POLICY **BRIEF**

Telebehavioral Health Workforce Opportunities During the COVID-19 Pandemic

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Background

The coronavirus disease 2019 (COVID-19) pandemic, which resulted in a declaration of national emergency in the U.S. in March 2020, caused a rapid transition to virtual healthcare services, including telebehavioral health. To better understand behavioral health workforce development opportunities for telebehavioral health, including training, and the impact of COVID-19, the National Council for Mental Wellbeing (National Council), in partnership with the University of Michigan Behavioral Health Workforce Center, conducted a mixed methods study between April and September 2020.

Methods

To better understand the workforce development and training opportunities to advance telebehavioral health and the impact of the COVID-19 pandemic on telebehavioral health services, National Council research staff collected quantitative and qualitative data from behavioral health provider organizations nationwide. Two phases of the study were conducted: (1) an electronic survey in August 2020, and (2) key informant interviews that took place in August and September 2020.

Phase 1 Methods

To collect quantitative data from a convenience sample of behavioral health providers from the National Council, an electronic survey tool was designed and administered. Prior to dissemination, the online survey was reviewed by Behavioral Health Workforce Center experts and pilot tested by several National Council team members and external behavioral health providers not involved in the research project. SurveyMonkey, an electronic research platform, was used to securely collect data. The survey was designed to be completed within approximately ≤15 minutes.

In July 2020, the survey tool was distributed via e-mail through the National Council's mass communications list, which includes more than 50,000 behavioral health stakeholders representing all 50 states. A response rate was not calculated due to the survey recruitment methods used. Participation in the survey was voluntary and a $25 electronic gift card was provided as an incentive to the first 350 participants to complete the survey. The survey was available online for 3 weeks. Quantitative data generated from the survey were analyzed with Microsoft Excel software.

Phase 2 Methods

To gain a deeper understanding of the impact of the COVID-19 pandemic on telebehavioral health and workforce training needs, qualitative data were collected through key informant interviews in August and September 2020. A semi-structured interview guide was developed to facilitate the interviews. Interviews

were recorded and transcribed and Microsoft Excel was used for data analysis. A thematic analysis was performed to identify common themes shared across respondents. Interviewees included behavioral healthcare providers and staff whose organizations offer telebehavioral health services. Participation in the key informant interviews was voluntary and key informants were offered a $25 gift card incentive.

Key Findings

There was an initial total of 832 individuals that responded to the survey, but 62 respondents were not providing behavioral health services and were therefore excluded from consideration. Among the remaining 770 participants, 89% (686/770) reported that their organizations were currently providing telebehavioral health services, 8% (64/770) reported that they were not, and 3% (20/770) reported that they did not know. However, 116 respondents elected not to participate in the rest of the survey and were therefore excluded from the remaining analyses. This leaves a final analytic sample of 654 providers from 48 states, the District of Columbia, Puerto Rico, and the Virgin Islands that responded to the survey. The 2 states not represented in the survey are Hawaii and Wyoming.

The most common types of organizations represented include mental health clinics (38%, 292/770), substance use disorder treatment organizations (23%, 179/770), and social services agencies (12%, 91/770). It should be noted that some organizations identified themselves as more than one type of organization, i.e. an organization could select mental health and substance use disorder treatment organization.

Approximately half of the respondents (53%, 328/619) were from urban areas with populations >50,000 people and one quarter of respondents (27%, 169/619) were from areas with populations of between 2,500 to 49,999 people. Nine percent (55/619) of respondents were from rural areas with <2,500 people. Eight percent (51/619) of respondents reported they were from medically underserved areas and 2% from Frontier Health Professional Shortage Areas. Approximately 1% (6/619) of respondents were from tribal areas. Half (314/622) of the respondents worked at organizations that serve <5,000 individuals annually. Seven percent (41/622) worked at organizations that serve >50,000 people annually.

