* 2006;26(5):600-625.
11. Gagne CA, Finch WL, Myrick KJ, Davis LM. Peer workers in the behavioral and integrated health workforce: opportunities and future directions. *Am J Prev Med.* 2018;54(6):S258-S266.
12. Rural Healthcare Workforce. Rural Health Information Hub. https://www.ruralhealthinfo.org/topics/health-care-workforce. Accessed.
13. Andrilla CHA, Patterson DG, Garberson LA, Coulthard C, Larson EH. Geographic variation in the supply of selected behavioral health providers. *Am J Prev Med.* 2018;54(6):S199-S207.
14. Ellis AR, Konrad TR, Thomas KC, Morrissey JP. County-level estimates of mental health professional supply in the United States. *Psychiatr Serv.* 2009;60(10):1315-1322.
15. Domino ME, Lin CCC, Morrissey JP, et al. Training psychologists for rural practice: Exploring opportunities and constraints. 2019;35(1):35-41.
16. Hartley D, Nancy P, Loux M, Stephenie L. Are advanced practice psychiatric nurses a solution to rural mental health workforce shortages? 2004.
17. Chaple MJ, Freese TE, Rutkowski BA, et al. Using ECHO clinics to promote capacity building in clinical supervision. 2018;54(6):S275-S280.
18. Keeler H, Sjuts T, Niitsu K, Watanabe-Galloway S, Mackie PF-E, Liu H. Virtual mentorship network to address the rural shortage of mental health providers. *Am J Prev Med.* 2018;54(6):S290-S295.
19. Kepley HO, Streeter RA. Closing behavioral health workforce gaps: a HRSA program expanding direct mental health service access in underserved areas. In: Elsevier; 2018.
20. Joint Center for Housing Studies of Harvard University and the Center for Workforce Preparation of the U.S. Chamber of Commerce. *Strengthening the Workforce and Communities through Housing Solutions.* Available at: https://www.innovations.harvard.edu/sites/default/files/wh05-1_workforce_housing_report.pdf2005.
21. National Resource Network. *Bridging the Gap: Affordable Housing and Workforce Development Strategies.* Available at: https://connect.chattanooga.gov/wp-content/uploads/2017/02/NRN-Full-report-with-appendix.pdf2016.
22. Oregon Health Authority. CCO 2.0 Report.
23. *QuickStats: Percentage of Mental Health-Related Primary Care Office Visits, by Age Group — National Ambulatory Medical Care Survey, United States, 2010.* Centers for Disease Control and Prevention; November 28, 2014 2014.
24. Alegria M, Jackson JS, Kessler RC, Takeuchi D. Collaborative Psychiatric Epidemiology Surveys (CPES), 2001-2003 [United States]. *Inter-university Consortium for Political and Social Research [distributor].* 2015.
25. Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Ustun TB. Age of onset of mental disorders: a review of recent literature. *Current opinion in psychiatry.* 2007;20(4):359.

26. Kessler RC, Angermeyer M, Anthony JC, et al. Lifetime prevalence and age-of-onset distributions of mental disorders in the World Health Organization's World Mental Health Survey Initiative. *World psychiatry.* 2007;6(3):168.
27. Atkins MS, Hoagwood KE, Kutash K, Seidman E. Toward the integration of education and mental health in schools. *Administration and Policy in Mental Health and Mental Health Services Research.* 2010;37(1-2):40-47.
28. Costello EJ, He J-p, Sampson NA, Kessler RC, Merikangas KR. Services for adolescents with psychiatric disorders: 12-month data from the National Comorbidity Survey–Adolescent. *Psychiatr Serv.* 2014;65(3):359-366.
29. Balasubramanian BA, Cohen DJ, Jetelina KK, et al. Outcomes of integrated behavioral health with primary care. *The Journal of the American Board of Family Medicine.* 2017;30(2):130-139.
30. Asarnow JR, Rozenman M, Wiblin J, Zeltzer L. Integrated medical-behavioral care compared with usual primary care for child and adolescent behavioral health: a meta-analysis. *JAMA pediatrics.* 2015;169(10):929-937.
31. Bains RM, Diallo AF. Mental health services in school-based health centers: a systematic review. *The Journal of School Nursing.* 2016;32(1):8-19.
32. Brener N, Demissie Z. Counseling, psychological, and social services staffing: policies in US school districts. *Am J Prev Med.* 2018;54(6):S215-S219.
33. Kim G, Loi CXA, Chiriboga DA, Jang Y, Parmelee P, Allen RS. Limited English proficiency as a barrier to mental health service use: A study of Latino and Asian immigrants with psychiatric disorders. *J Psychiatr Res.* 2011;45(1):104-110.
