

Help Wanted: Reshaping the Behavioral Health Workforce

Report of the 31st Annual Rosalynn Carter Symposium on Mental Health Policy

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Introduction

For behavioral health consumers and advocates in the United States, the past four decades have been a period of accelerating and (mostly) positive change. To be sure, there were setbacks due to shifting political winds and persistent cultural stigma, but ever since Jimmy Carter was elected President in 1976 and, alongside First Lady Rosalynn Carter, began using the White House's bully pulpit to press the issue, the clear trend line has moved ever closer to improved care, more personalized care, and greater popular understanding of the nature of and challenges posed by mental disorders.

However, such progress has been the keenest of double-edged swords. Even as fewer Americans have been hustled off to involuntary commitments, as conditions such as addiction and substance abuse have been recognized as illness, and as the evolution of behavioral health care has resulted in a proliferation of new practitioner roles, these advances have in turn created their own challenge: Where are the people to do the work? Where are the trained professionals and paraprofessionals to staff our current, much less future needs in mental health? And, even assuming that the supply of labor is sufficient (a big and not at all justified assumption), how will these people be trained efficiently and effectively to deal with a practical and technological landscape that continues to change rapidly?

Such were the topics of discussion at the 31st Annual Rosalynn Carter Symposium on Mental Health, titled "Help Wanted: Reshaping the Behavioral Health Workforce." Over a day-and-a-half in The Carter Center's Cecil B. Day Chapel, attendees from around the country discussed policy solutions, the impact of integrated care on the behavioral health workforce, and emerging models for training and care delivery that will go a long way toward determining the size and nature of the nation's corps of behavioral health personnel.

"I will not tell you or show you slides about the prevalence of mental health and addiction problems in this country, or slides showing the direct and indirect costs associated with these illnesses [when they] are not treated," said Gail Stuart, Distinguished University Professor and dean of the Medical College of South Carolina's School of Nursing, said in her opening keynote. "I will not talk about the fact that the lack of behavioral health workforce is a worldwide problem and every country is experiencing it. I will not talk about the issues related to recruitment and retention of those who work in the behavioral health workforce ... [or] the chronic poor salaries that continue to plague us. These issues you all know."

Instead, Stuart continued, she would use her time to "challenge your notions, stir the pot a little, raise some controversial ideas that not all of you will agree with, and stimulate the discussion that will carry over for the next day-and-a-half."

And that's exactly what she did, as did all the speakers and panelists and moderators who followed her. They described their plans, their recommendations and even their dreams not just for turning a new generation of peers, clinicians, researchers and leaders on to the field of mental health, but for reshaping the very nature of their workforce to fit a 21st century model of care. For more than one speaker, the time had come to look beyond incremental change.

"This is a propitious moment for all of us, specifically for mental health. We can either evolve, or collectively we can lead a revolution," said panelist Benjamin Miller, assistant professor at the University of Colorado School of Medicine and director of its Office of Integrated Healthcare Research and Policy. "I don't want to evolve. I want something bigger, better, more egregious—something huge that literally shakes the foundations of what we have established. I want to create something that is comprehensive and integrated."

Still, gathered in the audience were many of the very individuals responsible for a half-century of steady, deliberate progress—foremost among them, the former First Lady herself.

"I've spent all of my life in the mental health field," Mrs. Carter said in welcoming the 2015 Symposium audience on Thursday afternoon. "The issues of workforce have been around for decades. But there have been a lot of changes lately, significant changes."

For two days in November 2015, those changes—and the arduous but hopeful futures they portend—took center stage at The Carter Center.

1

Current Issues in the Behavioral Health Workforce

“These issues [regarding the behavioral health workforce] you all know. They have plagued us for decades. In fact, we have so many reports and data summaries of these problems that, if you stacked them [on top of each other], it would be double the size of the Washington Monument.”

—Gail Stuart, Dean, Medical University of South Carolina School of Nursing

In November 1976, while Jimmy Carter was being elected President of the United States, panelist Ken Thompson was being accepted into the Boston University School of Medicine. A National Health Service Corps (NHSC) scholarship covered his tuition, but it was the newly elected First Couple and their commitment to improving mental health care that inspired Thompson’s sense of duty.

“At that point I was pretty sure I wanted to be a psychiatrist,” said Thompson, now president of the American Association for Social Psychiatry and speaking directly to Rosalynn Carter, who was seated just two rows from the podium. “I decided I was going to hitch my wagon to everything you did, and I’ve been following your lead ever since.”

However, Thompson added, one of the many causes for the current shortage of young people choosing to work in behavioral health, or at least the public sector, is they are not being challenged like previous generations to consider lives of service. While the NHSC still retains the scholarship program that put him through medical school, Thompson said the Corps’ primary focus now is on a loan repayment program.

“The ethos of public service,” he said, “is not really pushed as hard as it could be.”

This diminution of public service was coupled with a slow withdrawal of financial support for public mental health care, which inevitably caused a reduction in training opportunities.

“In the 1980s and ‘90s, as fee-for-service became the mode and we abandoned the federally funded community mental health centers, there was a wholesale retreat of applied training in the public sector,” said panelist Dennis Mohatt, vice president for behavioral health at the Western Interstate Commission for Higher Education. “State hospitals stopped having residencies, community mental health centers stopped having internships, because they had to have people producing billable hours of service. A few years ago, we had 800-plus internship-ready psychologists that could not match for internships because the slots were not there.”

“Psychiatry, of all specialties, probably is the most dependent on public funding,” Thompson said. “When there is a crisis in public sector funding, we will have a crisis in mental health and therefore psychiatry.”

Of course, the workforce issues facing contemporary behavioral health range beyond the public sector. At the highest level, recent policy changes and shifts in the marketplace toward integrated care have combined to steer a significant number of new consumers toward mental health care at the same time the profession that historically has delivered it is (a) threatening to gray out and (b) not distributed how it needs to be on the map. The average age of both psychiatrists and psychologists reclines comfortably in the late 50s, while the field overall groans under the weight of burnout and worker fatigue, low salaries, high turnover, and prevailing stigma, even (perhaps especially) within the medical field itself.

Clearly the workforce challenge is a complex case of comorbidity, with causes rooted in government, economics, technology, science, research—and, yes, society’s recent progress in all of the above. A more thorough diagnosis is in order.

