
Diversity, Equity and Inclusion: Emerging Opportunities for the Behavioral Health Workforce

Introduction

It has been established that our nation cannot meet the growing demand for behavioral health services because of workforce shortages. These access and service delivery challenges are further exacerbated by, and contribute to, increased health disparities and inequities among populations served.

Studies demonstrate that training and retaining a diverse workforce is a key strategy to eliminate behavioral health disparities. However, establishing a “pipeline to practice” requires active engagement and relationship building with individuals and populations that inspires their participation in the behavioral health workforce. A diverse workforce is pivotal to engaging populations with historic and structural disparities and ultimately building trust with providers and the health care system more broadly. It starts with trust building and shifting training and retention approaches, especially attention to inclusive environments that are based in non-white organizational structure (Wilbur et al., 2020).

“When a behavioral health professional understands the role that cultural differences play in the diagnosis of a condition and incorporates cultural needs and differences into a person’s care, it significantly improves outcomes. Behavioral health care must be tailored to the individual — to their identity, culture and experience.”

- NAMI, 2021

According to the National Alliance on Mental Illness (NAMI, n.d.), the personal and socially constructed identities and characteristics that determine diversity (such as culture, beliefs, ethnicity, sexual identity and gender orientation, values, race, disability status and language) influence our perceptions and experiences related to behavioral health, including which types of treatments, coping mechanisms, and types of support are effective.

A diverse behavioral health workforce is a critical element to achieving equity. Individuals must feel comfortable and find a sense of trust and mutual understanding to develop positive therapeutic relationships with providers and those in their care networks. However, we have a long way to go to achieve a diverse and inclusive behavioral health workforce. This brief seeks to provide practical resources and best practices for states, and mental health and substance use organizations, looking to diversify their workforce. Promoting diversity, equity and inclusion (DEI) when developing a workforce requires a multi-pronged approach that involves states partnering with provider organizations and moving beyond simply implementing hiring practices that prioritize racial/ethnic diversity. A DEI-focused strategy also includes recruiting, training, supporting and retaining a workforce that is representative of the population served and is trained to tailor care based on an individual’s experience, which may include historic discrimination and poor outcomes.

Defining Key Terms

As states and provider organizations begin to engage in conversations about Diversity, Equity and Inclusion (DEI), it is important to have a shared understanding of the meaning of common terms, including fundamental drivers, such as unconscious bias and institutional, or structural, racism. This will facilitate clear communication and avoid misinterpretations.

Diversity.

Diversity answers the question, “How are we different?” It refers to wide-ranging backgrounds and characteristics such as race, ethnicity, gender expression, sexual orientation, disability, age, socioeconomic status, level of education and religion, among others. When we talk about diversity in this brief, we refer to the organization or workforce as a whole, not individuals.

Equity.

Equity is defined as “the state, quality or ideal of being just, impartial and fair” (Annie E. Casey Foundation, 2021). To achieve equity in the workplace, organizations must recognize that everyone needs different levels of support to achieve the same results. Equity is not the same as equality. Equality implies the same treatment for everyone. Equity levels the playing field.

Inclusion.

Having a diverse workforce does not equate to a culture of inclusion. Inclusion means giving everyone a voice and the same opportunities to participate in a meaningful way. It must be reflected in all programs, policies and procedures at all levels of the organization.

Unconscious bias.

Unconscious biases are assumptions, prejudices and behaviors we have or display without being aware of them. Developing self-awareness of those preconceptions and how we unconsciously think or act toward others leads to change, both personally and organizationally. The “underlying causes of racial inequality are rooted in people’s hidden biases and the institutional culture that normalizes whiteness” (Ginwright & Seigel, 2019).

Explore implicit bias along or with your team to uncover multiple biases and spark important conversations.

Institutional racism.

Institutional racism, also known as systemic racism, refers specifically to the ways institutional policies and practices create different outcomes and opportunities for different groups based on race and ethnicity. Social justice activities are policy, communal and other efforts to recognize the legacy of institutional racism and end these efforts to promote inclusion, equity and belonging as well as improve the distribution of wealth, opportunity and resources.



