Position/Policy Statement

Mental Health Prevention and Treatment

Policy/Position:

The National Safety Council supports actions by stakeholders on the federal, state and local levels, in addition to employers and other organizations, to advance the following initiatives that support mental health as part of overall health. These actions fall into two categories – prioritizing prevention and promotion, and increasing access to treatment services. Specific recommendations are as follows:

1. Prioritizing Mental Health Prevention and Promotion
   a. Supporting policies and programs that increase funding to evidence-based prevention and promotion interventions, and those that encourage health care systems and reimburse health care providers for providing prevention services, including routine mental health screening and other early intervention services
   b. Supporting efforts to align and integrate systems and services and encourage cooperation between systems and sectors to that impact mental health (housing, the criminal justice system, education, etc.)
2. Increasing Access to and Availability of Treatment
   a. Supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and other parity measures
   b. Maintaining increased access to and coverage of telehealth (access and coverage were temporarily increased due to the COVID-19 pandemic)
   c. Supporting and funding Certified Community Behavioral Health Centers (CCBHCs)
   d. Increasing and stabilizing the behavioral health workforce

Mental health, wellbeing and illness are critical components of worker health and wellbeing. Workplaces should prioritize protecting employees' mental health on a level equal to physical safety. Addressing mental health in the workplace requires continuous leadership and commitment from leaders, buy-in from managers, supervisor and employee training, compassionate and flexible policies and programs, the facilitation of education, awareness, and supporting a strong understanding and respect for the complexities of mental health, wellbeing and illness from the top down.

Background
Both mental health distress and mental illness, including general symptoms of depression, anxiety, substance use and stress as well as diagnosable conditions, are common, affecting individuals, their families, co-workers and the broader community. Mental health distress is a common experience that can be brought on by short-term or long-term conditions impacting mental wellbeing. At some point, approximately 50% of people will meet criteria for some kind of mental health disorder during their lifetime, and most will experience mental health distress or challenges to their mental wellbeing. Over 46 million Americans – nearly one in five – live with a mental illness.[1] Over 11 million Americans have a serious mental illness, which, in some cases, can result in functional impairment and impact life activities. Mental illness is the No. 1 cause of disability in the United States.[2]

Mental health (also referred to as mental wellbeing) is the foundation for emotions, thinking, communication, learning, resilience and self-esteem. Mental health is key to relationships, personal and emotional wellbeing, contributing to one's community or society and effectively functioning in daily activities such as attending work or school. It also includes reacting to, coping with and adapting to adversity.[3,4,5] Some challenges, or types of mental health distress, include stress, grief and feeling depressed or anxious. These differ from mental illness in that they are not diagnosed conditions but are mostly situational and resolve before becoming severe. Mental health distress can become a mental illness when ongoing signs and symptoms become chronic and they interfere with or limit one's ability to function in daily life.[6]

Mental illness (also referred to as mental disorders, diagnoses or conditions) refers collectively to all diagnosable mental health disorders – health conditions involving significant changes in thinking, emotion, behavior and/or distress, and problems functioning in social, work, educational or family activities.[7] There are many different mental illnesses, each with different symptoms that influence people in different ways and ranging in degrees of severity.

Individual and social or systemic risk factors resulting from issues present in the overall system (e.g., economic vulnerability) play a role in causing mental distress. Mental health and mental illness are also shaped, to great extent, by the social, economic and physical environments in which people live and operate.[8] Some of these factors are addressed in-depth below.

Individual factors could include changes at work or school, illness, injuries, and problems with relationships, family, money or housing, all of which can cause stress. Long-term or chronic stress can contribute to mental health distress and mental illness through effects on the heart, immune and metabolic functions and hormones acting on the brain.[9]

Social and systemic factors contribute significantly to the occurrence of mental health distress and development mental illness. Some examples of these include access to health care