34. Bain B, Barber S, Bieber B, et al. *Colorado Framework for School Behavioral Health Services.*: Colorado Legacy Foundation;2014.
35. Stempel H, Yebuah C, Wong SL. *Aligning the Education and Healthcare Sectors: The Role of Integrated Behavioral Health.*
36. Safe Schools/Health Students National Evaluation 2015. https://www.samhsa.gov/safe-schoolshealthy-students/national-evaluation. Accessed.
37. Bruns EJ, Duong MT, Lyon AR, et al. Fostering SMART partnerships to develop an effective continuum of behavioral health services and supports in schools. *Am J Orthopsychiatry.* 2016;86(2):156.
38. Lever N, Stephan S, Castle M, et al. Community-partnered school behavioral health: State of the field in Maryland. Baltimore, MD: Center for School Mental Health. In:2015.
39. Selby-Nelson EM, Bradley JM, Schiefer RA, Hoover-Thompson AJF, Systems,, Health. Primary care integration in rural areas: A community-focused approach. 2018;36(4):528.
40. Hewitt A, Larson S, Sauer J, O'Nell S. Removing the Revolving Door: Strategies To Address Recruitment and Retention Challenges. Facilitator Guide [and] Learner Guide. 2001.
41. Tobin Tyler E, Hulkower RL, Kaminski JW. *Behavioral Health Integration in Pediatric Primary Care: Considerations and Opportunities for Policymakers, Planners, and Providers.* Milbank Memorial Fund;2017.
42. Njoroge WF, Hostutler CA, Schwartz BS, Mautone JAJCpr. Integrated behavioral health in pediatric primary care. 2016;18(12):106.
43. Bartels SJ, Dums AR, Oxman TE, et al. Evidence-based practices in geriatric mental health care. *Psychiatr Serv.* 2002;53(11):1419-1431.
44. Oregon Health Authority. Peer Delivered Services. Accessed.
45. Kelly E, Fulginiti A, Pahwa R, Tallen L, Duan L, Brekke JS. A pilot test of a peer navigator intervention for improving the health of individuals with serious mental illness. *Community Ment Health J.* 2014;50(4):435-446.
46. Sledge WH, Lawless M, Sells D, Wieland M, O'Connell MJ, Davidson L. Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations. *Psychiatr Serv.* 2011;62(5):541-544.
47. Landers GM, Zhou M. An analysis of relationships among peer support, psychiatric hospitalization, and crisis stabilization. *Community Ment Health J.* 2011;47(1):106-112.
48. Chapman SA, Blash LK, Mayer K, Spetz J. Emerging roles for peer providers in mental health and substance use disorders. *Am J Prev Med.* 2018;54(6):S267-S274.
49. Pager D. The mark of a criminal record. *American journal of sociology.* 2003;108(5):937-975.
50. EEOC Enforcement Guidance of Arrest and Conviction Records in Employment Decisions under Title VII. https://www.eeoc.gov/laws/guidance/arrest_conviction.cfm#I. Accessed.
51. *A study by the Legal Action Center. After Prison: Roadblacks to Reentry. A report on state legal barriers facing people with criminal records (2009 Update).* Legal Action Center and Open Society Institute;2009.
52. *Enhancing the Peer Provider Workforce: Recruitment, Supervision and Retention.* National Association of State Mental Health Program Directors (NASMHPD);2014.
53. *Evidence for Peer Support.* Mental Health America;2018.

54. *Support for community health workers to increase health access and to reduce health inequities.* American Public Health Association;2009.
55. *Meeting the Demand for Health: Final Report of the Califronia Future Health Workforce Comission.* 2019.
56. Chapman S, Phoenix B, Hahn T, Strod D. Utilization and economic contribution of psychiatric mental health nurse practitioners in public behavioral health services. *Am J Prev Med.* 2018;54:S243-S249.
57. Fung Y, Chan Z, Chien W. Role performance of psychiatric nurses in advanced practice: A systematic review of the literature. *Journal of psychiatric mental health nursing.* 2014;21(8):698-714.
58. Baker J, Travers JL, Buschman P, Merrill JA. An efficient nurse practitioner–led community-based service model for delivering coordinated care to persons with serious mental illness at risk for homelessness. *J Am Psychiatr Nurses Assoc.* 2018;24(2):101-108.
59. Alexander D, Schnell M. Just what the nurse practitioner ordered: Independent prescriptive authority and population mental health. 2016.
60. McCutchen B, Patel S, Copeland D. Expanding the role of PAs in the treatment of severe and persistent mental illness. *Journal of the American Academy of PAs.* 2017;30(8):36-37.