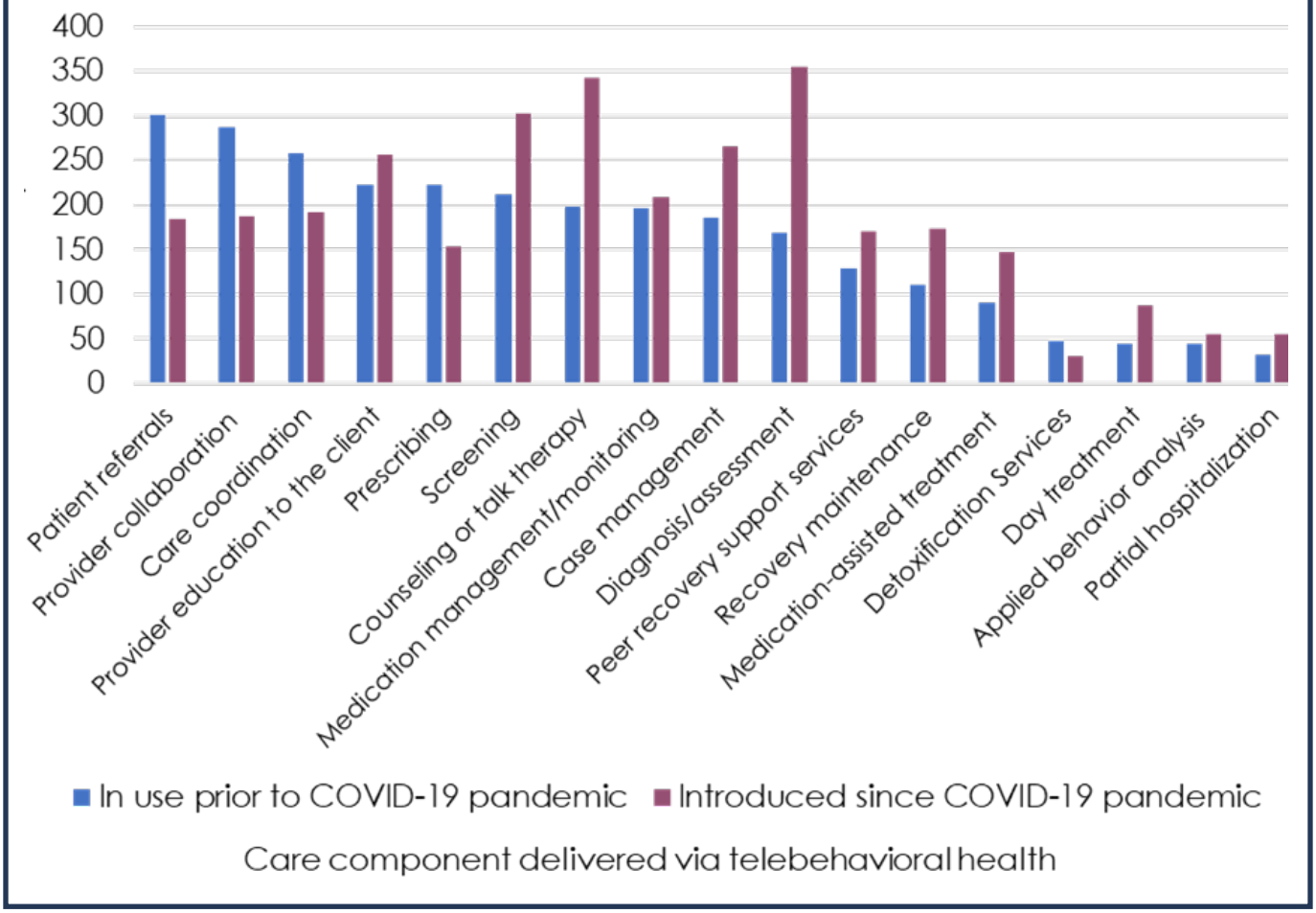
Since the onset of the COVID-19 pandemic, there has been a significant increase in the utilization of telebehavioral health services. Almost all survey respondents (95%, 543/573) reported that the percentage of patients using telebehavioral health services increased since the beginning of the pandemic. Survey participants were asked to estimate what percentage of their patients were using telebehavioral health services at the time of the survey. More than half (56%, 320/571) reported that 76%–100% of patients were currently using telebehavioral health services. Less than one percent (0.4%, 2/571) reported that none of their patients were using telebehavioral health services.