The Nation is Becoming More Diverse

In 2019, for the first time, more than half of the nation’s population under age 16 identified as a racial or ethnic minority. Among this group, Hispanic/Latinx and Black residents together comprise nearly 40% of the population. Given the greater projected growth of all nonwhite racial minority groups compared to whites—along with their younger age structure—the racial diversity of the nation that was already forecasted to flow upward from the younger to older age groups looks to be accelerating. The white population share in the census is declining and the Latino or Hispanic and Asian American populations continue to show marked gains. 2020 census: **57.8% white, 18.7% Hispanic, 12.4% Black and 6% Asian**

(Frey, 2022).

Defining the Challenge

If the current behavioral health workforce shortage is not addressed through a DEI lens, people who need services will continue to face limited access to behavioral health care, and those who are looking for providers of color, for example, will face compounded access challenges. According to a 2020 Centers for Disease Control and Prevention (CDC) survey, 48% of non-Hispanic Black Americans and 46% of Hispanic/Latinx Americans experienced adverse behavioral health symptoms related to COVID-19, reporting higher behavioral health distress and higher rates of substance use to cope with their distress than their white counterparts (Czeisler et al., 2020). Drug overdose fatalities are rising at faster rates among Black and Hispanic/Latinx populations (AHRQ.gov, 2020). For example, a recent report reviewing opioid overdose fatality data in Philadelphia showed that during the first few months preceding and into the pandemic, fatal overdoses decreased 7.3% among White individuals, but increased 5.9% among Latinx individuals and 40.3% among Black individuals (Khatri, 2021).

However, the workforce is not representative of these populations. A 2019 report by the American Psychological Association's Center for Workforce Studies found that 83% of psychologists in the U.S. workforce were White, 4% were Asian, 7% were Hispanic, 3% were Black/African American and 2% were multiracial or from other racial/ethnic groups (2019). A 2017 Health Resources and Services Administration (HRSA) report noted that 61% of social workers and 65% of counselors in the U.S. are White (National Center for Health Workforce Analysis, 2017).

State Diversity vs. Workforce Diversity.

Achieving a diverse behavioral health workforce will, and should, look different for every state and provider organization. States and organizations should aim to achieve a behavioral health workforce that reflects the regional diversity of the population, particularly at the local level. When assessing diversity, considerations must go far beyond race and ethnicity to include, for example, cultural practices, sexual orientation, gender identity and age. This analysis should include using the workforce pipeline as a forecasting tool and baseline to develop strategies for recruitment and retention.

Education and Licensure.

Encouraging the development of a diverse behavioral health workforce requires creative approaches to expose high school students and graduates to behavioral health career options, provide tuition support and assist with apprenticeship, clinical supervision, mentorship and job search programs. Nebraska exposes high school students to the field through the Frontier Area Rural Mental Health Camp and Ambassador Program and oversees a Virtual Mentor Network that matches students with professionals employed in the behavioral health field (Kirchner, 2022). Other initiatives include:

- » Enhancing the capacity of individuals who serve young children, including, teachers, law enforcement officers, attorneys, mental health professionals, local primary care physicians and others to handle child mental health concerns in their communities through free or low-cost infant early childhood mental health training.
- » Provider organizations establishing partnerships with junior colleges and accelerated programs for people with undergraduate degrees in other fields has been utilized to close nursing gaps and could be promising in behavioral health. Also exploring partnership opportunities with organizations devoted to supporting DEI in education/training and in the workplace.
- » Exploring mentorship opportunities and site visit opportunities where provider organizations can host career days at mental health and substance use organizations.
- » Leveraging recruitment from Black colleges (often referred to as Historically Black Colleges and Universities, or HBCUs) is one option.

Opportunities and Strategies

The impact of historic institutional racism in psychiatry and clinical psychology goes beyond racial disparities in diagnoses. States are advised to acknowledge the history of racism, discrimination and marginalization, which includes calling out policies with adverse impacts on communities. States and provider organizations can collaborate to leverage trust in communities and learn what is really needed to improve effective care.

