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# Implementation of Behavioral Health Workforce Education and Training in South Florida

**Staci L. Morris[1*], Katherine R. Perez[2], Jordan E. Quintana[2], Eric F. Wagner[3] and Michelle M. Hospital[4]**

*[1]Florida International University, Community-Based Research Institute, Robert Stempel College of Public Health & Social Work, USA*

*[2]Florida International University, Community-Based Research Institute, USA*

*[3]Florida International University, Community-Based Research Institute, School of Social Work, USA*

*[4]Florida International University, Community-Based Research Institute, Department of Biostatistics, USA*

## Abstract

**Background:** Expanding the behavioral health workforce requires training models that include evidence-based interventions to adequately prepare practitioners for integrated, interprofessional care in a wide range of settings and communities. **Objective:** This paper describes the implementation of a HRSA-funded Behavioral Health Workforce Education and Training Program for Professionals at Florida International University (BHWET-Pro@FIU). The program foci include trauma-informed, team-based practice, and technology-enhanced instruction to prepare master's-level social work, counseling, and psychology trainees for clinical practice in behavioral healthcare settings. **Methods:** BHWET-Pro@FIU follows a hybrid model that combines remote didactic instruction with experiential learning at community-based training sites over the course of two semesters. Curricular innovations include training in telehealth etiquette, trauma-informed care, substance use disorders, as well expert guest speakers on aging, neurodiversity, overdose prevention, and the use of AI in healthcare. Training incorporates standardized patient role-plays and accompanying self-reflections, pre- and post-interprofessional competency using standardized assessments, and consumer feedback from program directors. **Results:** Analysis of 200 BHWET-Pro@FIU alumni demonstrated significant improvements in interprofessional competencies across SPICE-R2 total and subscale scores, with large effect sizes ($\eta^2$ = 0.18–0.30). Fellows reported increased preparedness for integrated behavioral health roles, particularly in trauma-informed care, telehealth delivery, and team-based collaboration. RCQI-informed curricular refinements further enhanced training outcomes. **Conclusion:** Implementation of BHWET-Pro@FIU demonstrates the feasibility and effectiveness of integrating hybrid didactic instruction, trauma-informed approaches, and interprofessional experiential training to prepare clinicians for behavioral health workforce needs. This model provides a scalable framework for academic-community partnerships aimed at expanding and enhancing behavioral healthcare workers' clinical contributions in integrated primary care settings.

**Keywords:** Integrated behavioral health; Community mental health; Trauma-informed care; Telehealth; Workforce development

## Introduction

Clinical problems for three out of every four primary care patients involve a significant behavioral component [1]. Expanding the professional workforce trained to provide interprofessional, team-based behavioral health care remains a health priority [1-3]. Training clinicians to deliver contextually appropriate integrated behavioral health care is particularly urgent for populations and communities experiencing health disparities [4].

Workforce shortages and uneven access to integrated behavioral health care persist, with over one-third of the U.S. population residing in Mental Health Professional Shortage Areas [5]. These health disparities are particularly pronounced in rural and isolated communities, where residents often face significant barriers to accessing care [5]. To address these challenges, federal agencies such as the Health Resources and Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA) have emphasized the importance of preparing professionals for integrated care delivery. HRSA's Behavioral Health Workforce Education and Training Program for Professionals (BHWET-Pro) aims to increase the supply and distribution of behavioral health professionals, with a focus on children, adolescents, and young adults at risk for mental health and substance use disorders [6]. Similarly, SAMHSA collaborates with federal and other partners to increase the supply of trained and culturally aware professionals to address the nation's behavioral health needs [4]. These initiatives underscore the national emphasis on equipping professionals with the skills necessary for effective integrated care in underserved populations.

### Purpose and Need

Primary care settings are often where individuals with behavioral health needs initially present and offer a prime opportunity for screening and referral for a wide range of behavioral health services and supports. Primary care settings remain a critical first point of contact for behavioral health needs, with around 40% of adults visiting primary care providers (PCPs) for mental health concerns, yet only 20% of these providers are incentivized to conduct behavioral health

screenings [7]. In response, federal initiatives like HRSA's support for behavioral health integration and Centers for Medicare & Medicaid Services (CMS's) reimbursement codes have significantly expanded access to screening, treatment, and mobility between primary and behavioral health systems [8,9]. Expanding the workforce trained to provide interprofessional team-based behavioral health care is critical to reducing health disparities [10,11]. The Agency for Healthcare Research and Quality [AHRQ] [12,13] has advocated for increasing integrated behavioral health care but notes progress is limited due to a persistent shortage of qualified professionals.