Definitions of Workforce

When Gail Stuart consulted the Centers for Medicare and Medicaid Services (CMS) for some help in quantifying the current behavioral health workforce, she found ready data on the nation’s number of psychiatrists and psychologists, its counselors and social workers and therapists, and some other roles. But there were some pretty big holes.

“Where are the nurses?” Stuart recalled thinking. “Excuse me, there are 17,000 advance practice psychiatric nurses in this country, 84,000 nurses working in mental health facilities, hospitals and clinics, and they aren’t even on [the list]? How is that possible? But we are missing other people as well. Where are the peers and consumers? Where are the family and friends? Where are the lay community workers?”

The literal explanation, Stuart shared, was that the roles listed by CMS were those that could direct-bill for their services. But on a deeper level, one problem hindering a proper analysis of the workforce challenge is a lack of adequate data—and that’s where people like panelist Angela Beck come in. Beck directs the Behavioral Health Workforce Research Center at the University of Michigan School of Public Health, where she works with a consortium of organizations to gather, study and vet information. The consortium’s first task? Define what they are all talking about.

“Like in public health, behavioral health does not have a uniform, systematic method for collecting workforce data, so there are a lot of issues with data quality, or lack thereof,” Beck said. “We are trying to ... do a better job. We were funded to have a very broad focus of the behavioral health workforce, so we are not limiting our research to licensed providers, for example. We are also including non-licensed providers, peer providers, volunteers. We would like to cast the net as wide as possible.”

To accomplish its goals, Beck's center has identified three areas of focus, the first being to simply establish minimum data sets and identify the sources from which the data will be gathered. Next will be an examination of worker characteristics and practice settings, including workforce diversity, core competencies, service delivery to underserved populations, and team-based care. And finally, the center will collect scopes of practice from across the country in a variety of behavioral health occupations to study both commonalities and inconsistencies.

"We were struck by the similarities in workforce research challenges between public health and behavioral health," Beck said. "We hope that we can use the methods that we've applied to the public health workforce to look at things like supply, size, composition, and scope of the workforce and use them to guide our work."

Opening the Black Box

Stuart's discovery that CMS only "recognized" behavioral health providers who could bill for their work is but one example of how payments have in large part dictated the U.S. health care system, and there was certainly plenty of talk at the Symposium about that system's evolution and the forces that influenced it. From the Mental Health Systems Act (1980) to the Mental Health Parity and Addiction Equity Act (2008) to the Affordable Care Act (2010), policy has worked alongside market forces to shape a system that is, without question, much improved from the mid-20th century world of state hospitals and hushed visits to the psychiatrist for those who got any treatment at all for mental illness. But, like the U.S. health care system as a whole, it still operates very much under a traditional disease-care, "repair shop" mentality.

"There's a conceptual frame for how we think about behavioral health, and it's a black box: People get ill, they go to treatment, we fix them, and they leave fixed, correct?" said moderator Arthur Evans, commissioner of Philadelphia's Department of Behavioral Health and Intellectual Disability Service. "That's the way we were all trained, and it's certainly the way our health care system is financed. You don't get help unless you meet the criteria to enter the black box, and if you are no longer symptomatic, you have to leave."

Yet nearly every speaker talked about how this system is slowly giving way to a world of integrated health services that not only acknowledges the relationship between mind and body but also aspires to integrate health care itself—in its broadest definition—more seamlessly into the lives of consumers. This is prompting a wholesale reexamination of care delivery and practitioner roles that has, in some instances, resulted in some truly novel approaches to care.

These new approaches, backed by evidence, are encouraged both publicly and privately. The Affordable Care Act spurs innovation through both the carrot and stick approach—sticks in the form of mandated essential health benefits, carrots in the form of incentives for integrated care facilities and outcome-based, population-level care. Even the insurance industry has recognized the limitations of fee-for-service and begun to move more purposefully into the realm of capitation and bundled payments.

“The lowest-hanging fruit, the largest single gesture you can make toward [integrated care] is to incorporate behavioral health into primary care,” said panelist Frank DeGruy III, Woodward Chisholm Professor and chair of family medicine at the University of Colorado School of Medicine. “There is no way to be properly comprehensive in the primary care setting without integrating behavioral health into it.”

Underserved Populations

Of course, integrated care only works if you have the human resources to fill all the caregiver roles, and the health care system alone is not the only social institution putting a strain on the behavioral health workforce. There is currently in the United States a broad, bipartisan appetite to reform the criminal justice system, driven by the fact that the U.S. spends some \$75 billion annually on corrections and accounts for 22 percent of the world’s prisoners despite having just 4 percent of its overall population.

According to panelist Andrew Cummings, the key to success in criminal justice reform—i.e., reducing the prison population while minimizing recidivism—is an adequately staffed, integrated and community-based mental health system.

“Recidivism rides exclusively on the health of our behavioral health workforce and what we can deliver,” said Cummings, consultant for the Casey Family Program. “No workforce reform, [and] criminal justice reform ultimately is not successful. We may keep people from being incarcerated, but we will not necessarily bend the recidivism curve.”

That would be a tremendous missed opportunity, Cummings went on, not only in reforming the justice system but also in the nation’s foster care system. Not only have studies shown that criminal recidivism can be reduced from the current 70% rate down to as low as 30% with the proper monitoring and behavioral care support, but research also shows that minors living in homes under juvenile court supervision have more in common with adult offenders than with other children their age. Cummings called that finding an “eye-opener.”

In Georgia alone, he continued, recent initiatives to drive down juvenile detention, combined with individuals leaving the prison population, result in about 56,000 people per year under the broad umbrella of justice reform in need of behavioral health care services.

“Where are all those people going?” Cummings said. “Who is serving them? We have a long way to go in terms of fidelity to the model when it comes to these evidence-based practices, and if you don’t have fidelity to the model, you don’t have an evidence-based practice. We are in [the discussion of criminal justice reform] whether we like it or not. If reform is successful, it should be a big win for us, right? But if it’s not successful, we share in the blame, even if we haven’t necessarily been at the table. You bet.”

Closely related to this issue is the challenge of rural care. Much has been written about the urbanization of the United States, but as panelist Paul Force-Emery Mackie said, just because America’s cities are becoming more densely populated does not necessarily mean the spaces between them are

becoming less populated—only relatively so, meaning the demand for health services in rural areas is growing just like everywhere else. And since providers tend to cluster in urban areas—to the tune of 90 percent of psychiatrists and psychologists, and 80 percent of clinical social workers—that is putting a tremendous strain on rural providers. Citing one of his own papers, Mackie said that for every 10 miles one moves away from an urban center, it becomes 3 percent more difficult to hire behavioral health professionals.

