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Health Workforce Policy Brief

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Behavioral Health Service Delivery for Vulnerable Populations

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BACKGROUND

Studies show that the nation's mental health care system is not sufficiently meeting the needs of the public. Data from the National Survey on Drug Use and Health suggests 18% of adults had any mental illness in the past year[1] and only 43% received services for their condition[2]. Further, only 51% of children diagnosed with mental health disorders receive any treatment.[3] In response, broad policies, like the Affordable Care Act, have been enacted to help correct these imbalances by increasing healthcare access and service provision for Americans[4], yet there are many subpopulations within the United States that continue to have a high prevalence of mental health disorders and/or less access to mental health services, and they are often deemed *vulnerable populations*.

As part of a vulnerable population, patients face numerous barriers to accessing quality behavioral health care that are not easily remedied. This is especially true for individuals living in rural and geographically isolated regions who have substantial physical barriers to accessing behavioral health care.[5] The provision of care for rural and geographically isolated, vulnerable populations presents substantial challenges for the behavioral health workforce related to its supply and retention of clinicians. This issue is a barrier to providing accessible services to those most in need. The purpose of this pilot study is to assess behavioral health workforce supply and need, barriers to recruiting and retaining care providers, and the extent to which care coordination occurs with primary care providers serving primarily underserved, rural populations in Michigan.

METHODS

The Behavioral Health Workforce Research Center issued an online survey in June-October 2016 to collect information from behavioral health provider organizations that serve rural communities in Michigan. The survey was disseminated by Southwest Michigan Behavioral Health (SWMBH) to 52 of its members, which represent community mental health organizations and substance use treatment facilities in Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren counties. These counties reflect a mix of urban and rural communities, with Branch and St. Joseph designated as rural counties. Barry, Branch, Cass, St. Joseph, and Van Buren counties are designated as Medically Underserved Areas, and Calhoun and Kalamazoo counties are designated as having a Medically

CONCLUSIONS AND POLICY IMPLICATIONS

Key findings of this study show that behavioral health service delivery in rural populations is complicated by numerous workforce limitations, including:

- A need for more provider training, particularly around addressing cultural and language barriers between patients and providers, implementing integrated care models, management, and leadership development.
- Concerns about adequacy of the workforce pipeline; larger, more qualified candidate pools are needed to fill positions.
- A need for recruitment incentives such as flexible work hours or financial incentives to attract providers to rural populations.

In summary, policies and programs around addressing recruitment and retention barriers, enhancing training initiatives, and implementing integrated care to treat co-occurring disorders may help enhance workforce capacity in areas with vulnerable and underserved populations.

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[1] Center for Behavioral Health Statistics and Quality. (2016). Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health. *DHHS Publication No. SMA 16 4984, NSDUH Series H-51.* Retrieved from http://www.samhsa.gov/data/

[2] Park-Lee, E. Lipari, R.N., Hedden, S.L., Copello, E.A.P, & Kroutil, L.A. (2016). Receipt of Services for Substance Use and Mental Health Issues among Adults: Results from the 2015 National Survey on Drug Use and Health. *NSDUH Data Review.* Retrieved from www.samhsa.gov/data/sites/default/files/NSDUH-ServiceUseAdult-2015/NSDUH-ServiceUseAdult-2015/NSDUH-ServiceUseAdult-2015.htm

[3] Substance Abuse and Mental Health Services Administration. (2008). National Survey on Drug Use and Health (NSDUH). *Population Data/NSDUH.* Retrieved from http://www.samhsa.gov/data/population-data-nsduh

[4] U.S. Centers for Medicare & Medicaid Services. (2016). Mental Health & Substance Abuse Coverage. *HealthCare.gov.* Retrieved from https://www.healthcare.gov/coverage/mental-health-substance-abuse-coverage/

[5] Thomas, D., MacDowell, M., & Glasser, M. (2012). Rural Mental Health Workforce Needs Assessment - a national survey. *Rural and Remote Health 12*(2176). Retrieved from http://www.rrh.org.au/articles/subviewnew.asp?ArticleID=2176

