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Psychiatric workforce needs and recommendations for the community mental health system: A state needs assessment

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Abstract

Similar to other states, Georgia is facing workforce challenges within its community mental health system. Georgia's Department of Behavioral Health and Developmental Disabilities commissioned a needs assessment to examine the shortage of prescribing providers in the state's public mental health system. A unique partnership of key stakeholders developed and conducted the needs assessment. We examined the extent and impact of psychiatric workforce shortages, and opportunities for optimizing the psychiatric workforce and training the next generation of community psychiatrists. This column describes the partnership guiding this needs assessment process and summarizes the results and recommendations.

A number of challenges are facing the behavioral health workforce, including inadequate numbers of psychiatrists and other providers, difficulties with recruitment and retention, and the uneven geographic distribution of providers. These issues may be exacerbated as implementation of the Affordable Care Act (ACA) expands demand for behavioral health services (1).

In Georgia, leaders from Community Mental Health Centers (CMHCs) reported growing challenges in recruiting and retaining qualified psychiatrists, as well as Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs), who have prescribing authority under physician supervision. In response, Georgia's Department of Behavioral Health and Developmental Disabilities (DBHDD) commissioned a needs assessment to examine the shortage of prescribing providers in the state's community mental health system. In this

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Disclosures

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column, we describe the partnership that guided this needs assessment and summarize the results and recommendations.

Partnership

In Georgia, DBHDD oversees the delivery of behavioral health services through 27 CMHCs. Six of these CMHCs comprise the North Georgia Partnership for Behavioral Healthcare (NoGAP), which serves over 40,000 individuals with mental and substance use disorders in 44 counties in northern Georgia. Two of the CMHCs serve primarily metropolitan areas, two serve primarily rural areas, and two include a mix of rural, suburban, and metropolitan counties.

A partnership between DBHDD, NoGAP, and Emory University was developed to examine the extent and impact of psychiatric workforce shortages in the Georgia CMHCs. The five member advisory board, comprised of DBHDD's Commissioner and Deputy Commissioner, two NoGAP members, and an Emory psychiatry faculty member, met regularly by conference call with the two person assessment team from Emory's School of Public Health. The group discussed the process, reviewed materials and results, and developed priorities and recommendations.

Assessment methods

Mixed methods were used to understand current issues and needs related to Georgia's psychiatric workforce. The Georgia Board for Physician Workforce provided data from 2010/2011 on the number and distribution of psychiatrists and PAs in Georgia. NoGAP provided administrative data on the CMHCs and patient population. NoGAP administrators completed an electronic survey with closed and open-ended questions on recruitment, retention, and staffing models. Frequencies were reported for closed-ended questions and main themes were identified for open-ended questions. We conducted six semi-structured hour-long interviews with 11 NoGAP administrators (1-3 from each site) and two patient focus groups (6 and 7 participants in each). Patients were recruited from two ongoing research studies and provided additional consent. The moderator used semi-structured guides for the interviews and focus groups; main themes were identified. Finally, we reviewed the research literature on evidence-based strategies for optimizing the psychiatric workforce and examples of community psychiatry training. We compiled results across data sources to identify broader themes and to develop recommendations.

Psychiatric workforce needs and findings

In Georgia, there are 10.9 psychiatrists per 100,000 people and 5.9 child and adolescent psychiatrists per 100,000 youth, which are lower than national estimates (2, 3). Of the 19,830 physicians practicing in Georgia, 5.3% are psychiatrists compared to 34.9% in primary care. Almost half of these psychiatrists (47%) are 55 years of age or older, indicating that the psychiatric workforce could substantially turnover or shrink in the next decade. The majority of psychiatrists are male (65%) and over two-thirds are white. Only 12% of psychiatrists are black, compared to 31% of Georgia's population (4), which suggests the importance of increasing diversity in the psychiatric workforce.

Annually, over 40,000 patients attend more than 115,000 appointments with NoGAP providers. Over half of the patients are female (55%) and 70% are white. The majority of patients are 18-64, with 12% under 18 years and 3% over 65 years. Half of the patients are uninsured; the most common types of insurance are Medicaid (24%) and Medicare (14%). Of the 62 NoGAP psychiatrists, 77% serve adults and 23% serve children and adolescents, 37% work full-time, and 37% are contracted or locum tenens. Most psychiatrists work in outpatient clinics, and some work in crisis stabilization units or on Assertive Community Treatment (ACT) teams.

Georgia also experiences shortages of other mental health prescribers; only 3% of all APRNs and 0.8% of PAs currently practice in psychiatry. The provider-to-population ratio of psychiatric APRNs in Georgia (2.9 per 100,000) is lower than the national ratio (3.3 per 100,000) (2, 4, 5).

Major themes from the surveys and interviews centered on challenges in finding qualified candidates, filling open positions, and retaining psychiatrists. CMHC administrators described difficulties offering competitive salaries and filling positions that were not full-time with benefits; additionally, retention was low among part-time psychiatrists. Rural CMHCs reported particular trouble in hiring qualified psychiatrists. Once psychiatrists were hired, high case loads, patients' complex psychosocial needs, and required guidelines often limited psychiatrists' ability to acculturate to the new settings and hampered retention efforts. Recruiting psychiatrists for ACT teams, which require intensive community-based services, was especially challenging. Another theme was the potential for physician burnout among psychiatrists without proper training or support practicing in the public psychiatry system.

