



## CHAPTER 4

### GENERAL FINDINGS

During the strategic planning process, a series of major themes emerged. The themes constitute a set of general findings about the state of the workforce and provide a context for understanding the specific goals, objectives, and actions that are offered as recommendations in the latter sections of this report.

#### **Widespread Concern about a Workforce Crisis**

Across the nation there is a high degree of concern about the state of the current workforce and pessimism about its future. The varied problems and issues are outlined in detail in the Special Topics section of this report. Below is a sampling of issues designed to highlight some of the most troubling concerns.

- There is a critical shortage of individuals trained to meet the needs of children and youth, and their families. As just one example, the federal government has projected the need for 12,624 child and adolescent psychiatrists by 2020, which far exceeds the projected supply of 8,312. There currently are only 6,300 child and adolescent psychiatrists nationwide, with relatively few located in rural and low-income areas (American Academy of Child and Adolescent Psychiatry [AACAP] Task Force, 2001). There is an even more severe shortage of practitioners trained and credentialed to treat adolescents with substance use disorders, and only five states require adolescent-specific knowledge for licensure (Pollio, 2002). There is a significant shortage of behavioral health professionals who have been trained to work in the nation's schools. This particular shortage is critical because, as noted by the President's New Freedom Commission, the majority of children who would benefit from behavioral health interventions do not become engaged adequately with traditional community-based treatment settings, and schools offer unparalleled access as points of engagement with children to address their behavioral health needs. By and large, training programs that focus on prevention and treatment within this age group have not kept pace with current trends in the field. The trends have been shifting toward strengths-based and resiliency-oriented approaches, systems of care, and evidence-based

practices (Curie, Brounstein, & Davis, 2004; McLellan & Meyers, 2004; Meyers, Kaufman, & Goldman, 1999).

- There is a pronounced shortfall in the current workforce of providers with expertise in geriatrics. This deficit is expected to worsen. Nationwide, only 700 practicing psychologists view older adults as their principal population of focus, well short of the estimated 5,000 to 7,500 geropsychologists necessary to meet current needs (Jeste et al., 1999). Similarly, only 640 members of the American Psychiatric Nurses Association (2002) have a subspecialization in geriatrics. In 2001, there were only 81 geriatric psychiatry fellows in training in the nation, and 39% of the available fellowships went unfilled (Warshaw, Bragg, Shaull, & Lindsell, 2002). These figures indicate that simply adding training opportunities is not enough. In order to address the dramatic shortfall in trained providers with specialized competencies (many of whom have substantial student loans to repay), there needs to be a fundamental change in the way that services are organized and reimbursed.
- Each year, only 20% of the individuals in the United States who need treatment for substance use disorders receive it. This is due, in part, to severe difficulties in recruiting and retaining qualified staff in sufficient numbers (Gallon, Gabriel, & Knudsen, 2003; Hall & Hall, 2002; Northeast Addiction Technology Transfer Center, 2005). In the most compelling study of this issue, McLellan, Carise, and Kleber (2003) found a 50% turnover in frontline staff *and* directors of substance use disorder treatment agencies in a single year. Furthermore, 70% of frontline staff members in these agencies did not have access to basic information technology to support their daily work.
- The substance abuse prevention sector faces critical workforce issues, which center on the lack of clear educational and career pathways for workers. This hampers recruitment and contributes to turnover, as many skilled prevention workers leave the sector in the search for upward career mobility.
- In rural America, the workforce crisis is particularly acute. More than 85% of the 1,669 federally designed mental health professional shortage areas are rural (Bird, Dempsey, & Hartley, 2001). There are 3,075 counties in the country; 55% have no practicing psychiatrists, psychologists, or social workers, and all of these counties are rural. It has been extraordinarily difficult to recruit, train, and retain professionals in rural areas. Few training programs for providing behavioral health in rural areas exist.