“Sixty percent of rural America is underserved with behavioral health needs, and more than 85 percent of the United States’ behavioral health shortage areas are rural,” said Mackie, professor of social work and university assessment coordinator at Minnesota State University, Mankato, as well as president of the National Association for Rural Mental Health. “Rural is becoming a smaller component [of the whole], but we have more rural residents because they are growing, just not at the same rate. As more and more people are seeking access to behavioral health services, this issue is going to become even more problematic.”

An Educational Assessment

In some very important ways, the United States’ system of higher education parallels its health care system: The opportunities provided by the best American universities are without peer anywhere in the world—provided a student has access and a way to afford those opportunities. But when one looks beyond optimal examples, the data begin to tell a different story.

“The cold hard fact is that higher education attainment in the United States isn’t all that good,” Mohatt said. “We’re not in the top five, not in the top 10, not even in the top 20 in terms of producing college graduates. Higher education fails so many people [in this country], and I don’t mean they flunk them. I mean they *fail* them. They fail to reach them.”

Too often, Mohatt explained, this is the literal reason for lack of access: Potential students do not live in close enough proximity to colleges, vocational centers or other training facilities to reach them. Some 37 million Americans, he said—20 percent of the American workforce—have some higher education but no college degree, and a good number of them are “place bound,” meaning they live in rural or remote areas without physical access to training opportunities.

“There is a lot of stigma with the term ‘place bound.’ It’s like you’re in jail,” Mohatt said. “Everything I’ve learned about higher education and making it accessible to people locked out, I’ve learned in Alaska. In Alaska, the term ‘place bound’ is verboten. You don’t use that. You talk about people who are ‘place committed,’ and the goal of higher education is to reach out to them.”

Cost, of course, is another factor. According to the National Center for Education Statistics (NCES), educational cost (tuition, fees, room and board) at all U.S. colleges and universities has risen more than fivefold in actual dollars over the past 30 years. Decreasing public investment in higher education, together with rising institutional administrative costs and a rapid expansion in the for-profit educational sector, have all combined to drive prices up for students, and the results are well

documented. According to the NCES again, the average loan debt for new college graduates has risen from under \$10,000 in 1993 to just over \$35,000 in 2015.

“There has been a wholesale retreat from public support for higher education. The monies have dried up, and it’s the new normal,” Mohatt said. “We have to have an adult conversation about that. Do we really want undergraduate students coming out with \$50,000 of debt, starting in the hole? It’s wrong. It’s morally wrong.”

Finally, the institutional checks established to guarantee standards and rigor across all types of education and training—such as accreditation and regulatory agencies—were created in a different era, for a very different care model, and those agencies are struggling to keep up in a rapidly changing world. They are understandably, even justifiably, slow to embrace change.

“The fact of the matter is, as well intentioned as those [agencies] are, they are invested in the status quo,” Stuart said. “They are not risk takers.”

“We need to consider how we accredit some of our behavioral health programs and what type of providers we are turning out,” Miller agreed. “This is no disrespect to any of our accrediting bodies, but if we really believe the future is more holistic and integrated, we might consider going back and re-checking what it is that we are accrediting people to do.”

Overcoming a Thousand Points of No

As several speakers noted, the current challenges facing the behavioral health workforce did not sneak up on anyone. In 2001, the nonprofit Annapolis Coalition was formed to take a systematic look at those challenges and come up with recommendations. It had grown, Stuart recalled in her keynote, out of a summit held by the American College of Health Administrators, had both backing and funding from SAMHSA, and drew upon the efforts of some 5,000 contributors over two years in putting together its National Action Plan. The plan outlined seven goals addressing every angle of the workforce issue, from broadening the definition of who’s included in that workforce, to addressing education and training, to developing the next generation of leaders, and more.

Specifically, the plan called upon those invested in behavioral health to:

1. Expand the role of individuals in recovery and their families
2. Expand the role and capacity of communities
3. Implement systematic recruitment/retention strategies
4. Increase the relevance, effectiveness and accessibility of training and education
5. Actively foster leadership development
6. Enhance the infrastructure for workforce development
7. Implement a national research and evaluation agenda

“The good news is that, 14 years later, the Annapolis Coalition is alive and well,” Stuart said. “The bad news is we are alive and well because we haven’t made too much progress. We learned that

there are a thousand points of 'no.' Every time you raise something, there is someone out there telling you why you can't do it."

This sentiment surely came as no surprise to many in the room, people who had worked steadily, painstakingly over decades to achieve small, incremental gains for the mentally ill and the system that cares for them. No doubt that helped explain why, even as they looked at slides and listened to statistics that conveyed the full scale of the problems facing them, several speakers maintained both their resolve and their optimism.

"I get the chance to work from the mountains to the piedmont to the coastal plain, and we have a workforce issue every place along the way," Cummings said. "I do not think it is doom and gloom."

"Policy change does not come easy," said David Satcher, who personally helped spur some of that change by issuing in 1999 the first-ever Surgeon General's Report on Mental Health. "We have to be committed to this as a long-distance run."

Clinical Practice in the Era of Integrated Care & Population Health

*“I’m here, close to the ground, with mud on my boots, to talk about what integration efforts look like.
Primary care is a messy, noisy, chaotic place.”*

—Frank de Gruy III, Woodward Chisholm Professor and Chair of Family Medicine, University of Colorado
School of Medicine

The U.S. health care system, as more than one speaker noted, traditionally has been characterized by a Platonic duality: one side took care of the body, while the other busied itself with the mind, and rarely the twain would meet in a practice setting. However that bifurcated system over the past few decades has slowly begun to change, and today one would be hard pressed to find anyone who still believes the “two-door” model of health care has a long future—even if the policy and economics of health care haven’t yet caught up to the shift in philosophy.

But those factors are changing too. As noted earlier, the Affordable Care Act explicitly incentivizes integrated approaches, and even the ACA’s most vocal opponents speak with passion about building a “patient-centered” system of care that (at least in theory) orients providers to the consumers, rather than vice versa. And every day yields more positive data from local and regional providers and care networks experimenting in new ways to lower barriers between the specialties, to offer fair and even market-based compensation for holistic health outcomes, and to construct that single point-of-entry—or, perhaps, multiple points of entry—for consumers to conveniently meet their health care needs.