As well, attention to workforce DEI requires interventions that go beyond hiring. It is critical that state leaders understand what communities need to address workforce challenges and establish the partnerships necessary to develop innovative solutions (Antezzo, 2021).

The National Academy for State Health Policy (NASHP) recently released a comprehensive compilation of strategies and opportunities for states looking to diversify the behavioral health workforce. Their “State Strategies to Increase Diversity in the Behavioral Health Workforce” brief identifies the following high-level strategies:

Engage Black, Indigenous and People of Color (BIPOC) through planning, outreach and progress reporting.

Consider opportunities to directly involve BIPOC stakeholders and staff in building diversity and equity initiatives and develop meaningful outreach to diverse communities in recruitment activities. States should engage and collaborate with a diverse array of stakeholders in various positions of influence to develop a uniform, comprehensive measurement approach to conduct a thorough statewide assessment of diversity in the behavioral health workforce, identify short- and long-term goals (including required human and capital investments and timelines), develop specific, valid evaluation measures, evaluate these initiatives by local geographic region, remain accountable, analyze this data along with health disparities data to inform any connectivity, assist with targeted strategies with long-term impact and communicate progress through community-driven channels.

Use data to understand behavioral health workforce needs.

Using provider licensure and certification information, states can collect and maintain demographic and geographic data to illuminate workforce gaps and opportunities for development.

Build DEI into state workforce planning.

State Workforce Innovation Opportunity Act plans offer policymakers opportunities to integrate diversity initiatives across agencies and programs that support workforce development.

Align across state agencies and branches.

Engage all relevant agencies under centralized state leadership to make connections that reduce duplication and maximize resources that support diversity and equity initiatives.

Prioritize behavioral health in recruitment and retention of the health care workforce.

As states implement initiatives to address health care workforce shortages, dedicating efforts specifically to engage BIPOC within the behavioral health workforce helps focus resources and policies for the particular needs related to behavioral health service delivery.

Identify and address structural and systemic barriers to increasing share of BIPOC behavioral health professionals.

Recognizing and responding to the lived experiences of BIPOC in behavioral health workplaces can help state policymakers address retention issues within the field and elevates BIPOC in environments where client-provider relationships are essential.

Leverage new and emerging funding opportunities to invest in diverse workforce.

Recent funding options through both federal initiatives and potential legal settlements offer states a unique opportunity to consider using non-workforce specific dollars to address behavioral health workforce needs. (Antezzo, 2021)

OTHER METHODS INCLUDE:

Create licensure and certification policies that establish and support new pathways into behavioral health occupations,

such as the “registered apprenticeship” method used in the trades.

In Alabama, Agricultural and Mechanical University (Alabama A and M) students seeking a Masters in Social Work are able to attain a targeted case management certificate from the Alabama Department of Mental Health and Board Licensure, which then subsidizes apprenticeships, based on the demand experienced by providers. Private sector employers subsidize the cost of the apprenticeships (National Governor’s Association, 2022).

Provide flexibility under state and local provider funding streams to support retention bonuses to preserve and promote DEI goals.

Alaska created a support-for-service [incentive program](#) that provides partial financial support to healthcare practitioners in medical, dental, and behavioral health disciplines” to support education loan repayments and/or provide direct incentives (to engage providers who do not have student debt). Approximately 515 mental health providers have benefited from the program and enrollment rates increase annually.

SPOTLIGHT:

Addressing health disparities and diversity, equity and inclusion in the workforce

The Certified Community Behavioral Health Clinic (CCBHC) demonstration offers an opportunity for states and provider organizations to partner to address health disparities and social determinants of health for underserved and marginalized populations. The CCBHC model is structured to provide culturally competent care and linguistically responsive services.

CCBHC status supports clinics in providing targeted outreach services to underserved communities, creating internal policies to uplift BIPOC and LGBTQ+ staff members and clients and increasing wrap-around supports for individuals with unmet social needs to begin addressing these disparities.

The financial flexibility that CCBHCs receive supports clinics' data collection and evaluation activities to better understand their engagement of underserved populations in their community. This data can inform hiring and recruitment efforts aligned to reflect the demographics in the communities served.