Underserved Population. All eight counties are designated as mental health profession shortage areas; 21 rural health clinics and 6 Community Health Centers are within this catchment area. The survey was completed by clinical and/or human resource executives employed at each organization. A $25 gift card was used as a response incentive. Survey question themes include: 1) behavioral health needs of the population and services provided to them; 2) workforce needs; 3) cultural and linguistic competence of the existing workforce; 4) workforce development initiatives; 5) factors impacting worker recruitment and retention; and 6) the status, future plans, barriers, and facilitators to adoption of integrated care. Frequency analyses were conducted for all study variables; this brief highlights key findings related to organizational characteristics, workforce needs, and worker recruitment and retention.

KEY FINDINGS

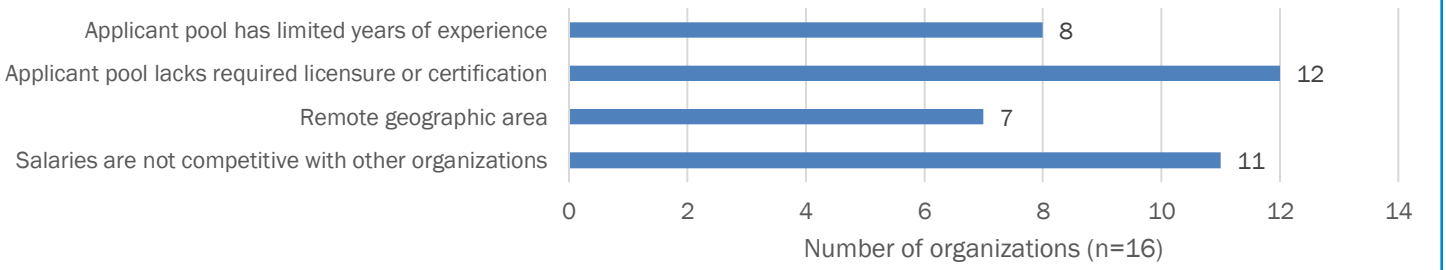
In total, 16 representatives (31%) from the SWMBH organizations participated in the pilot study. Respondents represented 7 (43%) non-profit organizations, three (19%) community health centers, two (13%) private practices, one (6%) social service agency, and one (6%) hospital or health system. Fourteen (88%) organizations offered only behavioral health/substance use disorder services; two (12%) offered both behavioral health and primary care services. Responding organizations accepted patients covered by Medicaid (100%), Medicare (75%), under-insured patients (94%), and uninsured patients (93%), and provided services for mental health or substance use disorders to the following vulnerable and underserved groups listed in Table 1.

Table 1. Vulnerable and Underserved Populations Served by Rural and Geographically Remote Organizations

Homeless or near-homeless patients (82%)	School-based health patients (63%)	Public housing patients (81%)	Medication-assisted clients (88%)
Farmworker patients (56%)	Veteran patients (81%)	Victims of trafficking (56%)	

Nearly 70% of responding organizations are trying to fill vacancies for behavioral health provider positions, including clinical social workers (73%), case managers (46%), addiction counselors (36%), psychiatrists (27%), and counselors (27%). Barriers these organizations experience when trying to fill provider positions can be found in (Figure 1).

Figure 1. Barriers to Filling Vacant Behavioral Health Provider Positions



To combat these challenges, organizations noted positive factors or incentives provided to fill vacant positions: flexible work hours (75%); affordable health insurance (69%); 401k (50%); disability insurance (44%); signing bonuses (13%); extended vacation (13%); accelerated bonuses (6%); and pension (6%).

Barriers to providing behavioral health care services included: a need for more training in the treatment of behavioral health (31%); cultural and/or language differences between health care providers and patients/clients (25%); and providers' lack of training in evidence-based behavioral health treatments (25%). Reported workforce barriers included: too few clinicians (31%), physical separation of primary and behavioral health providers (31%), information-sharing obstacles between primary care and behavioral health providers (50%), and providers' limited time to address both physical and behavioral health concerns (38%). Organizations also identified training needs in cultural competency (44%), integrated care (50%), leadership develoment (56%), management (44%), and technical training (69%).

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