“There is a growing emphasis on integrated care and treatment of co-occurring disorders and co-morbidities,” said panelist Angela Beck. “What does that mean for the workforce? What kind of training do [those providers] need? What type of changes in their job scopes or functions need to happen to be able to deliver integrated care in an effective and efficient manner?”

Continuum of Integration

“For the longest time we had a lot of difficulty even identifying what we meant by ‘integrated care,’” keynoter Gail Stuart said. “But now there is a large consensus that integrated care is care rendered by primary care and behavioral health providers working together ... with patients and families, using systematic and effective approaches to provide patient-centered care.”

Stuart noted that under this definition there are any number of models for integration, from blending behavioral health providers into a primary care setting and vice versa, to co-located services

and “health home”-type facilities, to full system integration. After evaluating hundreds of “more or less” successful examples of integrated practice, panelist Frank DeGruy and his research group identified three general types or levels of integration.

“The deepest and most complete is *collaboration*, where personal care plans are formulated together, with conversation, where [the caregivers] are one team working on one care plan for a patient,” DeGruy said. “Then we see a less extensive sort of partnership that involves ... *coordination*. It’s almost like tennis; there is a volleying back and forth: ‘You take care of the depression, I’ll take care of the diabetes, let’s keep talking with each other and making sure we are managing these together.’ And at the most rudimentary level, we have a *consultation* mode, and that is where you’d see me as a primary care physician saying, ‘This is the deep end. I’m over my head. Please would you take care of this scary patient that I think is bipolar, but there is some stuff I don’t know how to deal with.’”

DeGruy said his research has yielded some general formulas and ratios for blending the care specialties (one behavioral health clinician for every four PCPs in a primary care setting, for example), but most important is flexibility in scheduling to help balance the needs of acute versus chronic patients. And, coining a few new terms, he also described three physically related common attributes of practices that do integration well—*proximity*, *interruptibility*, and *bumpability*—and said the floorplan of a care facility has a tremendous impact on the kind of care delivered.

“You can actually predict on the basis of what the space looks like whether this is going to be successful or not,” DeGruy said. “The most successfully integrated practices have behavioral clinicians and primary care clinicians bumping into each other, interrupting each other. If you want an office down the hall with your name on it, this is probably not the place for you. We all work in a common bullpen in the middle of the exam rooms.”

Team Practice

Underneath all the organization modeling and evidence-based best practices in service integration, there are still living, breathing human beings working in our hospitals and managed care facilities, and in a brave new world of integrated care, they must learn to work together. This fact might be simple and self-evident, but it is not to be taken for granted. Workplace culture is no simple thing to change, even less so as it extends across specialties.

“We are challenging people to think differently about their jobs,” said panelist Glenda Wrenn, director of behavioral health for the Satcher Health Leadership Institute at the Morehouse School of Medicine. “You have to navigate a lot of different cultures. Anyone doing this work on the ground probably has the wounds to prove that it is really hard to shift people into a state of being open-minded about what they do.”

“When we introduce primary care clinicians into the behavioral setting, the most common thing we hear is, ‘Why do you need so many rooms? Why do you need *stuff*? Don’t you just want to sit down and talk?’” DeGruy said. “Probably the biggest change that both behavioral clinicians and primary care

clinicians have to make is ... learning how to practice in teams. That's a new skill, it's a fundamentally new skill for both, and it's hard."

"Folks like Frank have been talking about [behavioral health into primary care] for a long time," said fellow panelist Benjamin Miller. "When you look at the other side, and you consider how primary care providers can go work in a behavioral health setting, it's the same type of cultural barriers and challenges."

And just because behavioral health professionals have generally been the ones clamoring for a more holistic approach to care, that doesn't necessarily mean they are the ones most adaptive to change. In order to create and sustain a truly integrated environment, keynoter Gail Stuart said, everyone is going to have to expand their comfort zones.

"Behavioral health providers [can be] real quick to tell primary care providers all the things they need to do: 'OK, you need to do this, and this, and this and that,'" Stuart said. "Then when the primary care providers say, 'As behavioral health providers, you need to do these things,' it was like, 'Whoa, we don't touch patients. We don't do blood pressures.' Behavioral health providers: Let's be real. Blood pressures are done by machines. You don't have to touch the patient, but you need to know what the printouts are of the lab values; you need to know what the blood pressure value is; you need to be able to get a patient on a scale and weigh them."

The Potential of Peers

Of the many new caregiver roles being acknowledged in the world of behavioral health, none has the potential to transform quality of care like peer specialists. Nearly every Symposium speaker touched on the importance of peer support and how it is anticipated to grow, quickly, over the next decade. For years marginalized due to a relative lack of data about its effectiveness, peer support is now starting to get the marketplace validation it deserves.

"Managed care, if they're good at one thing, it's keeping track of numbers and dollars," said panelist Patrick Hendry, vice president of consumer advocacy for Mental Health America. "They are beginning to see that peer support dramatically reduces re-hospitalization rates and inpatient stays; people are staying in their treatment longer, people are being engaged in treatment more easily, and [they experience] much higher quality of life and satisfaction in services."

Hendry said there are currently between 5,000 and 10,000 people working in peer support across the country out of a behavioral health workforce of roughly 300,000. Led by the Veterans Administration, which is the largest employer of peers in the country, the public sector is leading the way in incorporating peer specialists into care practice, but the private sector is starting to catch on. Hendry cited his colleague and fellow speaker Ron Manderscheid, executive director of the National Association of County Behavioral Health and Developmental Disability Directors, in predicting that, within five years, peers will comprise some 20 percent of the total behavioral health workforce. And this makes many people, who have long believed in the power of peers, very happy.

“Integrated health seeks to facilitate people getting the effective treatments of their choice—peer specialists do this. They normalize the experience of receiving services,” said panelist Lisa Goodale, vice president for peer support services for the Depression and Bipolar Support Alliance. “Peers understand the confusion, the doubt and the shame that more often than not accompanies mental health and substance abuse conditions.

“Telling their stories, serving as an almost instantly trusted role model, is not one of the things a clinician can do—in fact, as a clinician, I’m not supposed to talk about that,” Goodale continued. “Peers may not have the same story as the people they are serving, but they have a story. As one peer specialist recently commented to us, she tells the people she serves, ‘I may not have walked in your shoes, but I’ve been in that shoe store.’”