100%

of Responding Clinics indicate that CCBHC status has helped them in some way to serve people of color, improve access to care and reduce health disparities in their communities

75%

Increased screening for unmet social needs that affect health, like housing, income, insurance status, transportation and more.

60%

Hired staff who are demographically similar to the populations their clinics serve.

67%

Developed organizational policies and protocols related to improving diversity, equity and inclusion.

53%

initiated or expanded translation services.

A Clear Impact.

The adoption of CCBHCs helped organizations expand their workforce; however, only select states can participate in the full demonstration. As a result of becoming a CCBHC, more than 9,000 staff have been hired and roughly 41 new positions per clinic were created, including youth psychiatrists and staff representing the demographics of communities served.

CCBHC Organization Examples

The **Amherst Wilder H. Foundation** is a [CCBHC in Minnesota](#) that offers the following services to meet the needs of its diverse population:

» **Center for Social Healing.**

A gathering place for Southeast Asian adults for support, fellowship, shared meals and healing, which provides a “soft entrance into mental health treatment” by providing Western mental health services in combination with traditional healing practices.

» **Karen Cultural Brokers Program.**

A specialized care team member able to support holistic services by bridging cultural gaps.

» **Community Equity Program.**

An immersive political leadership program that brings together up to [20 BIPOC individuals](#) who want to get involved in state-level policy and fight for change in their communities.

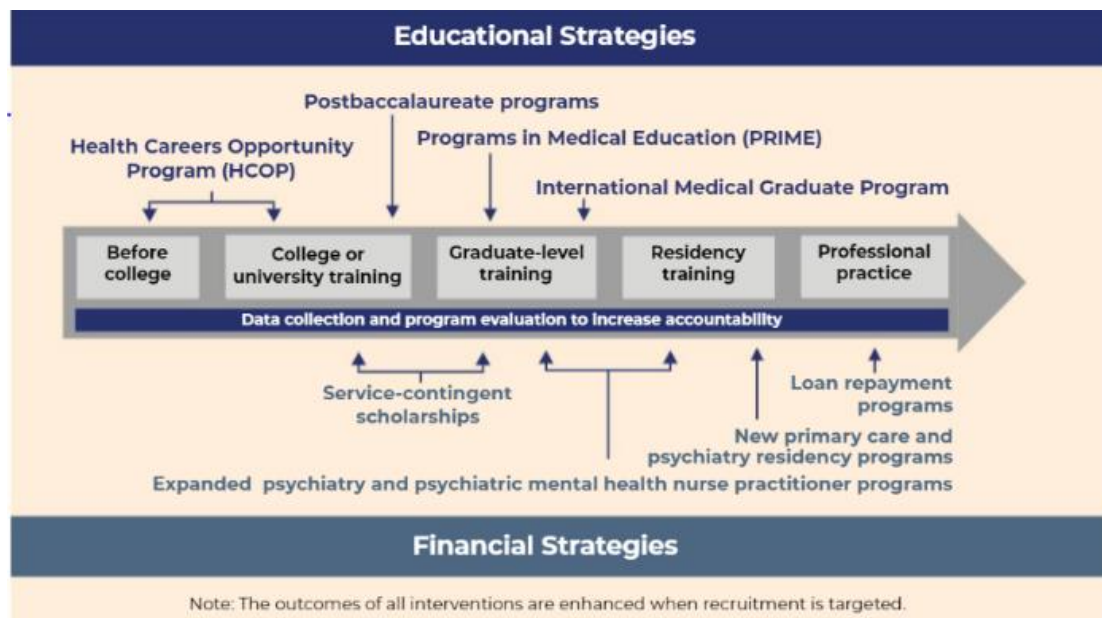
Helio Health in New York State leveraged the [CCBHC model](#) and funding to establish a DEI committee and design DEI policies and procedures to increase the number of diverse populations served and strengthen the number of demographically similar staff.