- Figures from the 2000 U.S. Census indicated that 30% of the nation's population is drawn from the four major ethnic groups; Latinos, African Americans, Asian American/Pacific Islanders, and Native Americans. In contrast, the behavioral health workforce lacks such cultural diversity, particularly in mental health. For example, non-Hispanic Whites currently account for 75.7% of all psychiatrists, 94.7% of psychologists, 85.1% of social workers, 80% of counselors, 91.5% of marriage and family therapists, 69.8% of psychosocial rehabilitation practitioners, 95.1% of school psychologists, 83.8% of pastoral counselors, and 90.2% of female psychiatric nurses (Duffy et al., 2004). While cross-cultural training has the potential to improve quality of care and service use among people of color (Fortier & Bishop, 2003), the workforce at large cannot be characterized as culturally or linguistically competent.

### **High Levels of Dissatisfaction among Persons in Recovery and Families**

Workforce issues are a personal matter for individuals with mental health problems and illnesses and substance use disorders. While the experiences of the people who receive care obviously vary greatly, the individuals whose voices were heard during the process of developing this plan expressed strong dissatisfaction with the workforce.

Many of the complaints carried an air of sympathy for members of the workforce. Individuals receiving care acknowledged the heavy workloads, large paperwork burden, comparatively low wages, lack of access to training in state-of-the-art practices, and absence of administrative and technological support that confront the staff. But they also expressed considerable anger for what many described as the stigmatizing attitudes within the workforce about persons with mental and addictive disorders. There is frank concern that many of the professionals and staff members in the field have negative attitudes toward the very persons they are to serve, and that these attitudes impede the ability of workers to be respectful of the people receiving care. At times, a more benevolent but still negative interpretation was offered. It centered on the notion that the workforce is uninformed about recovery-oriented approaches to care and unreceptive to shared decision-making with persons in recovery, children, youth, and family members by virtue of having been trained in a model that emphasizes traditional doctor-patient relationships in which patients are viewed as the passive recipients of the experts' services.

Perhaps of most concern is the perspective of many persons in recovery, children, youth, and family members that the emphasis on compassionate and caring therapeutic relationships has been significantly eroded in behavioral health care. The angriest voices argue that compassion and caring are not eroding because they weren't there to begin with in the mental health community. Advocates continue to report demeaning and dismissive attitudes on the part of treatment professionals as occurring altogether too often. The IOM (2006) has highlighted the central importance of "continuous healing relationships" in all

aspects of health care, and such a tradition has deep roots in the treatment of persons with mental illnesses and substance use disorders. In mental health, for example, training has historically centered on the development of empathic relationships and working alliances. Whether due to a shift in training approaches, the multiple burdens on staff, or the emphasis on evidence-based or manualized therapies, there is considerable concern that the basic human connections between the people providing and the people receiving care are being lost.

### **Employer Dissatisfaction with the Preservice Education of Professionals**

Another group that has voiced strong concerns comprises managers within organizations that employ the workforce. Their constant lament is that recent graduates of professional training programs are unprepared for the realities of practice in real-world settings, or worse, have to unlearn an array of attitudes, assumptions, and practices developed during graduate training that hinder their ability to function. University-based training programs and professional schools, despite their academic base, are largely viewed as out of touch with the realities of contemporary practice and as failing to provide substantive training in evidence-based practices. These concerns exist regardless of the professional discipline. It is simply difficult to overstate the level of concern among workforce employers about the current relevance of professional education in the behavioral health disciplines.

### **Change Occurs with the Generations**

There is general recognition in health care of the long delay between the emergence of evidence for the effectiveness of prevention or intervention strategies and their widespread adoption. This phenomenon exists in behavioral health and may be due, in part, to the fact that change in practice patterns is tied to the changing generations of practitioners within the field. Change occurs with the generations, which accounts for the 20-year lag that characterizes the transition from “science to services.”

Underlying this dynamic is the fact that educational systems in behavioral health, as in most of health care, emphasize the teaching of specific practices. The teaching is focused on content rather than on the process of continuous learning. Students learn certain skills and seem to practice them throughout their career, rather than “learning to learn” as a foundation for a lifelong process in which the evidence on effective interventions is continually re-examined, with personal practice patterns shifting in response to the changing evidence.