In Florida, approximately 30% of residents live in counties designated as Mental Health Professional Shortage Areas, highlighting the state's ongoing behavioral health workforce challenges [5]. In Miami-Dade County, home to approximately 2.70 million residents [14], about 14% of adults remain uninsured [15]. The county faces a notable provider shortage with 232 mental health professionals per 100,000 residents, which equates to roughly one provider for every 430 people [16]. Additionally, 20.8% of adults reported experiencing a mental health disorder in the past year, exceeding the Florida average [17]. Miami-Dade County, a community of approximately 2.77 million residents, includes 68.7% Hispanic or Latino, 14.0% non-Hispanic Black/African American, and 13.4% non-Hispanic White individuals. A majority (54%) are foreign-born, and nearly one-third speak a language other than English at home [18]. Despite overwhelming need, only around 1% of adults with serious mental illness (SMI) receive services through the public mental health system [19]. Factors such as poverty, housing instability, and lack of insurance further exacerbate challenges in access to behavioral health services.

Behavioral health workforce shortages continue to impede access to care [5]. Two key contributing factors are insufficient training capacity and inadequate clinical experience opportunities [20]. These challenges hinder the development of a well-prepared workforce capable of addressing the growing demand for behavioral health services. BHWET-Pro@FIU addresses these challenges by collaborating and drawing fellows from three graduate training programs: (1) Social Work, (2) Clinical Mental Health Counseling in Education, and (3) Professional Counseling in Psychology, providing a 50-hour interdisciplinary course concurrent with experiential placements at community agencies, and promoting consolidation of knowledge and skills in real-world settings.

## Methods and Program Model

### Program Overview

BHWET-Pro@FIU is currently in its ninth year of implementation. To date, it has trained and graduated 216 fellows from three master's-level programs: Social Work, Clinical Mental Health Counseling in Education, and Professional Counseling in Psychology. Fellows complete a 50-hour interdisciplinary course delivered concurrently with supervised clinical placements across seven community partner sites in South Florida (Table 1). A curriculum summary appears in Table 2, and an accompanying infographic (Figure 1) depicts the BHWET-Pro@FIU training model:

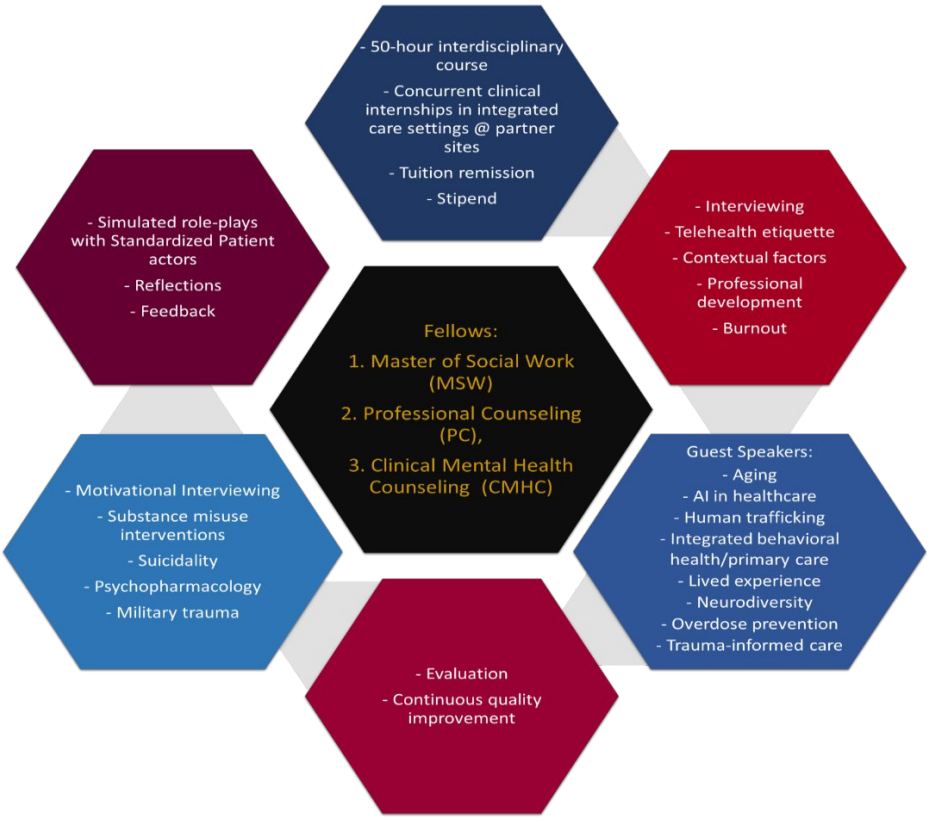


**Figure 1:** Overview of BHWET-Pro@FIU training components.

| Site* | Type | Primary Service Population | Training Emphases |
|---|---|---|---|
| 1 | Community behavioral health & primary care | Low-income, uninsured/underinsured adults & families | Integrated primary care–behavioral health, SUD services, telehealth workflows |
| 2 | Community behavioral health & primary care | Adults, children, complex comorbidity | Care coordination, EMR team communication, trauma-informed screening |
| 3 | Federally qualified health center | Low access, multilingual communities | Team-based chronic care, brief interventions, SBIRT |
| 4 | Community mental health | Court-involved youth & families, IPV, trauma | Family systems, trauma-informed care, community collaboration |
| 5 | Academic–community program | High-need neighborhoods | Interprofessional home-/community-based care, contextual factors |
| 6 | Community mental health | SMI/SED, justice-involved adults | Severe mental illness management, care transitions |
| 7 | Behavioral health & SUD | Adults & adolescents with SUD | MAT coordination, relapse prevention, integrated SUD–MH care |

*Notes.*
*Sites are numbered to protect confidentiality.
EMR = electronic medical record; IPV = intimate partner violence; MAT = Medication-Assisted Treatment; SBIRT = Screening, Brief Intervention, and Referral to Treatment; SMI/SED = serious mental illness/serious emotional disturbance; SUD = substance use disorder

**Table 1:** BHWET-Pro@FIU experiential training sites and characteristics.

### Didactic Training

BHWET-Pro@FIU employs a hybrid didactic model with content modules addressing the following topics:

- Telehealth Etiquette
- Professional Development
- Motivational Interviewing Techniques
- Trauma-Informed Principles and Suicide Assessment
- Substance Use Interventions and Overdose Prevention
- Aging
- Neurodiversity
- Artificial intelligence (AI) in healthcare
- Human Trafficking
- Lived Experience

In addition to these modules, the program incorporates structured assignments, including guided readings, case-based exercises, and Standardized Patient role-plays, to deepen fellows' applied learning. Fellows also engage in experiential training through clinical case supervision provided by licensed professionals at each partnering site, reinforcing skill development in real-world settings.

## Program Goals

The overarching goal of BHWET-Pro is to increase the supply of behavioral health professionals who are trained to provide integrated behavioral health care and committed to work in high-need and high-demand areas. The BHWET-Pro@FIU methodology is structured to meet five objectives:

**Objective 1:** Increase the number of new or expanded community partnerships with experiential training sites in high-need and high-demand areas.

**Objective 2:** Promote collaborative training by using team-based models of care to integrate behavioral health care into interprofessional primary care settings.

**Objective 3:** Recruit a qualified workforce interested in working with children, adolescents, and young adults.

**Objective 4:** Recruit, develop, and expand the capacity to train clinical supervisors to support and mentor behavioral health trainees.

**Objective 5:** Enhance monitoring, data collection, and evaluation for continuous program improvement.

### Pre- and Post-Assessment of Interprofessional Skills

BHWET-Pro@FIU Fellows' interprofessional competencies were assessed at program entry and completion using validated measures. The Student Perceptions of Interprofessional Clinical Education–Revised, Version 2 (SPICE-R2) instrument captures fellows' self-reported perceptions of interprofessional teamwork, roles and responsibilities, and patient outcomes [21,22].

Results from repeated-measures analyses of variance (ANOVA) data from alumni who consented to participate in the research (N = 200) indicated a significant increase in overall interprofessional competencies from pre-program ($M = 4.32$, $SD = 0.48$) to post-program ($M = 4.56$, $SD = 0.40$), Wilks' $\Lambda = 0.77$, $F(1, 199) = 59.19$, $p < 0.001$, $\eta^2 = 0.23$ (see Table 3). Significant improvements were also observed for the Roles/Responsibilities subscale, increasing from $M = 3.89$ ($SD = 0.72$) to $M = 4.38$ ($SD = 0.57$), Wilks' $\Lambda = 0.70$, $F(1, 199) = 85.00$, $p < 0.001$, $\eta^2 = 0.30$, and the Patient Outcomes subscale, from $M = 4.28$ ($SD = 0.60$) to $M = 4.54$ ($SD = 0.48$), Wilks' $\Lambda = 0.82$, $F(1, 198) = 42.51$, $p < 0.001$, $\eta^2 = 0.18$. In contrast, no statistically significant change was observed on the Teamwork subscale (Pre $M = 4.67$, $SD = 0.50$; Post $M = 4.72$, $SD = 0.40$), Wilks' $\Lambda = 0.99$, $F(1, 199) = 2.58$, $p = 0.110$, $\eta^2 = 0.01$.