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[1] https://www.nimh.nih.gov/health/statistics/mental-illness.shtml
[2] https://www.nimh.nih.gov/health/statistics/disability/us-leading-categories-of-diseases-disorders.shtml
[3] https://www.psychiatry.org/patients-families/what-is-mental-illness
[4] https://www.psychologytoday.com/us/blog/reaching-across-the-divide/201804/the-difference-between-mental-health-and-mental-illness
[5] https://www.psychiatry.org/patients-families/what-is-mental-illness
[6] https://www.cdc.gov/mentalhealth/learn/index.htm
[7] Ibid
[8] https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf?sequence=1
[9] https://pubmed.ncbi.nlm.nih.gov/24514565/

services, social norms and attitudes (e.g. discrimination, racism, etc.), socioeconomic variables, and economic stability or vulnerability.[10] The relationship between mental health, mental illness, substance use disorders (SUDs) and the economy is bidirectional – mental health, mental illness, and SUDs are known drivers of lower productivity, increased health care costs and higher mortality.[11] Unemployment, stress (including stress caused by the workplace) and economic vulnerability are linked to increases in mental health distress and substance misuse. In a study done on the 2008 recession, researchers found that for every 1% increase in unemployment in the United States, researchers observed an approximate 1% increase in suicide. A 4% increase in unemployment during that time was commensurate with a 4% increase in suicide.[12] This emphasizes the additional role that a person's environment plays in impacting mental health and wellbeing.

One particular factor that impacts prevention of mental health distress and mental illness, as well as access to treatment, is stigma against those with mental health issues or mental illness. Stigma is the "labeling, stereotyping, separation, status loss, and discrimination" of and against people with a particular social identity, and can manifest on several levels, including stigma from the public, stigma occurring in systems and structures (criminal justice system, medical systems, etc.), and self-stigma.[13] Stigma prevents people from seeking help with they need it, and can decrease the quality of care they get when they do seek help. Additionally, stigma results in individuals with mental illness being more likely to experience housing and employment discrimination and homelessness compared to people without mental illness.[14] Comprehensive action to address public, structural and self-stigma will be needed to increase access to treatment.

Mental health distress and mental illness also impact the global economy. The World Health Organization (WHO) has noted that depression and anxiety alone have an estimated cost to the global economy of $1 trillion per year in lost productivity,[15] with the direct impact on mental health in the United States costing $500 billion in lost productivity annually.[16] Many of these costs are indirect (associated with care seeking, lost productivity, disability, etc.) as opposed to direct costs (medication, medical visits, etc.), which is different from other chronic illness and conditions.[17]

It is clear that treatment works for mental illness and mental health conditions. Treatment for depression works 80% of the time.[18] Strengthening the mental health treatment system, increasing capacity and getting people the care they need at the time of early onset could save

[10] https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health
[11] Davenport S et al., *Potential economic impact of integrated medical-behavioral health care: Updated projections for 2017*, Milliman, February 12, 2018, milliman.com.
[12] https://www.healio.com/psychiatry/suicide/news/online/%7B53327db4-7cc9-4833-9ae8-5da7ec016150%7D/unemployment-linked-to-roughly-45000-suicides-per-year
[13] https://www.shatterproof.org/sites/default/files/2020-07/A-Movement-to-End-Addiction-Stigma.pdf
[14] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3835659/
[15] *Mental health in the workplace*, World Health Organization, May 2019, who.int
[16] https://www.mhanational.org/sites/default/files/Mind%20the%20Workplace%20%20MHA%20Workplace%20Health%20Survey%202017%20FINAL.pdf
[17] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5007565/
[18] http://workplacementalhealth.org/getattachment/Making-The-Business-Case/Link-2-Title/working-well-toolkit.pdf?lang=en-US

up to $48 billion annually in health care costs.[19] However, not everyone receives the care needed. Only 43% of all people living with mental illness receive treatment for their condition,[20] and 10 million adults experiencing a mental illness still report having an unmet need.[21] Common barriers include cost and poor insurance coverage for accessing mental health care, and stigma. If behavioral health care coverage is provided, many people must meet thorough and serious medical necessity criteria to qualify for treatment approval, which often leaves people unable to access services.[22]

Impacts of COVID-19

The Mental Health America (MHA) 2017 Workplace Health Survey[23] found that 63% of respondents reported that workplace stress resulted in a significant impact on their mental and behavioral health, with more than one in three reporting that they engaged in unhealthy behaviors in response to that stress. The COVID-19 pandemic has emphasized the need to respond to the mental health crisis as it has disrupted the normal working lives of millions of Americans, increasing stress both at home and at work. To help employers address mental health in workplaces, NSC through the SAFER (Safe Actions for Employee Returns) initiative has developed mental health resources.[24]

COVID-19 is having a material impact on the behavioral health of society.[25] COVID-19 has caused the sharpest economic pullback in modern history and a record-breaking spike in unemployment; job loss is associated with increased depression, anxiety, distress and low self-esteem and may lead to higher rates of substance misuse, SUDs and suicide.[26]

Mental health support is becoming a top concern for employers as more employees struggle with increased anxiety, loneliness and depression related to remote work and other stressors and impacts related to the pandemic. Mental health distress has increased as measures taken to slow the spread of the virus, such as physical distancing, business and school closures, and shelter-in-place orders, lead to greater isolation and potential financial distress. Beyond the negative impact of a traditional economic downturn, COVID-19 presents additional challenges – fear of the virus itself, collective grief, heightened uncertainty about the future, prolonged physical distancing and associated social isolation. We must also specifically acknowledge the unique grief experienced by families who have lost loved ones to the pandemic.