## **Multiple Silos and an Absence of Coordination**

The recent report from the IOM (2006) particularly noted the myriad disciplines, differing levels of training, and variability across states in licensing and credentialing the diverse groups that constitute the behavioral health workforce. A labyrinth of organizations, associations, councils, and committees also shapes the training and oversight processes for various segments of the workforce. Diversity can be an asset, but the disciplinary “silos” that are firmly in place appear to impede interdisciplinary training and experience, despite the heavy emphasis on interdisciplinary, team-based practice in systems of care. Furthermore, there is little cooperative or coordinated effort among the disciplines on workforce efforts, such as the development and assessment of competencies, despite the fact that there are many shared competencies across the diverse sectors of the workforce.

Another version of the fragmentation in the field consists of the divide and tensions between the mental health and addiction sectors, with a similar gulf between the areas of behavioral health treatment and prevention. These rifts have major negative consequences. It is difficult to promote change in any large-scale measure throughout the nation’s behavioral health care system because of the multiple divisions and the tendency of each discipline or sector to work in isolation. But perhaps more tragic is that no discipline or sector has adequate resources to pursue on its own a robust agenda for quality improvement, including workforce development. The ultimate negative consequence of the legacy of these silos is that pioneering work by one discipline or sector remains largely unknown to the rest of the field; given the missed opportunities to collaborate and build on each other’s work, there is little synergy of effort.

## **A Narrow Focus on Urban White Adults**

A comprehensive review of workforce issues and needs in the diverse sectors of the behavioral health field brings into stark relief the narrow focus that pervades the field and, in turn, its workforce. Prevention and intervention strategies have been developed and tested principally through research by individuals who are Caucasian residents of America’s metropolitan centers. The vast majority of intervention strategies have been designed principally for young and middle-age adults, and have excluded children and older Americans. Similarly, the participants in effectiveness and efficacy studies largely have been non-Hispanic, White adults residing in the nation’s urban and suburban cores. The vast majority of individuals who provide prevention and treatment services similarly are non-Hispanic Whites and are clustered in the major population centers.

A life-span approach is markedly missing throughout this field and manifests itself in workforce development, as relatively few individuals are trained to meet the needs of America’s children, youth, and

elders. The unique needs of the country's rapidly growing ethnically and racially diverse populations also receive sparse attention, with parallels in a behavioral health workforce that lacks cultural and linguistic diversity and cultural competence. Similarly ignored are the unique circumstances of Americans in rural and frontier areas, where traditional approaches to workforce development, centered on "programs and professionals," simply fail to address local needs.

### **A Scarcity of Data on the Workforce and its Development**

While estimates vary, it appears that as much as 80% of behavioral health expenditures are in human resources. Given the core role of the workforce in prevention and treatment, there is a striking lack of data about the workforce and about workforce development practices. The scattered information that does exist has no uniformity, which hinders cross comparison or aggregation of the data to examine trends. Furthermore, the reliability of much of these data is open to question. There is little consensus about key workforce variables, and there are few benchmarks that organizations can use as a reference point in assessing the magnitude of their workforce problems or the success in addressing the problems.

As the Annapolis Coalition and advisors managing the planning process sought evidence on effective workforce development practices, it became abundantly clear that the workforce is seldom the focus of research. There certainly have been a range of scholarly articles and reviews on the workforce topic; most, however, contain no data or data that are simply descriptive in nature. Even on critical topics such as the retention of staff, there is little data drawn from carefully executed research or evaluation on which to identify effective practices.