61. Trumbo JM. PAs: The perfect bridge between medical and mental health. American Academoy of Physician Assistants. https://www.aapa.org/news-central/2017/04/pas-perfect-bridge-vetween-medical-mental-health/. Accessed.
62. Buchbinder M, Regan J, Aldea M, Makowski D. Improving Mental Health Services Through Physician Assistants: Legislation in Several Southern States. *South Med J.* 2017;110(4):239-243.
63. Lê Cook B, Kim G, Morgan KL, et al. Measuring Geographic" Hot Spots" of Racial/Ethnic Disparities: An Application to Mental Health Care. 2016;27(2):663-684.
64. Lê Cook B, Doksum T, Chen C-n, Carle A, Alegría MJSS, Medicine. The role of provider supply and organization in reducing racial/ethnic disparities in mental health care in the US. 2013;84:102-109.
65. Hyde PS. *Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues.* U.S. Department of Health and Human Services: Substance Abuse and Mental Health Services Administration (SAMHSA);2013.
66. Fernandez A, Schillinger D, Warton EM, et al. Language barriers, physician-patient language concordance, and glycemic control among insured Latinos with diabetes: the Diabetes Study of Northern California (DISTANCE). *J Gen Intern Med.* 2011;26(2):170-176.
67. Sanchez K, Ybarra R, Chapa T, Martinez ONJPS. Eliminating behavioral health disparities and improving outcomes for racial and ethnic minority populations. 2015;67(1):13-15.
68. Chapa T, Acosta H. *Movilizandonos por Nuestro Futuro: Strategic Development of a Mental Health Workforce for Latinos: Consensus and Recommendations.* 2010.
69. Sentell T, Shumway M, Snowden LJJogim. Access to mental health treatment by English language proficiency and race/ethnicity. *J Gen Intern Med.* 2007;22(2):289-293.
70. Ibaraki AY, Hall GCNH. The components of cultural match in psychotherapy. *J Soc Clin Psychol.* 2014;33(10):936-953.
71. Cabral RR, Smith TB. Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *J Couns Psychol.* 2011;58(4):537.
72. Coleman HL, Wampold BE, Casali SL. Ethnic minorities' ratings of ethnically similar and European American counselors: A meta-analysis. *J Couns Psychol.* 1995;42(1):55.
73. Maramba GG, Nagayama Hall GC. Meta-analyses of ethnic match as a predictor of dropout, utilization, and level of functioning. *Cultural diversity and ethnic minority psychology.* 2002;8(3):290.
74. Shin S-M, Chow C, Camacho-Gonsalves T, Levy RJ, Allen IE, Leff HS. A Meta-Analytic Review of Racial-Ethnic Matching for African American and Caucasian American Clients and Clinicians. *J Couns Psychol.* 2005;52(1):45.
75. Page C, Buche J, Beck AJ, Stamm K, Lin L, Christidis P. *Understanding the Divresity of Students and Faculy in Health Service Psychology Doctoral Programs.* University of Michigan: School of Public Health Behavioral Health Workforce Research Center;2017.
76. Duffy FF, West JC, Wilk J, et al. Mental health practitioners and trainees. 2002;3938:327-368.
77. Altschul DB, Bonham CA, Faulkner MJ, et al. State legislative approach to enumerating behavioral health workforce shortages: lessons learned in New Mexico. 2018;54(6):S220-S229.
78. Moore BA, Muse M. Medical psychology: Definitions, controversies, and new directions. 2012.
79. Gattman NE, McCarty RL, Balassa A, Skillman SM. Washington State Behavioral Health Workforce AssessmentL Project Phase I. Workforce Training and Education Coordinating Board. 2016.

80. Provider Recruitment and Placement. North Carolina Department of Health and Human Services Office of Rural Health. Published 2019. AccessedAccessed March 04, 2019.
81. Causin HF, Tremmel DC, Rufty TW, Reynolds JFJAjob. Growth, nitrogen uptake, and metabolism in two semiarid shrubs grown at ambient and elevated atmospheric CO2 concentrations: effects of nitrogen supply and source. 2004;91(4):565-572.
82. Substance Abuse Mental Health Services Administration. *Bringing Recovery Supports to Scale in Massachusetts: Final Report.* Available at: https://www.umassmed.edu/globalassets/center-for-mental-health-services-research/documents/brss-tacs-.pdf2013.
83. Rhett-Mariscal WJPPS, CA: California Institute of Mental Health. Promotores in Mental Health in California and the Prevention and Early Intervention Component of the MHSA. 2008.
84. Substance Abuse Mental Health Services Administration. *National Summit on Recovery: Conference Report.* Available at: https://www.samhsa.gov/sites/default/files/partnersforrecovery/docs/Summit_Rpt_1.pdf2005.