

Behavioral Health Workforce Innovations and Challenges

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Learning Objectives

- Review behavioral health workforce challenges
- Workforce initiatives
- Tele-behavioral health and other technology
- Expanding scope of practice
- Realities
- Recommendations

Workforce Challenges

- Rural professionals shortage rates unchanged for past 5 decades
- Rural BH systems average 30% staff vacancy rates
- Average psychiatrist recruitment time for rural practices – 32 mo.
 - Times increases for solo practices
- Providers with rural training & practica are more likely to enter rural practice
- 100-Mile Rule: The majority of healthcare providers practice within 100 miles of where they trained
- Inadequate supervision is a major retention factor in rural practice - employees leave supervisors not jobs

Findings from the Annapolis Coalition Report

- Workforce crisis for specialty populations - children, geriatrics, substance abuse, persons of color
- Dissatisfaction among persons in recovery and families
- Employer dissatisfaction with pre-service education of professionals
- Delays: Science to service
- Multiple silos & absence of coordination
- Narrow focus on urban, white adults
- Need better data & tools
- Propensity to do what is affordable, not what is effective
- Pockets of workforce innovation: Difficult to sustain or disseminate

Realities

- > 60% of rural Americans live in mental health HPSAs
- > 90% of all psychologists and psychiatrists, and 80% of MSWs, work in metro areas
- > 65% of rural Americans get their mental health care from their primary care provider
- Rural Americans enter care later in the course of their disorders, with more advanced symptoms, resulting in more intensive & expensive interventions
- EMS for rural MH crisis usually law enforcement

Challenges to Recruitment and Retention

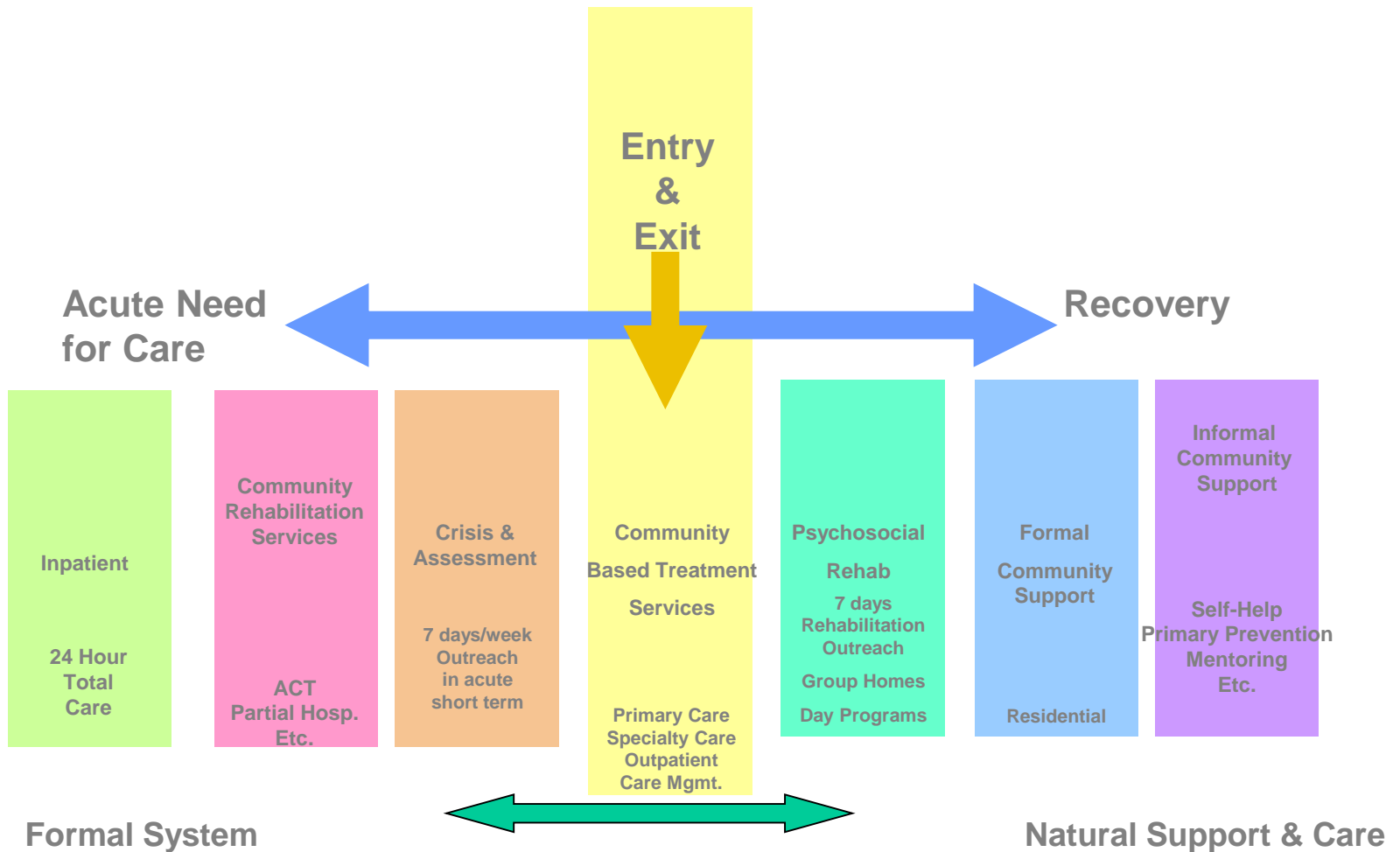
- Urban-trained providers individuals are reluctant to move to rural communities
- Lower than standard wages and salaries
- Life in the “fish bowl”
- Lack of rural specific training opportunities
- Limited access to supervision & mentorship opportunities, & peer support

Workforce Development Framework

- Broadening the concept of workforce
 - Individuals in recovery & families
 - Expanded capacity of communities
 - All health & social service providers
- Strengthen the workforce
 - Systematic recruitment & retention
 - Training (accessible/relevant/effective)
 - Leadership development
- Structures
 - Financing & compensation
 - Technical assistance
 - Evaluation & Research

Community Systems of Care

Source: Mohatt 2009



Needed systems changes

- Rational systems of care
 - Core community based services
 - regionalized specialty services
 - Tertiary and quaternary care
- Use of effective treatment teams
- Care management
- Have providers work at the top of their licenses
- Reduce unnecessary administrative burden
- Expand number of masters-prepared and mid-level providers (med mgt is key)
- Explore new team members

Innovative Interventions

- Nurse-led medical homes - shifts some treatment responsibility to advanced practice psychiatric nurses (med management)
- Locate primary care providers within mental health centers - frees psychiatrists from providing basic medical services and frees mental health case managers from spending time linking consumers to primary care providers
- Rebalance the mix of counseling and medications – lessens reliance on psychiatrists and increases engagement of other mental health professionals

Innovative Interventions

- Telemental health – addresses distribution and travel issues
- Peer support - enhances patient engagement, reduces intensive hospital stays, lessens the strain on the professional workforce

Peer Specialists

- Reduces reliance on mental health specialists
- As of 2012, 36 states had training and certification programs
- A total of 31 states reportedly have Medicaid reimbursement for certified peer specialists
- National practice guidelines for peer supporters