### **A Propensity to do What is Affordable, Not What is Effective**

Most behavioral health organizations feel under siege, given the multiple demands for improved access to and quality of treatment and prevention services amid worsening economics surrounding the provision of those services. In such an environment, the need to train and support the workforce is generally recognized, but not made a priority. A peculiar dynamic has emerged in many settings that involves token efforts to develop the workforce, even though managers recognize that the efforts are inadequate and unlikely to have significant effects. The most glaring example is the provision of, didactic, in-services or workshops. These constitute the most common approach to staff training and development, even though there is clear evidence that such sessions are ineffective in changing the practice of the workers who participate. In a parallel fashion, many organizations have introduced training in evidence-based practices to frontline staff without being able to educate or train supervisors and managers in the practices, and without being able to provide the ongoing training, consultation, and staff development that would be required to accomplish and sustain adoption of the practices within the organization.

## **The Field is Hungry for Workforce Tools**

With broad recognition of a workforce crisis, there is a palpable demand in the field for practical models, strategies, and tools to address the myriad problems. Employers of the behavioral health workforce, by and large, are interested in moving rapidly to improve recruitment, training, and retention, but are finding relatively few interventions or models that are well described, portable, and easily adaptable to different settings.

## **Pockets of Workforce Innovation that are Difficult to Sustain or Disseminate**

Across the nation, selected states and organizations are creatively addressing workforce problems. These initiatives can best be described as pockets of innovation, as systematic and substantive efforts to bolster the workforce remain the exception rather than the rule. Many of the workforce efforts detected during the planning process appeared to be sorely underfinanced because there are few sources of dedicated funding for workforce development. Thus, workforce initiatives are difficult to sustain in a single organization or jurisdiction, let alone to disseminate and replicate in other jurisdictions. Most innovations simply remain unknown to colleagues in the field who are grappling with similar issues.

## **The Workforce Crisis Extends Throughout Health and Human Services**

While there are aspects of the workforce crisis in behavioral health care that are unique, the existence of such a crisis is common to multiple areas of health and human services. Recruiting and retaining capable frontline staff has been a crippling problem in the developmental disabilities field (Larson & Hewitt, 2005). The workforce crisis in the field of child welfare, where staff with minimal training is asked to help families burdened by multiple medical, social, and financial problems, has been described in graphic and sobering detail by the Annie E. Casey Foundation (2003). The recruitment and retention of nurses in all areas of health have received national attention and federal- and state-level intervention. Recent national reports have highlighted the growing crisis in recruiting individuals to pursue careers as pharmacists (DHHS, 2000) and in public health (Association of State and Territorial Health Officials [ASTHO], 2004). The national crisis of confidence regarding the safety and quality of health care (IOM, 2000, 2001) is largely responsible for the recent efforts in medicine, across all disciplines, to identify core competencies and demonstrate the competency of those within their ranks.

## Hope for the Future

Despite the dire state of the workforce, there are a number of causes for optimism about the future. Many dedicated members of the workforce and committed leaders in the behavioral health field understand the critical need to seriously address the many issues outlined in this Action Plan. The workforce problems are now receiving federal, state, and local attention. The existing pockets of innovation are good starting points and building blocks for more comprehensive and systematic solutions to current workforce dilemmas. The field can and must move forward and tackle this challenge.