Education Programs, Partnerships, Student Debt and Licensing

The [Allied Health Workforce Diversity Act of 2019, H.R.3637 \(116th\)](#) did not pass; however, it proposed allowing the Department of Health and Human Services (HHS) to provide grants to accredited education programs to increase diversity in the physical therapy, occupational therapy, audiology and speech-language pathology professions. Similar state legislation may be used to provide scholarships, loan forgiveness, training stipends and other strategies to support recruitment and retention of students from under-represented groups to provide behavioral health services. Federal programs such as HRSA’s National Health Service Corps Loan repayment program could also be made more accessible to diverse populations.

States may also consider funding programs and strategies to expand BIPOC licensure in behavioral health, including pipeline programs, scholarship programs, loan repayment programs, funding of graduate-level health profession training programs and residency funding. Such policies would support providers, like The Anesis Center for Marriage and Family Therapy in Dane County, Minn., which recruits racially, culturally and linguistically diverse case managers with the intentional vision of encouraging them to pursue a master’s degree, secure in knowing that Anesis will provide both their internship site and ongoing employment.

Other examples of states implementing policies to expand behavioral health employment opportunities that expand access for BIPOC include:



California

developed and implemented a comprehensive approach to diversifying the health workforce through the creation of the California Future Health Workforce Commission, which laid out strategies to engage the education systems from high school to college (Olszuk, 2021).

Washington

launched an initiative to improve demographic data collection for pre-license and licensed behavioral health professionals, as well as hiring and retention information to understand the diversity of their workforce and develop targeted strategies to address shortages.

Minnesota

expanded the state's definition of "behavioral health practitioner" to include undergraduate and graduate psychology, social work and counseling students in formal practicum/internship placements. [HF 970](#) will require fewer students to choose between working to support their families or completing their internship and college education. It will expand the behavioral health field to represent a broader array of the workforce. It also includes establishment of a statewide, culturally responsive behavioral health task force; funding to support licensed behavioral health providers from BIPOC and other underrepresented communities to become board-approved supervisors in their respective fields; and cultural competency continuing education standards and diversity memberships standards for state licensing boards for psychology, social work, marriage and family therapy and behavioral health (Amherst H Wilder Foundation, September 2021).

Integrate DEI Requirements into MCO Contracts Minnesota.

The Minnesota Department of Human Services Contract for Prepaid Medical Assistance and MinnesotaCare includes a requirement that contracted managed care organizations “offer appropriate services” for an array of special needs groups including those who are cultural and racial minorities and those who are Lesbians, Gay Men, Bisexual and Transgender Persons. Prospective MCO applicants seeking to manage its Families and Children Medical Assistance and MinnesotaCare program benefits were asked to describe “How does your organization address structural racism? What steps have you taken to become an antiracist organization? How do you plan to improve your systems and processes to be more antiracist?”

Engage Organizations Representing Community Diversity Pennsylvania.

The Pennsylvania Department of Human Services has revamped its community-based care management program to allow community-based organizations (CBO) to perform care management activities. Managed care organizations (MCOs) are now required to partner with CBOs through contract requirements and value-based purchasing (VBP) arrangements addressing health equity and social determinants of health (Pennsylvania Department of Human Services, 2021). New contract requirements were added to the physical health and behavioral health HealthChoices programs for 2021. Specifically, CBOs must be incorporated into medium- and high-risk VBP arrangements to address social needs such as transportation, childcare, employment, food security and housing.

Incentivize Organizational Progress and Create Opportunities to Advance Organizations that Demonstrate Success with DEI New York.

Using a value-based benefit design (Bailit Health for Princeton University Woodrow Wilson School of Public and International Affairs, 2021), New York State has developed guidance to encourage all MCOs and providers to follow a set of principles in their design and implementation of member services: cultural sensitivity, unbiased approaches, equity, timeliness in communication and relevance.

Conclusion

The health workforce crisis is pervasive in physical and behavioral health care as a direct result of the COVID-19 pandemic and increasing demand for services. The challenge is even greater for the behavioral health workforce which was under-resourced prior to the pandemic and comprised mostly White providers. DEI informed strategies to recruit, train and support behavioral health care providers may lead to improvements in patient-provider engagement, clinical outcomes and health equity. These strategies lead to more effective communication with patients and the ability to provide culturally responsive care.

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