Healthy Populations

If a national system of truly integrated care is approaching but still not on the immediate horizon, then a functioning and effective model of population health is even further away. A “very close cousin” to public health, according to Manderscheid, population health also covers a range of definitions but most Symposium speakers talked about it as a model of care where interventions are conceived and executed at the community level, targeted at subsets of the population that each have their own risk factors and health profiles.

“When you partition a population, you can introduce community interventions to address the issues of these various groups—they will not be the same,” Manderscheid said. “In the future workforce in behavioral health, we are going to need to work much more closely with public health, and I think a lot more people in behavioral health will also have training in public health.”

Moderator Arthur Evans outlined six “conceptual shifts” required by any significant shift toward population health, including: (1) a focus on groups and communities rather than simply individuals; (2) working “further upstream” the care chain; (3) adoption of a broader set of care strategies; (4) an effort to work with non-diagnosed populations; (5) delivery of health promotion interventions; (6) working in community and non-clinical settings; and (7) an increased emphasis on health activation.

When one starts talking about the fifth of Evans’ shifts—population-level interventions—the conversation can quickly turn to social determinants of health—the conditions in which people are born, grown, learn, live, age and die—which one speaker said account for 70 percent of individuals’ overall health. If, this speaker continued, the entity best poised to introduce population-level interventions is the government, that means any answer is a political answer. And this speaker would know.

“As the Affordable Care Act was being put together, then-Surgeon General Regina Benjamin was heading a council looking at how we can impact the social determinants of health—how can we make communities healthier?” said David Satcher, director of the Satcher Health Leadership Institute at Morehouse School of Medicine and former U.S. Surgeon General under President Bill Clinton. “They ended up with a budget of [about] \$15 billion over five years that would be invested in the CDC’s budget. Congress has taken almost every penny of that money out, because many people in Congress

don't believe the government should be doing those kinds of things. They say those are personal responsibilities."

Politics or no, other speakers believed a future health care world of full integration and population health is coming, and it's just a matter of how long before it gets here. As the forward-thinking providers and health systems continue to show the economic value of holistic care and model a system of *health* care rather than disease care, big changes become inevitable.

"Health is health is health," Miller said. "Redefining the concept of health as naturally inclusive of mental health is where we should be right now. There should be no wrong door for behavioral health anywhere. This is no longer just a good idea—people don't stand on stages like this anymore and talk about the novelty of integration. We have a movement on our hands, folks."

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Impact of Innovation & Emerging Models 1: Providers & Care Delivery

“We have to accept that our workforce looks different than it used to. It does not look like the people in this room.”

—Andrew Cummings, Consultant, Casey Family Program

Despite all the progress in behavioral health care over the last few decades—or, perhaps, inspired and challenged by it—there was at the 2015 Symposium plenty of appetite for bold and ambitious change, and change not limited solely to payment systems or care integration, or to training models or accreditation, but to all those things and more. It is time, keynoter Gail Stuart said, for revolution.

“We need to not only talk about revolutionary strategies but figure out ways to *implement* them,” Stuart said. “We know the problems. We need to have solutions and specific ways in which we can move them forward.”

She outlined four areas in need of revolutionary change: care settings, care providers, practice models, and education. All four would be implicated in any meaningful shift toward the kind of patient-centered system that people on all sides of the political spectrum say they want (even if they disagree on how to get there). At its core, such a system mandates that care at some level *must be delivered to the patient*, rather than vice versa, and this implies an expansion of traditional definitions of who provides care, where and how it’s provided, how much care any given professional can deliver, and the nature of how those professionals are trained and certified.

“So much of what we do is clinician and clinic-centered, even though we say it is ‘patient-centered,’” said panelist Frank DeGruy. “This is going to be a very radical transformation. It’s not that patients get to join the team—they own the team. The patients are Jerry Jones, Mark Cuban, and they own the team. We play if we behave well and have something to offer that is of value. That requires that we behave very differently than we do now.”

“Entrenchment in the status quo is the biggest challenge,” said panelist Glenda Wrenn. When you’re trying to have any kind of transformative revolution, and you’re asking groups [to change] that are heavily invested in the way things are, you’re going to get very slow, incremental progress. If we are

interested in transformative and revolutionary change, we have to create pathways, policy, funding opportunities, for the innovators to come out and do what they do.”

The Providers Around Us

Thanks to the growth of both integrated care and peer support, there has already begun a wholesale shift in thinking about who can and should provide behavioral health care services. Primary care clinicians are increasingly integrating those services into their skillsets, and the number of peer specialists in the field is exploding. Indeed, in the emerging era of care, DeGruy even questioned the dichotomy of provider vs. consumer and the one-way relationship it suggests.

“I don’t like being defined as a ‘provider,’” he said. “It creates an assumption about the nature of that transaction that I think is a bit unhealthy. If we are going to have true partnerships, and patients are at the center, it’s not patients as consumers—it’s patients as operators, as participants, as engineers, as partners.”

Perhaps better than anyone else, peers can assume the role of “partner” in a care relationship. The inherent credibility and empathy they bring has made peers an increasingly valuable component of effective integrated care, but is that all they can do? Are peers relegated merely to being mentors or “care buddies,” or could they deliver services traditionally handled by clinical staff?

“Peers are [often] told, ‘Your job is to tell your story,’” said panelist Lisa Goodale. “Well, that’s true, but this effectively can turn a peer into a professional patient or advice-giver. That’s not what peer support is about. Peer specialists provide real services.”

Goodale also had a ready-made answer for those unwilling to expand peer responsibilities without the rock-solid backing of research and evidence-based practices, characterizing such a bias as perhaps a lingering vestige of stigma, even among those who should know better.

“When is the last time somebody said to you, ‘Where is the evidence that psychiatrists are effective?’” Goodale asked. “Bringing peers into the workforce uncovers some very deeply hidden biases. I can tell you that peer specialists ... opened my eyes to some ugly beliefs about the potential of people living with mental health conditions that I didn’t even know I had.”

Two other groups to which people’s eyes are opening are families and community leaders such as clergy. The Satcher Health Leadership Institute runs a community-based program called “Smart and Secure Children” that reaches families—especially parents, whom Wrenn called a “large, uncompensated workforce” for health—through classes at local churches and other community centers. With the goal of reducing health disparities in the critical early-childhood years, the program trains family members to become mentors and leaders themselves, helping to spread healthy parenting practices throughout their communities.

“We believe ultimately that parents are the most important leaders in our society,” said David Satcher. “If we can help to empower them, to really do an outstanding job of helping child development in that period [from 0-5 years], we could make the greatest difference in our society.”