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[19] Ibid
[20] https://www.thenationalcouncil.org/wp-content/uploads/2019/09/UFBH_FactSheet-1.pdf?daf=375ateTbd56
[21] https://www.mentalhealthamerica.net/issues/state-mental-health-america
[22] https://www.thenationalcouncil.org/press-releases/new-study-reveals-lack-of-access-as-root-cause-for-mental-health-crisis-in-america/
[23] https://www.mhanational.org/sites/default/files/Mind%20the%20Workplace%20-%20MHA%20Workplace%20Health%20Survey%202017%20FINAL.pdf
[24] https://www.nsc.org/Portals/0/Documents/NSCDocuments_Advocacy/Safety%20at%20Work/covid-19/safer-playbooks/mental-health.pdf?ver=2020-06-10-094235-910 and https://www.nsc.org/Portals/0/Documents/NSCDocuments_Advocacy/Safety%20at%20Work/covid-19/safer/qh-issue-paper-mental-health.pdf?ver=2020-07-15-215639-477
[25] https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/returning-to-resilience-the-impact-of-covid-19-on-behavioral-health
[26] https://www.kff.org/report-section/the-implications-of-covid-19-for-mental-health-and-substance-use-issue-brief/#endnote_link_460419-1

Natural disasters provide a comparison point for the experience of Americans today during COVID-19. Prevalence of mental health problems in natural disaster-affected populations is already found to be two to three times higher than that of the general population (varies from 8.6% – 57.3%).[27] One example from the aftermath of Hurricane Katrina showed that the prevalence of serious mental illness had doubled, and nearly half of the respondents in the study had post-traumatic stress disorder (PTSD).[28]

The mental health distress and mental illness stemming from the pandemic will not disappear as the country recovers and people regain a sense of normalcy. It can be expected that the mental health impacts of the COVID-19 pandemic will continue to manifest in the coming weeks, months and years, given the economic, emotional and physical impacts on the entire country. Some of these long-term impacts include a likely surge of people experiencing acute behavioral health problems and symptoms from mental illness. Some of these may be new symptoms and diagnoses, and existing conditions may be exacerbated.[29] Some of these acute behavioral health problems may become chronic. Some populations will be more vulnerable than others, including frontline employees (health care employees, first responders, grocery workers, etc.) who are experiencing elevated levels of trauma, burnout, stress and other impacts on their mental health.[30] These short- and long-term impacts must be carefully monitored and proactively addressed to protect the health and wellbeing of frontline employees of all types.

There will also be long-term impacts of the COVID-19 pandemic that have yet to be identified. There is evidence, for example, that some COVID-19 patients who are intubated experience delirium and hallucinations,[31] recovery from which can take days to weeks, or potentially longer. Additionally, there is a risk for Post Intensive Care Syndrome, which can have aftereffects from treatment ranging from anxiety, post-traumatic stress and other cognitive challenges.[32] Similarly, fatigue (a long-lasting symptom of COVID-19 for many patients) impacts mental health[33]. For some, recovery from these mental symptoms may occur relatively quickly. For others, symptoms may evolve into a diagnosable mental illness. Regardless, comprehensive, coordinated care will be critical to caring for the mental health and wellbeing of COVID-19 patients.