### Project Sustainability

FIU is a Minority-Serving Institution with strong institutional support for integrated behavioral health training,

including administrative backing from the FIU President and Provost. Sustainability strategies include HRSA performance reporting, dissemination of program outcomes at national conferences, collaboration within the HRSA-funded technical assistance center, and ongoing partnerships with community agencies for field placements. Fellows are encouraged to stay connected with their BHWET-Pro@FIU cohorts to support continued professional development.

## Discussion

Workforce shortages and uneven access to integrated behavioral health care persist [4,5]. BHWET-Pro@FIU demonstrates a scalable model for preparing the behavioral health workforce with the skills and competencies needed to succeed in integrated primary care settings. By combining didactic, experiential, and reflective training across community clinical sites with team-based assessments, BHWET-Pro@FIU prepares contextually responsive clinicians to meaningfully contribute to addressing patients' behavioral health needs in integrated primary care settings. The inclusion of telehealth, Standardized Patient simulations, and rotating topics of interest further contribute to long-term sustainability [4,23].

## Conclusion

The BHWET-Pro@FIU model (Table 2 and Figure 1) demonstrates that remote didactic training combined with interprofessional experiential placements can effectively prepare trainees for integrated behavioral health roles. This model addresses urgent workforce needs while equipping clinicians with skills in trauma-informed care, telehealth, and interprofessional collaboration.

Implementation of BHWET-Pro@FIU demonstrates measurable gains in interprofessional competencies (see Table 3) while building a pipeline of clinicians trained in integrated, trauma-informed, and technology-enabled care who are committed to addressing the behavioral health needs of South Floridians. Continued university-community collaboration, robust evaluation capacity, and flexible curriculum adaptations support BHWET-Pro@FIU's long-term impact and sustainability.

| Domain | Core Topics | Representative Learning Activities |
|---|---|---|
| Fundamentals of Integrated Care | Telehealth Etiquette<br>Integrated behavioral health/primary care<br>Professional Development<br>Burnout | Seminars<br>Readings<br>Guest speakers<br>Technical Assistance Center |
| Clinical Strategies | Motivational Interviewing<br>Psychopharmacology<br>Suicidality | Seminars<br>Readings<br>SP simulations<br>Technical Assistance Center |
| Clinical Challenges | Aging<br>AI in Healthcare<br>Human Trafficking<br>Lived Experience<br>Military Trauma<br>Neurodiversity<br>Overdose prevention<br>Trauma-informed care | Guest speakers<br>Readings<br>SP simulations<br>Technical Assistance Center |
| Technology & Systems | Telehealth etiquette<br>Contextual Factors | Seminars<br>Readings<br>SP simulations |
| Interprofessional Collaboration & Assessment | Team communication<br>Conflict management<br>Evaluation | Seminars<br>Guest speakers<br>SP simulations<br>SPICE-R2 |

*Note.* SP = Standardized Patient

**Table 2:** BHWET-Pro@FIU curriculum components

| Outcome | Statistic | Value |
|---|---|---|
| **SPICE-R2 Total** | Wilks' Λ | 0.77 |
| | F(1,199) | 59.19 |
| | p | < 0.001 |
| | $\eta^2$ | 0.23 |
| **Teamwork** | Wilks' Λ | 0.99 |
| | F(1,199) | 2.58 |
| | p | 0.11 |
| | $\eta^2$ | 0.01 |
| **Roles/Responsibilities** | Wilks' Λ | 0.7 |
| | F(1,199) | 85 |

| | | |
|---|---|---|
| | p | < 0.001 |
| | $\eta^2$ | 0.3 |
| **Patient Outcomes** | Wilks' Λ | 0.82 |
| | F(1,199) | 42.51 |
| | p | < 0.001 |
| | $\eta^2$ | 0.18 |

*Note.* SPICE-R2 = Student Perceptions of Interprofessional Clinical Education–Revised, version 2 (Zorek & MacLaughlin, 2016).

**Table 3:** Pre- to Post-Program Changes in Interprofessional Competencies (SPICE-R2).

## Conflict of Interest

The authors deny any conflicts of interest.

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***Corresponding author:** Staci L. Morris, Psy.D., Florida International University, Community-Based Research Institute, Robert Stempel College of Public Health & Social Work, USA; e-mail: morrisl@fiu.edu

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