Finally, according to Stuart and other speakers, the current U.S. health care culture limits its own potential by circumscribing the amount and type of care that individual specialties can provide. There must be a push, they said, toward allowing clinicians across the spectrum to operate to the entirety of their training.

“We absolutely must allow for the full scope of practice for all licensed and credentialed clinicians,” Stuart said. “Notice I didn’t say any one profession—I said, if [they] are licensed or credentialed, let those people practice to the full scope of their license or education. We must use non-behavioral health providers as core behavioral health service providers. Even if we tripled ourselves, we will never be able to meet the needs in this country. We have to expand our definition of provider.”

Going Where They Live

As multiple speakers noted, providers are not the only aspect of health care that’s being redefined. The “minute clinic”-type offices that are opening in retail outlets around the country may soon be joined by primary care and screening facilities in train stations, in malls, in libraries and schools, in YMCAs and church basements, and in myriad other locations of greater convenience to consumers.

“Very interesting things happen when you do this kind of work,” said moderator Arthur Evans, from his experiences in Philadelphia, including the placement of a diagnostic kiosk in the Drexel University student center. “Originally people were very concerned that [consumers] wouldn’t go to a public setting and be screened for mental health conditions. We’ve had the exact opposite response. People are often curious; people are often in need.”

“If we truly want to address population health and do what is right for people, we cannot say, ‘You have to go here,’ or ‘You have to see that person,’” said panelist Benjamin Miller. “We need to create a patient-centered system that allows seamless access to behavioral health, wherever they are. I’m a big fan of the bumper sticker behavioral health in all contexts, because wherever you are, even if it’s at your hairdresser, or you’re talking to the fireman, or the mailman comes by, whatever it is, there’s behavioral health in that.”

Public schools, more than one speaker suggested, are another example of a potential, ready-made facility that is not being used to its fullest potential, either as a center for care, or training, or all of the above. Indeed, the idea of deploying enhanced pediatric behavioral health care in K-12 schools had strong support.

“We have schools all over the country, and 4 o’clock or thereabouts, they close their doors, and these beautiful buildings—or, at least, adequate buildings—with their parking spaces and electricity, sit vacant until the next morning,” Stuart said. “Why we don’t make those community health centers is beyond me.”

“With serious mental illness, 50% of cases occur by age 14,” said moderator Virginia Betts, professor of nursing and policy at the University of Tennessee Health Science Center. “Think about the opportunity for pediatricians and schoolteachers and kindergarten teachers to really make a difference.”

“[Children’s mental health] is one of those place where I think we have the most to gain by taking apart the elements of what we do in community health, public health, and primary care settings and reconstituting them in a different way,” DeGruy said. “School-based care for children—and their families—would create a dramatically improved population.”

Technology & Behavioral Health Care

Underlying most of the strategies and tactics that Symposium speakers discussed was the need to employ and adapt to the latest technology in any number of areas. From the promise of telehealth and virtual care delivery, to mobile phone apps that can help consumers better direct and manage their own care, to the enormous potential of data science and analytics, the 21st century behavioral health system will need to take advantage of 21st century tools.

Indeed, for a health care sector staring into the abyss of a massive worker shortage, technology and automation could prove a saving grace. That was the message from panelist Nakesh Dewan, an M.D. in the Tampa-area BayCare Medical Group, who cited the billions of venture capital dollars being poured into health care technology, the tens of thousands of existing mobile apps related to mental health issues, and some 300 clinical trials currently underway to measure the effectiveness of those apps.

“In an environment where the technology world, the enterprise technology world, is trying to help people work better, quicker, faster, smarter, and where the consumer technology world is trying to help people get control and have confidence in their health and believe in themselves, we have to recalculate how much workforce we really need,” Dewan said. “Can you imagine consumers spending ... 10 percent of their time with a clinician, 30 percent of their time with a peer, and 60 percent of their time with technology? Right there, that reduces the demand for the workforce.”

One example is, again, the screening kiosk at Drexel University cited by Evans in his remarks; the kiosk runs the HealthyMindsPhilly.org website, an online tool and resource that allows users to learn about mental health “first aid,” screen themselves for their own health, and learn about events and other information that might be of interest. The website, Evans said, is drawing about 15,000 users per year.

Mobile technology, of course, also brings new possibilities for providers. DeGruy said that most successful integrated care operations have their EMRs available via mobile, providing practitioners with real-time, anywhere access to critical patient information but also creating more “bandwidth” for them to communicate with their colleagues across the organization. And Dewan highlighted the critical role “Big Data” and the ability to analyze it will play in a health care system that operates at the population level. Not only will it inform and drive business decisions in the health care space, but it will also bring to consumers an incredibly precise and comprehensive profile of risk factors and individual health care recommendations.

“Finally, the patient will be in the driver’s seat,” Dewan said. “The patient will know their genetic blueprint. The patient will know their epi-genetics. The patient will know all the risk factors and data.

They will know what works and what doesn't. We will have such a huge cloud of data that the mathematicians and the engineers will develop new analytics to teach us how to use this.

"This is going to happen in the next five years," he continued. "There is too much investment and too much motion and too much data being collected, whether it's in the cloud or elsewhere, and we have to become ready. We have to teach our workforce how to think about technology, how to work with technology, and how to use technology."

4

Impact of Innovation & Emerging Models 2: Education & Training

“It’s not enough to think about ‘workforce’ and ‘training’ [separately]. It doesn’t just mean training people up in college and graduate school—one time—and then they are certified and done. Everything is always changing. You have to start thinking about training as a process that is ongoing ... throughout a lifetime.”

—Benjamin Druss, Rosalynn Carter Chair in Mental Health, Rollins School of Public Health, Emory University

For every new caregiver role, every update in care standards, every best practice implemented across an organization, every nifty technological tool deployed in pursuit of efficiency, there is almost certainly an attendant implication—or, more likely, host of implications—for how the people involved in that change are educated, trained and credentialed in what they do. And nearly every speaker at the 2015 Symposium wrestled with some of these implications. What does a set of core competencies look like for a peer specialist? How can technology help overcome distance and time as barriers to quality education and training? Or, even before the training question, how can behavioral health professionals work together to rebuild the recruitment pipeline and ensure a steady supply of new workers to a field that so desperately needs them?