Prioritizing Prevention of Mental Illness and Mental Health Prevention

Prevention and early detection of mental health distress and mental illness is an essential component of any comprehensive approach addressing mental health and illness. A commonly used framework for prevention interventions focuses on risk factors (circumstances that are harmful, increase risk for development of mental illness and impede successful treatment) and protective factors (circumstances that are helpful, decrease risk of development of mental illness and support successful treatment).[34]

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[27] Udomratn P. Mental health and the psychosocial consequences of natural disasters in Asia. Int Rev Psychiatry. 2008;20:441–4.
[28] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3276074/
[29] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2764404
[30] Ibid
[31] https://www.healthline.com/health-news/what-to-know-about-delirium-and-covid-19
[32] https://www.apa.org/monitor/2020/09/aftermath-covid-19
[33] The psychological and physiological health effects of fatigue
[34] https://www.mhanational.org/issues/prevention-and-early-intervention-mental-health

Risk factors can be physical or biological (family history of mental illness, alcohol or drug use, other health conditions), psychological (stress, trauma) or social (living in poverty, unstable housing, unemployment, racism, other forms of social injustice). Opposed to risk factors are protective factors, which promote mental wellbeing and help prevent development of mental illness. Some of these factors include physical or biological (healthy diet and exercise, lack of other health conditions, no substance misuse), psychological (reliable support from family, good coping skills) or social (good relationships with family and friends, economic and financial security).[35]

Mental health promotion seeks to foster individual competencies, resources and psychological strengths, and to strengthen community assets to prevent mental illnesses and enhance wellbeing and quality of life for people and communities. Mental health promotion aims to promote positive mental health by increasing psychological wellbeing, competence and resilience, and by creating supportive living conditions and environments. A positive focus on mental health serves as a powerful protective factor against mental illness.[36]

Many prevention and promotion programs focus on alleviating risk factors and strengthening protective factors. Other programs that focus on one particular issue (e.g., programs that work to alleviate homelessness and housing instability) simultaneously function as an enhancer of mental health protective factors. Recognizing the role that many systems (child welfare, education, juvenile justice, health care, etc.) play in effective prevention and promotion, NSC supports efforts to align and integrate systems and services and encourage cooperation between systems, services and sectors (e.g., housing, education, etc.).

Additionally, prevention programming must be proactive. It must be in place prior to someone developing a mental illness. Many of these interventions do not fit into the traditional health care financial system, meaning they require different funding sources than health care funds. NSC supports policies and programs that increase funding to evidence-based prevention and promotion interventions, as well as those that encourage health care systems to provide prevention services and reimburse health care providers for providing such services, including routine mental health screening and other early intervention services.

Increasing Access and Availability of Treatment

Increasing Access to Mental Health Treatment

As noted above, treatment for mental health works. However, access remains a significant barrier. Over 50% of adults with a mental illness go untreated and over 20% of adults with a mental illness reported not receiving the treatment they needed.[37] Access to care has increased since the Patient Protection and Affordable Care Act (ACA) passed, largely due to Medicaid expansion. Nearly 30% of people who are covered by Medicaid through the expansion have either a mental health disorder or an SUD.[38] NSC has a policy position on Medicaid as a support

[35] https://www.americanmentalwellness.org/prevention/risk-and-protective-factors/
[36] https://www.who.int/mental_health/media/en/545.pdf
[37] https://www.mhanational.org/issues/mental-health-america-access-care-data#adults_ami_no_treatmentt
[38] https://www.healthaffairs.org/do/10.1377/hblog20200205.346125/full/#:~:text=First%2C%20Medicaid%20expansion%20has%20been,uninsured%2C%20low%2Dincome%20adults.&text=Second%2C%20the%20ACA%20improved%20behavioral,Act%20(MHPAEA)%20of%201996.

to mental health treatment. Another mechanism to increase access to care is to work towards better integration of behavioral health care into primary health care to assure a more holistic approach to providing care, which requires better access to primary care – another benefit of Medicaid programs.[39]

MHPAEA and ACA both include provisions to ensure increased access to mental health and SUD treatment. However, insurers have not implemented these laws evenly, and neither the federal government nor state governments are adequately enforcing them.[40] Currently, there are no penalties for non-compliance. A 2017 study found that more than two-thirds of insurance plans contained obvious violations of ACA requirements and 88% lacked sufficient detail to evaluate parity compliance.[41] NSC supports mental health parity, and the policy position can be found here.

