

Sustaining the Behavioral Health Workforce: An Ongoing Challenge in Rural Areas

John Gale, MS
Maine Rural Health Research Center
Muskie School of Public Service

2008 Annual Meeting
National Organization of State Offices of Rural Health
September 25, 2008
Traverse City, MI



For further information:

Muskie School of Public Service
University of Southern Maine
96 Falmouth St., PO Box 9300
Portland, ME 04104-9300
Tel: 1-(207)-228-8246
E-mail: jgale@usm.maine.edu



Need for rural behavioral health (BH) services

- 60 million Americans live in rural and frontier areas
- Incidence/prevalence rates-comparable in urban and rural areas
- Rural residents- less likely to have access to services/providers
- Rural teens and older adults have higher rates of suicide
- Few programs to train and place rural BH providers, and those that exist are not often located in rural areas
- Rural residents-less likely to have BH insurance benefits
- Lack of transportation and social stigma are barriers



Two decades of BH change

- Managed care and shifts in financing
- Recovery and resilience
- Patient safety
- Cultural competency
- Performance/outcomes measurement
- Consumerism
- Co-occurring illnesses and medical co-morbidity
- Evidence-based practice with expanding body of evidence
- Reimbursement policies and scope of practice regulations are not in synch
- Growing reliance on medication interventions



Behavioral health underservice in rural areas

- For 40 years, 60% of rural America has been underserved by behavioral health (BH) professions
 - 60% live in mental health professional shortage areas
 - In 2003, 74% of Federally designated mental health professional shortage areas were located in rural counties
 - 90% of psychologists and psychiatrists and 80% of masters level social workers work in metro areas
 - 65% of rural Americans get their BH care from their primary care provider
 - 55% of counties have no practicing psychiatrists, psychologists, or social workers; all were rural



Problem increase with rurality and specialization

- Among counties with 2,500–20,000 population
 - 75% lack a psychiatrist
 - 95% lack a child psychiatrist.
- Among counties with less than 2,500 population:
 - 33% have no health professional able to address mental health needs
- Shortages are worse for children’s, elderly, and minority services
 - The federal government has projected the need for 12,624 child and adolescent psychiatrists by 2020, the projected supply is 8,312
 - There are only 6,300 such psychiatrists nationwide with relatively few are located in rural and low-income areas
 - There are severe shortages of practitioners trained and credentialed to treat adolescents with substance use disorders



Behavioral health workforce

- Psychiatrists
- Psychologists
- Social Workers
- Advanced Practice Nurses – Clinical nurse specialists, Nurse Practitioners, and Psychiatric Nurse Practitioners
- Emerging Professionals
 - Marriage and family therapists
 - Educational counseling
 - Pastoral counseling
 - Substance abuse counseling



Looming workforce issues

- Mental health work force is aging and predominantly white
 - 65% of psychiatrists, 66% of psychologists, and 58% of social workers are over 50 years of age
- Similarly, the substance abuse workforce is primarily female, older, and white
- High turnover rates among front line substance abuse staff and directors - 50% in the past year
- Substance abuse professionals suffer from a lack of clear educational and career pathways



Differing growth rates in the various professions

- Psychiatry – essentially static in terms of growth with International Medical Graduates filling almost 2/3rds of psychiatric residency slots
- Psychology – doubled in size over the past 25 years
- Clinical Social Workers – 20% over the past 15 years
- Psychiatric nursing – increases largely offset by the number leaving the active workforce and sharp reductions in students enrolling in this discipline’s graduate programs
- Substance Abuse – by 2010, need for addiction professionals and licensed treatment staff with graduate level degrees is expected to grow by 35%. Where they will come from?



National MH workforce shortage

- At present—50% of those in need of mental health services currently receive those services from 430,000 providers. 142,000 are likely to retire in the next 10 years
- In the future—to provide mental health services to 100% of those who need services, we must retain the 288,000 current providers still practicing, replace the 142,000 who retire, and add 430,000 new providers.
- 860,000 = total workforce needed before any changes in the underlying demand curve for providers



Factors that increase workforce demand

- Increases in stressors associated with BH conditions
- Aging of population and related BH concerns
- Expanded scope of practice/clinical roles for technicians, specialist, or non-physician clinicians
- Expansion of BH parity laws
- Reduction in stigma/increased awareness of BH issues
- Increases chronic illness rates and related BH effects
- Maintenance of segmented delivery models that foster duplication, waste resources, hinder team work, and avoid innovation