“Clayton Christensen talked about and designed ‘destructive innovation,’ and he said that the two institutions that are slowest to innovate in this country are ... can you guess them? Health care and education,” keynoter Gail Stuart said to more than a few chuckles. “Of those two, health care has the edge on education, because faculty love their autonomy. They love to do what they’ve been doing in the way that they were educated, and I can say that because I’m a dean and I’m talking about my own folks here.”

Of course, some universities are indeed trying to adapt with new approaches in curriculum or technology-assisted instruction, just as some public agencies and professional organizations are working to create new practitioner standards and credentialing options. And whether they surf the tide of change or start to sink, it seems likely that traditional training institutions and credentialing bodies will soon be faced with an environment that looks very different.

“When I was a med student, your goal was basically to ingest the entire body of medical knowledge, especially during your first two years, and then they would kind of set you loose on patients,” said moderator Benjamin Druss, Rosalynn Carter Chair in Mental Health in the Rollins School of Public Health at Emory University. “That worked, because essentially the body of knowledge was

static. The books would be updated from year to year, but for the most part they stayed the same. It may not have been the best possible model, but it was at least feasible because there was a relatively unchanging body of knowledge.

“That’s changed, of course.”

Rebuilding the Pipeline

Regardless of how future psychiatrists or any other practitioners are trained, they still have to decide to go into behavioral health in the first place, and that’s an increasingly tough sell in a field going grayer by the day. Even within the health field, there persists a bias against mental health that subtly steers students, in both quantity and quality, away toward other specialties.

“It’s not uncommon for us to hear from students that, when they tell some of their [advisors] they want to go into psychiatry or primary care, the unfortunate response is, ‘Why would a great student like you want to go into psychiatry or primary care?’” said panelist Kirsten Matthews Wilkins, associate professor of psychiatry in the Yale School of Medicine. “As a psychiatrist, of course, a little part of you dies inside. But we know the stigma exists against our profession.”

Panelist Glenda Wrenn shared her personal experience from “having been raised by an internist father who asked me if I was OK when I mentioned that I wanted to go into psychiatry.”

“He was very concerned,” Wrenn said. “He said, ‘You’re really smart, why would you want to do that?’”

Panelist Kenneth Thompson was not the only speaker to call for a revitalized National Health Service Corps scholarship program and a renewed appeal to young people’s sense of public service. He and others are urging the American Psychiatric Association to explore the idea of an American Psychiatric Service Corps to work alongside the Health Service Corps in supporting students who want to make a career in public behavioral health.

“In the United States right now, and I’m seeing this to some degree with the students and residents and folks I run to, there is a degree of commitment and interest in public service that I haven’t seen in a very long time. I hope we can figure out how to make it possible for them to have the kind of career I had doing public service.”

Of course, public service brings up another obstacle to recruitment: the perception of low wages for behavioral health workers, particularly for non-clinical and emerging roles like peer specialists. If peers are going to be relied upon to shoulder a significant portion of the care burden, they will have to be compensated fairly.

“None of us got into this field because we wanted to make our fortunes—if you did, I think you were guided down the wrong path,” said panelist Lisa Goodale. “But nobody can afford to stay in a field where they cannot earn a living wage.”

Still, at least in certain cases, the perception may not be reality. Wilkins said the gap in pay between psychiatry and other medical specialties is not so great as one might think, and psychiatrists often have more flexibility than their peers in terms of work hours and quality of life. And panelist Kenneth Thompson said at least one sector of behavioral health is doing quite well indeed.

“I am hearing that in some of the rural areas, salaries are going through the roof because they have no folks there,” Thompson said. “That’s not a good thing, because that actually means our shortages are so profound that we’re having to essentially buy people at incredible rates, and they don’t necessarily stick around once they’ve come.”

Speaking of rural America, panelist Paul Force-Emery Mackie called for a targeted recruitment effort to address the fact that 85 percent of the areas in the United States considered to have a shortage of behavioral health care resources are rural.

“We can do better,” Mackie said. “We can do better ... if we are prepared to grab that notion of rural as a culture, rural as a life way that transcends gender, ethnicity, even economics—that it’s the community of rural. I suggest we are more proactive as professionals and we focus on high schools, perhaps drop back to the middle schools, and I’ll even go so far as to say: Why stop there? Let’s have that conversation with our youth and say, ‘Mental health, behavioral health, is a wonderful, viable career choice.’”

A 21st Century Set of Skills

For peers and other new “official” segments of the behavioral health workforce to achieve full recognition and integration, their services will need to be quality-controlled by a consistent certification system. Several speakers mentioned both the need to re-examine current credentialing models and to establish new, standardized sets of core competencies that acknowledge the entire package of skills needed in an integrated primary care setting. Moderator Alex Ross, senior adviser for behavioral health in the U.S. Health Resources and Services Administration’s (HRSA) Bureau of Health Workforce, talked about his organization’s work with SAMHSA to address this need.

“HRSA’s interest is in bringing behavioral health providers to primary care settings, SAMHSA’s is obviously to bring primary care to behavioral health settings,” Ross said. “We have developed a series of curricula to help train providers in primary care settings. I am really proud of those core competencies because they are not profession-specific; they cross all disciplines. They are skills that can be used in primary care settings to build integrated care.”

Regarding peer support, panelist Patrick Hendry said some 40 states have some kind of certification for peer specialists, but this “widely varying” patchwork of requirements and governing bodies is a challenge for a group of nontraditional providers ready to demonstrate the value it brings. He said Mental Health America has convened a group of national behavioral health care experts, including administrators, physicians, nurses and other clinicians, and (of course) peers, to develop a new, more standardized certification. The group’s specific charge is to facilitate the wider adoption of peer services

in the private sector, with its greater hiring scales and higher salaries. Among its other competencies, the new credential will require a year's experience—more than 2,000 hours of practice.

“For a long time there has been a lot of discussion in the peer community about a fear of over-professionalizing peer support, that somehow gaining too much knowledge could take away from the unique nature of peer support,” Hendry said. “I think people can stay true to the nature of peer support and lived experience and a shared view of what it is like to live as a person with some kind of psychiatric disorder, but at the same time be extremely knowledgeable.”

Even the best of core competencies are only as good as the training and certification system that facilitates their adoption throughout the workforce, and Goodale said the system that trains and certifies peer specialists must be made both more reliable and more accessible. The Depression and Bipolar Support Alliance's peer specialist training programs would be double or triple their current size, she said, if all the interested students could afford the program. She also echoed Hendry's point about the debate in the peer community about certifications and training standards, urging that such standards maintain the “non-clinical” nature of peer support.