Supporting Certified Community Behavioral Health Clinics (CCBHCs)

CCBHCs are nonprofit organizations or units of a local government behavioral health authority. According to this National Council on Behavioral Health CCBHC brief, CCBHCs are designed to provide a comprehensive range of mental health and SUD services to vulnerable individuals. In return, CCBHCs receive an enhanced Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of these complex populations. They must directly provide (or contract with partner organizations to provide) nine types of services, with an emphasis on the provision of 24-hour crisis care, evidence-based practices, care coordination with local primary care and hospital partners, and integration with physical health care.[42]

The benefits of CCBHCs in addressing the behavioral health needs of Americans are clear. Some highlights include:

- An expanded and enhanced workforce that increases CCBHC capacity to provide care and increase the quality of the care
- Stronger services for people with SUDs
- Enhanced patient reach and engagement
- Service provision outside the traditional clinic

The CCBHC program is expanding from a demonstration program existing in certain states to a national initiative as its efficacy is demonstrated.[43] However, CCBHCs are reliant on federal funding, with the amount awarded decided annually. The National Safety Council supports measures to maintain or increase current funding, and to eventually secure long-term funding that stabilizes the program.

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[39] http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Medicaid-Expansion-Under-the-ACA-Updated-Findings-from-a-Literature-Review
[40] https://www.statnews.com/2018/12/10/policymakers-must-help-enforce-mental-health-parity-laws/
[41] https://www.drugrehab.com/2016/06/17/insurance-lacks-obamacare-addiction-benefits/
[42] https://www.thenationalcouncil.org/wp-content/uploads/2017/11/What-is-a-CCBHC-11.7.17.pdf?daf=375ateTbd56
[43] https://www.thenationalcouncil.org/

Using Telehealth to Increase Access to Treatment and Care

Telehealth is an underutilized tool that is essential for reaching hard-to-reach populations (e.g., rural and underserved communities). It can break down barriers to providing behavioral health services and care, and increase access and availability. In some cases, telehealth can allow for greater privacy, anonymity and avoidance of the stigma that can be attached to being a behavioral health patient. Additionally, it can improve care interventions outside the bounds of traditional care sites (particularly important for rural areas and people who are quarantined during the COVID-19 pandemic), enhancing communication between patients and providers and extending a limited workforce.[44] Another benefit to increased telehealth coverage and utilization is that it can increase the capacity to monitor remotely and improve the quality of remote monitoring of high-risk and remote populations, which can help shape interventions and provide better population-level and individual care.

COVID-19 has forced a rapid expansion of telehealth services, and utilization has risen accordingly, with one payer reporting an increase from 200 telehealth claims a day in February 2020 to 38,000 a day in May 2020.[45] Almost 50% of those claims were related to mental health. Maintaining increased access and availability of telehealth services after the COVID-19 pandemic will be critical to meeting the anticipated increased demand for services on an already overburdened workforce.

While telehealth has been a critical component of the COVID-19 response, increased telehealth access has been debated for years. Increasing access to telehealth, careful programming and increased funding are critical. Barriers exist to effective implementation of telehealth practices, including but not limited to:[46]

- Lack of patient internet or phone access
- Lack of health care coverage
- Lack of training on effective health care professional best practices
- Reimbursement discrepancies that pay at a lower rate than in-person visits, effectively disincentivizing health care professionals to offer their services via telehealth
- Disparate coverage models (both governmental and private) and payment mechanisms, with no standardization on funding sources and covered services across payers
- Perceived lower quality care in comparison to in-person appointments
- Mistrust of technology, including privacy concerns

While almost all state Medicaid programs reimburse for some level of telehealth services, coverage is inconsistent. This is also true for those with employer-sponsored coverage. In one 2019 survey, only 50% of employee respondents across the nation reported employer health care plan coverage of telehealth.[47] While coverage for telehealth has been enhanced and expanded due to the COVID-19 pandemic, this is not necessarily permanent. NSC recommends that employer sponsored plans continue to offer telehealth as an essential part of their coverage.

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[44] https://www.mhanational.org/blog/tele-mental-health-now-and-now
[45] https://healthpayerintelligence.com/news/mental-health-visits-take-majority-of-1m-payer-telehealth-claims
[46] https://www.ruralhealthinfo.org/toolkits/telehealth/1/barriers
[47] http://dmec.org/2019/05/30/2019-dmec-mental-health-pulse-survey-results/

In addition to making permanent the emergency provisions that have increased access to telehealth services during the COVID-19 pandemic, other policies that should be implemented include:

- Updating licensing requirements to make it easier to provide telehealth services, including allowing providers to practice across state lines, and permission for pre-licensure providers to utilize telehealth services under supervision
- Improving and standardizing coverage models, payment mechanisms and reimbursement practices for telehealth services across government (Medicaid, Medicare) and private payers
- Removing barriers to accessing telehealth services, including:
    - Covering technology and other services needed to ensure patients can access telehealth services
    - Allowing initiation of care virtually
- Increasing telehealth capacity and remove barriers for providers of medications for addiction treatment (MAT) and other SUD treatment interventions
- Researching to determine when telehealth is or is not a good stand-in for in-person care
- Developing standards of care for providing telehealth services
- Applying the developed standards of care to all telehealth providers to ensure quality of care is maintained and individualized to the specialty to avoid an overly general one-size-fits-all approach