Respondents were also asked whether they introduced new or expanded existing telebehavioral health services in response to the COVID-19 pandemic. Ninety-nine percent of the respondents to this question reported that they introduced new services (59%, 340/575) or expanded telebehavioral health services (40%, 229/575) in response to the pandemic. Only 1% (6/575) of respondents reported that their organizations did not introduce or expand telebehavioral health services in response to the pandemic.

The most common types of care components offered via telebehavioral health introduced since the COVID-19 pandemic included diagnosis/assessment (64%, 355/557), counseling or talk therapy (61%, 342/565), and screening (54%, 302/559). The least common types of care components offered via telebehavioral health introduced since the COVID-19 pandemic were detoxification services (6%, 30/519), partial hospitalization (10%, 55/526), and applied behavior analysis (11%, 55/520) (Figure 1).

Survey participants were asked to choose which factors facilitated or challenged the introduction or expansion of telebehavioral health services in response to the COVID-19 pandemic. The most commonly cited facilitators of telebehavioral health services in response to the pandemic include telebehavioral health

Figure 1. Types of Care Components Delivered via Telebehavioral Health



resources (68%, 382/562), reimbursement policy (60%, 339/562), and provider access and skill with technology (59%, 333/562).

Respondents were also asked to identify factors that were their greatest challenges related to introducing or expanding telebehavioral health services in response to the COVID-19 pandemic. The most commonly identified challenge was client access and skill with technology (80%, 448/560), followed by provider access and skill with technology (27%, 153/560), and telebehavioral health resources (17%, 96/560).

In addition to understanding the ways in which the COVID-19 pandemic has impacted telebehavioral health use, the goals of this study included better understanding training needs related to telebehavioral health. Among 650 survey respondents, 57% (373/650) reported that they had been trained in the delivery of telebehavioral health and 43% (277/650) reported that they did not receive training. Among 366 respondents who did receive telebehavioral health training, most individuals received training after they were employed at their current place of employment (77%, 283/366). Only 23% (83/366) of individuals received training prior to their current place of employment.

Among respondents who received training, more trainings took place following the onset of the pandemic (60%, 535/887) compared with prior to pandemic (36%, 320/887). The most common sources of training included nonprofit agencies (21%, 182/887), employer-provided sources (20%, 181/887), and private company providing continuing education credits (12%, 109/887). The least common sources of training included residency (0.8%, 7/887), field practicum or internship (2%, 17/887), and graduate school course work (4%, 32/887).

Conclusions & Policy Considerations

The telebehavioral health landscape fundamentally changed owing to the COVID-19 pandemic and subsequent policy and regulatory reforms. The rapid adoption of telebehavioral health services by providers has helped to engage and maintain clients in behavioral health services, which are especially critical during times of national crisis such as a pandemic. Telebehavioral health providers' experiences since the onset of the pandemic offer valuable information related to the workforce challenges and opportunities related to adopting, implementing, and sustaining telebehavioral health.

Nearly all survey respondents (99%, 569/575) reported that their organizations introduced new or expanding existing telebehavioral health services in response to the COVID-19 pandemic and a majority (79%, 452/573) of the organizations plan to continue to offer telebehavioral health beyond the pandemic period.

Training was identified as a major need and facilitator for the successful transition to telebehavioral health; however, training topics identified focused less on the technical aspects of employing technology and more so on how to adapt and integrate evidence-based, trauma-informed, and culturally relevant strategies within virtual settings. Training needs related to successfully engaging clients in telebehavioral health services and conducting thorough assessments were identified.

There are meaningful opportunities for more research in this area as the experiences, effects, and impacts of the rapid transition to telebehavioral health services, the pandemic, and related policy changes are currently continuing to happen.

Acknowledgements

This study was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1.1 million. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.