“Like any new profession, there is a desire for national recognition of competencies and standards,” Goodale said. “Like any newer profession, there is a tendency for other professions to want to be able to define what these people should be doing. Wrong thing—it's for [peers] to decide.”

Disruption on Campus

Just as health care—one of Clayton Christensen's two obstinately conservative American institutions—has been forced to keep up with 21st century change, so too has Christensen's other slow-footed example. Challenged as perhaps never before by a combination of soaring costs, declining public investment, competition from for-profit universities and other new training models, and technology that allows quality distance instruction on a massive scale, traditional higher education has been forced to adapt.

The Yale School of Medicine, for example, has embraced the move toward integrated care by reimagining its curriculum with an eye toward integration. Whereas integrated clinical internships or clerkships are not a new idea, Wilkins said Yale has bucked the tradition of pairing specialties that might make sense on the surface—psychiatry and neurology, for example—but don't take into account the real world of practice. Instead Yale, following what Wilkins called a national trend in medical school curricula of matching specialties with a common patient population, chose to pair psychiatry with primary care and provide a “clinical immersion” in both specialties. The change has made quite an impact on Yale students, she said.

“Most primary care physicians do not truly have the time to help patients with psychiatric illness,” Wilkins said, reading verbatim from student feedback to the experience. “I saw that people who were not in psychiatry sometimes have very little knowledge about how to practice psychiatry, which is concerning, given that sometimes primary physicians are actually the ones treating psychiatric conditions. This clerkship definitely opened my eyes.”

Picking up on this theme, multiple speakers stressed the need to break out of traditional training silos and make the training models in primary care and behavioral health more appropriately reflect the world of practice that future graduates will enter.

“I am beginning to see students,” said speaker Ron Manderscheid, “who come to me and say, ‘I’d like to have a joint degree in social work and public health—where can I go to get that degree?’ There are a number of universities that offer these cross-degrees.”

Furthermore, Mackie said some schools are recognizing the need to train not just for the clinical aspects of behavioral health but the administrative and managerial components as well.

“There are some institutions of higher education that are beginning to embrace this notion of middle management, both clinical as well as administrative, and we are seeing that in schools of counseling, social work, psychology,” he said. “As the behavioral health workforce ages out, as we’ve talked about, it’s becoming more and more apparent that we need to focus on developing that leadership.”

For her part, Stuart clearly felt a revolution is long overdue.

“If you look at the curricula of schools, any of the disciplines around the country, there is a lot of garbage in there—stuff that one faculty member loved and it stays in there, no matter what,” Stuart said. “We need to focus and teach people task sharing, task shifting, and delegation.”

Growing Our Own through Technology

Curriculum wasn’t the only thing Stuart said is ripe for change on college campuses. She dared to take aim at that most venerated of college traditions—indeed, the image most people probably see in their minds when they hear the word “university”: the learned, esteemed professor, lecturing in a hushed auditorium to a group of engaged young minds held in thrall by the lamp of learning.

“The world is changing,” she said. “People aren’t sitting in front of lecterns. We have to take advantage of the fact that people learn anytime and anywhere. We should be teaching [our students] about all this technology that’s out there. Every cohort of student becomes more intelligent than the faculty, with regards to technology. The faculty are really beginning to look like dinosaurs because they still want to lecture on a stage.”

That universities should facilitate greater student access by moving more of their offerings online was accepted as a given by several speakers. Stuart said the Medical University of South Carolina offers all its graduate nursing programs online, and panelist Dennis Mohatt went so far as to say that the Western Interstate Commission for Higher Education (WICHE), which tackles the challenges of educational access across the vast open spaces that define the American West and Alaska and the far-flung Pacific Islands, doesn’t even use the term “distance-learning” anymore. Mohatt cited a 2013 Sloane Foundation report that identified some 300,000 courses online and 6.7 million students—fully a third of all current college students—enrolled in at least one online course.

WICHE facilitates an Internet course exchange program that allows affiliated universities to share courses and fill out the gaps in their local curricula. It also operates the North American Network of Science Labs Online, with participating labs in Colorado, Montana and British Columbia, through which students can collaborate and conduct experiments in a virtual lab in real time.

“We talk about ‘technology enhanced education,’ ‘technology-enhanced teaching and learning,’” Mohatt said. “Technology is a tool to educate; it’s not education. It’s about reaching place-committed learners. It’s about training people where you want them, where they are. It should enhance, not duplicate a classroom experience. It’s connection beyond geographic barriers—it’s instruction beyond didactic shout-outs. It’s about connecting, sharing, learning and mentoring. It’s about growing our own.”

Epilogue

As several speakers noted, the challenge facing the behavioral health workforce is not simply one of numbers. Related but distinct to the overall shortage of behavioral workers is a relative dearth of behavioral health *leaders*. A field that struggles to attract practitioners will, inevitably, also find itself short of the leadership talent that will be so critical to help usher in a new age of integrated care and population health.

“Most public sector leadership positions are currently held by Baby Boomers, so we need to make the transition to the next generation down,” said Ron Manderscheid. “There’s a strong need for training the people who are 35 to 45, who tomorrow will wake up and be director, clinical director, and so on.”

A few organizations, like David Satcher’s Health Leadership Institute at Morehouse, have tackled the challenge head on. It works to train new leaders not only among those already engaged in behavioral health—the clinicians, the administrators—but also among the unpaid workforce of parents and family members and clergy and other local officials. The institute’s approach acknowledges that, given the right set of circumstances, just about anyone could provide leadership.

“We have a saying,” Satcher told the Symposium audience. “In order to eliminate disparities in health and achieve health equity, we need leaders who first *care* enough. We also need leaders who *know* enough, leaders who have the courage to *do* enough, and leaders who will *persevere* until a job is done.”

However, despite the Symposium’s frank talk about all the problems those leaders will have to address, there was, as ever, a spirit of optimism in the room for just about every session. As in past years, the speakers and attendees shared their ideas, their war stories, their findings and outcomes of another year’s worth of investigation and practice, and left The Carter Center on Friday ever hopeful of moving forward, of working together to roll up their collective sleeves and continue the progress that’s been made since Jimmy and Rosalynn Carter were in the White House.

“Every one of us can go home and do things locally—all health care is local,” Manderscheid said. “I’m going to leave with a very optimistic point of view because we have redefined the problem from being simply a problem of needing more people to a problem of changing the nature of the system we are dealing with.”

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