Increasing and Stabilizing the Behavioral Health Workforce

There is a shortage of the behavioral health workers. In states with the lowest workforce ratio, there are almost four times the number of individuals in need to one mental health provider available.[48] While roughly one in five Americans live with some form of mental illness in any given year, there are only enough mental health care professionals across the country to meet around 26% of the need for services, and the gaps are much higher for residents in rural areas. Specifically:

- By 2030, analysts predict that, if no workforce changes are made and other trends continue, there will be only one geriatric psychiatrist for every 6,000 older Americans with mental illness and substance use issues[49]
- The U.S. Bureau of Health Professions estimated that, in 2020, 12,624 child and adolescent psychiatrists will be needed, far exceeding the projected supply of 8,312[50]
- There is a shortage of 2,800 psychiatrists in rural and underserved areas, contributing to the fact that 85% of federally designated behavioral health professional shortage areas are in rural locations[51]

Barriers to increasing behavioral health workforce capacity include chronic underfunding of the behavioral health safety net, historically low wages, and high caseload demands, resulting in high burnout and turnover rates in provider organizations.[52] For substance use professionals in

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[48] https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_154785
[49] https://www.aha.org/system/files/hpoe/Reports-HPOE/2016/aha_Behavioral_FINAL.pdf/
[50] http://annapoliscoalition.org/wp-content/uploads/2013/11/action-plan-full-report.pdf
[51] https://www.bhecon.org/wp-content/uploads/2016/09/BHECON-Behavioral-Health-Workforce-Fact-Sheet-2018.pdf
[52] https://www.aha.org/system/files/hpoe/Reports-HPOE/2016/aha_Behavioral_FINAL.pdf

particular, the stigma associated with treating people with addiction has also been identified as a retention barrier.

The National Safety Council supports the following solutions (which were adapted from the American Hospital Association[53]):

- Broadening the concept of “workforce”
    - Expand the roles and responsibilities of patients and families, communities, social services and health professionals
    - Develop the capacity of health care providers other than behavioral health specialists to address behavioral health conditions (e.g. primary care providers, nurses, social employees, non-traditional health care employees, etc.) which can increase capacity without increasing the number of hires
- Strengthening the behavioral health workforce
    - Implement systematic recruitment and retention strategies
    - Increase the relevance, effectiveness and accessibility of training and education for incoming professionals and for retraining current medical professionals
    - Foster the development of leaders across the workforce continuum
    - Encourage and increase diversity in the workforce
- Creating structures to support employees and prevent burnout
    - Address financial disparities to appropriately compensate employees, recognizing that salaries and reimbursements are so low that students actively avoid the field (reimbursement amounts for psychiatric care often do not cover the provider’s costs, regardless of whether the patient is a Medicare or Medicaid recipient, or covered by private health insurance)
        - Increase pre-payment incentives and payments tied to managed care and Centers for Medicare & Medicaid Services (CMS) funding, and expand Medicare and Medicaid reimbursement
        - Enhance reimbursement policies to allow clinics to pay competitive wages
    - Increase employee support programs (employee assistance programs, peer-to-peer support, etc.) to address employee mental health impacts
    - Increase student loan repayment programs
    - Incentivize working in rural and underserved communities
    - Facilitate care – providers must have the freedom to use telehealth and other digital tools, especially to be able to serve those in rural areas
- Address the uneven distribution of behavioral health professionals and resources, intensifying the impacts and magnitude of provider shortages[54,55]
    - Ensure that building, redistributing and reshaping the behavioral health workforce must be aligned with other efforts to address the social determinants of health and improve overall delivery of care
    - Support efforts to move the behavioral health field toward improved coordination and integration with primary care, specialty emergency and rehabilitation care settings

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[53] https://www.aha.org/system/files/hpoe/Reports-HPOE/2016/aha_Behavioral_FINAL.pdf
[54] https://www.healthaffairs.org/doi/10.1377/hlthaff.2015.1619
[55] https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/Behavioral-Health-Workforce-Projections.pdf

This position statement reflects the opinions of the National Safety Council but not necessarily those of each member organization.

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