Factors that decrease workforce demand

- Increased provision of BH services by primary care providers
- Increased early intervention, which lowers the need for acute/emergency interventions
- Hospital and program closures or mergers
- Substituting nursing/allied staff for some BH workers
- Increased regulations of BH providers
- Increased minimum training and licensure criteria



Factors with unpredictable effects on demand

- Policies influencing types of care available to patients and types of providers authorized to provide care
- Expanded prescribing privileges for psychologists and advanced practice nurses
- Effects of an aging BH workforce on career and practice characteristics
- Over-representation of women in BH professions on hours worked, career length, practice characteristics, or attractiveness of these careers to future workers



Rural Healthy People 2010

- Rural Health People 2010 recommendations to address workforce shortages
 - Develop rural-focused didactic and experiential training for BH health graduate students
 - Recruit rural-connected individuals into BH training programs
 - Increase training-related placement of BH students in rural areas to increase the supply of rural BH providers and improve access
 - Incorporate training support activities for BH services into area health education centers
 - Provide federal and state funds to train rural BH providers



Quality through Collaboration: The Future of Rural Health Care

- The third recommendation of this IOM report calls for:

“experientially based workforce training programs in rural areas to ensure that all health care professionals master the core competencies of providing patient-centered care, working in interdisciplinary teams, employing evidence-based practice, applying quality improvement, and utilizing informatics.”



National Advisory Committee on Rural Health and Human Services

- The 2004 Report to the Secretary suggested that:
“Rural communities would benefit greatly from integrating behavioral health and primary care in rural settings.”
- Barriers to this integration include:
 - Reimbursement that is tied to a particular type of service provider
 - Restrictive state licensure practices
 - Institutional resistance toward integration
 - Lack of integrated training curricula



The Annapolis Coalition National Action Plan

- “Not only are there too few providers, but many of those who do exist have not been taught the skills they need to practice safely or effectively.”
- Identified six paradoxes in BH workforce education
 - Graduate students & residents are trained for a world that no longer exists
 - Those who spend the most time with consumers receive the least training
 - Continuing education programs utilizing ineffective teaching strategies
 - We train only where willing crowds gather
 - Consumers and families receive little educational support
 - Students are rewarded for “Doing Time” in our educational systems



General findings from the National Action Plan

- Scarcity of national and state-level data on practice activities and distribution of active clinicians
- Doing what is easy or affordable but not necessarily effective
- A hunger for “tools”
- Pockets of innovation
- Difficulties with sustainability and dissemination
- Workforce crisis extends throughout health and human services



Rural strategies: Develop the existing workforce

- Improve supervision to nurture existing staff and promote retention
- Enhance access to telehealth technology for professional training, continuing education, peer support, and care delivery
- Enhance mental health capacity of primary care
- Integrate science and practice to support evidence-based practices
- Enhance cultural competence



Rural strategies: Expand the workforce

- Incorporate BH into rural recruitment and retention programs
- Use distance learning across the career ladder to enable rural persons to learn from rural places
- “Grow your own” through strategies targeting rural residents including recruitment from rural areas and pipeline programs
- Develop mid-level provider strategy to extend doctoral level workforce including expanded use of emerging BH professions
- Support rural-focused training opportunities
- Enable BH providers to participate in state-sponsored loan repayment programs
- Develop targeted state programs



State activities can make a difference

- Alaska – partnership (providers, state agencies, and university) supported a “grow our own” mentality and focused on training an indigenous workforce that is community-focused and culturally competent. Results include a curricula that supports a career ladder to provide growth opportunities.
- South Dakota – development of a culturally driven Lakota mental health worker curriculum through Oglala Lakota College to provide training and education in the delivery of prevention and treatment services that are culturally appropriate to the needs of Lakota people



State activities can make a difference

- New Mexico – development of a rural psychiatric residency program at the University of New Mexico Health Science Center. Have of the resident’s time in the rural settings involves doing clinical work. The remainder is spend engaging with community agencies, practices, and systems to integrate with local service systems.
- North Dakota – statewide action plan to improve rural mental health workforce development
- Minnesota – development of a rural community health worker to improve access and support
- Idaho – system redesign study focused on improved services to rural and other underserved populations.