To ensure necessary coverage, CMHCs developed various staffing models with combinations of full and part-time positions, and salaried and contracted positions. Part-time psychiatrists were often offered flexibility in scheduling and payment methods. Challenges with contracting agencies included the high costs for recruitment and psychiatrists' fees, extra time for psychiatrist training and communication with the agencies, and disruption to continuity of care. Locum tenens providers did not always have a strong interest or training in community psychiatry. CMHCs looking to increase the number of salaried positions compared to contracting positions found that providing benefits packages could be cost prohibitive.

Establishing a steady stream of psychiatrists from Georgia, particularly those with a passion for working in community psychiatry, could ease difficulties in recruiting and increase the likelihood that physicians would want to remain at the CMHC. Another theme was the importance of partnering with medical schools in order to train future psychiatrists in the array of services the CMHCs provide.

Recruiting and retaining other mental health prescribers, particularly those with experience in community psychiatry, was also challenging. CMHC administrators noted that supervision of APRNs and PAs can take up a significant amount of a psychiatrist's time. For

APRNs and PAs with limited psychiatric experience, additional supervision and training was often needed to expand their scope of practice.

A main theme in the patient focus groups was the effect of staff turnover on patient-provider relationships. Patients reported that consistently seeing the same provider and building up a therapeutic relationship was important. Staff turnover was disruptive to the therapeutic relationship, reduced the patients' comfort level, and could delay appointments. Patients also mentioned wanting more time with their psychiatrist.

Our literature review focused on strategies for optimizing the existing psychiatric workforce and models of workforce training. Briefly, collaborative care approaches are effective in treating mental conditions in primary care settings and extending the reach of psychiatrists by allowing them to focus on the most complex patients (6,7). Expanded use of registries and electronic records facilitate tracking of patients and driving better outcomes. Health homes, which are a patient-centered strategy in the ACA, provide organizational and financial structures for collaborative care (8). Telepsychiatry helps to overcome geographic barriers and improve access in rural areas by allowing psychiatrists to practice at a distance (9).

Training in community psychiatry can occur in medical school rotations, residency programs, and post-residency fellowships. Early training in community psychiatry expands students' and young doctors' experiences and skills, and can motivate them to pursue a career in public psychiatry. Community psychiatry fellowships are the main vehicle for building the public sector psychiatric workforce. These programs involve partnerships between academic institutions and behavioral health agencies to provide didactic, clinical, administrative, and scholarship experiences. Model programs, including those at Columbia University and the University of California San Francisco, successfully connect fellows to community-based organizations, where they often remain after completing the fellowship (10).

Recommendations

The recommendations developed by advisory board and assessment team centered on: 1) Building workforce capacity in Georgia through increased training opportunities, and 2) Enhanced use of evidence-based strategies to optimize the current public sector psychiatric workforce.

The first set of recommendations focused on building the capacity of Georgia's community mental health workforce. Recommendations included: **1) Develop a community psychiatry fellowship** that will recruit psychiatrists committed to working in public psychiatry, train them to effectively work in and take on leadership roles in CMHCs, and connect them with available positions. **2) Enhance community psychiatry training in medical school and residency programs** to ensure that future psychiatrists have basic skills for working in the public sector. This early exposure could increase future psychiatrists' intentions in pursuing a career at a CMHC. **3) Develop psychiatric training and supervision opportunities for APRNs and PAs** in traditional graduate school curricula and postgraduation to increase their number and experience.

Expanding the psychiatric workforce will take time; therefore, the second set of recommendations focused on evidence-based strategies for extending the reach of current providers. Recommended strategies included: **1) Increase the use of mental health teams,** with the psychiatrist providing leadership and facilitating communication. Diversifying the psychiatrist's role may also help prevent burnout and bolster job satisfaction. **2) Expand the use of information technology**. Telepsychiatry can extend psychiatrists' reach, particularly in rural areas. Registries and electronic records can be instrumental in tracking patients and driving better outcomes. **3) Explore opportunities for greater collaboration and standardization across the CMHCs.** CMHCs could standardize service delivery and reimbursement methodologies to develop a consistent and comprehensive model of care.

Conclusions

This needs assessment identified a major gap in the broader mental health workforce—the need for trained community psychiatrists and other prescribing providers in CMHCs. Although the assessment was specific to Georgia, we expect that this need will be mirrored in other states. Workforce shortages are an issue for behavioral health in general (1), and our results indicate that community mental health settings are significantly affected. Compounding the problem of an overall shortage of prescribing providers is their uneven distribution, which leaves rural areas underserved. Additionally, our needs assessment highlights the importance of cultivating providers who are interested in and trained to practice in community settings.

The limitations to this needs assessment should be considered. Although the NoGAP CMHCs serve a variety of patient populations, CMHCs in other parts of Georgia may have different experiences regarding the psychiatric workforce. Additionally, we had small samples for the surveys, interviews, and focus groups; however, these results aligned with the state workforce data and literature review.

The partnership between the advisory group and assessment team proved to be a valuable model for identifying and addressing workforce needs, with each stakeholder providing unique information. Engagement by a diverse set of stakeholders helped to ensure buy in to both the process and the recommendations. This commitment will be critical for initiating concrete steps for addressing workforce challenges.

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