## References

- American Academy of Child and Adolescent Psychiatry. (2001). *Meeting the mental health needs of children and adolescents: Addressing the problems of access to care*. Washington, DC: Report of the AACAP Task Force on Work Force Needs.
- American Psychiatric Nurses Association. (2002). *Member profile*. Retrieved May 15, 2006, from <http://www.apna.org/membership/profile.html>
- Annie E. Casey Foundation. (2003). *The unsolved challenge of system reform: The condition of the frontline human services workforce*. Baltimore, MD: Author. Retrieved May 22, 2006, from [http://www.aecf.org/initiatives/hswi/report\\_rev.pdf](http://www.aecf.org/initiatives/hswi/report_rev.pdf)
- Association of State and Territorial Health Officials. (2004). *State public health employee workforce shortage report: A civil service recruitment and retention crisis*. Washington, DC: ASTHO.
- Bird, D. C., Dempsey, P., & Hartley, D. (2001). *Addressing mental health workforce needs in underserved rural areas: Accomplishments and challenges*. Portland, ME: Maine Rural Health Research Center, Muskie Institute, University of Southern Maine.
- Curie, C., Brounstein, P., & Davis, N. (2004). Resilience-building prevention programs that work: A federal perspective. In C. Clauss-Ehlers & M. Weist (Eds.), *Community planning to foster resilience in children*. New York: Kluwer Academic/Plenum Publishers.
- Duffy, F. F., West, J. C., Wilk, J., Narrow, W. E., Hales, D., Thompson, J., et al. (2004). Mental health practitioners and trainees. In R. W. Manderscheid & M. J. Henderson (Eds.), *Mental health, United States, 2002* (pp. 327-368; DHHS Publication No. SMA 04-3938). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.
- Fortier, J. P., & Bishop, D. (2003). *Setting the agenda for research on cultural competence in health care: Final report*. Rockville, MD: U.S. Department of Health and Human Services, Office of Minority Health, Agency for Healthcare Research and Quality.
- Gallon, S. L., Gabriel, R. M., & Knudsen, J. R. W. (2003). The toughest job you'll ever love: A Pacific Northwest treatment workforce survey. *Journal of Substance Abuse Treatment, 24*, 183-196.
- Hall, P. S., & Hall, N. D. (2002). Hiring and retaining direct-care staff: After fifty years of research, what do we know? *Mental Retardation, 40*(3), 210-211.
- Institute of Medicine. (2000). *To err is human: Building a safer health system* (L. T. Kohn, J. M. Corrigan, & M. S. Donaldson, Eds.). Washington, DC: National Academies Press.
- Institute of Medicine (2001). *Crossing the quality chasm: A new health system for the 21<sup>st</sup> century*. Washington, DC: National Academies Press.
- Institute of Medicine. (2006). *Improving the quality of health care for mental and substance-use conditions: Quality chasm series*. Washington, DC: National Academies Press.
- Jeste, D. V., Alexopoulos, G. S., Bartels, S. J., Cummings, J. L., Gallo, J. J., Gottlieb, G. L., et al. (1999). Consensus statement on the upcoming crisis in geriatric mental health: Research agenda for the next 2 decades. *Archives of General Psychiatry, 56*(9), 848-853.
- Larson, S. A., & Hewitt, A. S. (2005). *Staff recruitment, retention, & training strategies for community human services organizations*. Baltimore, MD: Paul H. Brookes Publishing Co.

McLellan, A. T., Carise, D., & Kleber, H. D. (2003). Can the national addiction treatment infrastructure support the public's demand for quality care? *Journal of Substance Abuse Treatment, 25*, 117-121.

McLellan, T., & Meyers, K. (2004). Contemporary addiction treatment: A review of systems problems for adults and adolescents. *Biological Psychiatry, 56*, 764-770.

Meyers, J., Kaufman, M., & Goldman, S. (1999). *Promising practices: Training strategies for serving children with serious emotional disturbance and their families in a system of care. Systems of care: Promising practices in children's mental health* (1998 Series, Vol. V). Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

Northeast Addiction Technology Transfer Center. (2005). Workforce development: Taking action to build a stronger workforce. *Resource Links, 4*(1), 3.

Pollio, D. E. (2002). *Training and certification needs for adolescent addiction treatment*. Rockville, MD: Presentation to the Center for Substance Abuse Treatment/Robert Wood Johnson Foundation Adolescent Treatment Summit.

U.S. Census Bureau. (2000). *Population by race and Hispanic origin for the United States*. Washington, DC: U.S. Department of Commerce.

U.S. Department of Health and Human Services. (2000, December). *The pharmacist workforce: A study of the supply and demand for pharmacists*. Rockville, MD: U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions. Retrieved May 22, 2006, from <ftp://ftp.hrsa.gov/bhpr/nationalcenter/pharmacy/pharmstudy.pdf>

Warshaw, G. A., Bragg, E. J., Shaul, R. W., & Lindsell, C. J. (2002). Academic geriatric programs in U.S. allopathic and osteopathic medical schools. *Journal of the American Medical Association, 288*(18), 2313-2319.