

# RESTRUCTURING CALIFORNIA'S MENTAL HEALTH WORKFORCE: INTERVIEWS WITH KEY STAKEHOLDERS

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## Introduction and Purpose

There is a great need for mental health care in the United States. The National Comorbidity Survey Replication estimated that over a quarter of adults in the U.S. were diagnosed with a mental disorder between 2001 and 2003.<sup>1</sup> In 2001, the California Center for Health Statistics reported that roughly 16 percent of the State's adults were diagnosed with a mental disorder.<sup>2</sup> Given this demand for mental health care, it is important to assess whether there is a sufficient mental health workforce in the state.

The mental health workforce is comprised of several types of providers who deliver services in a wide variety of settings such as community-based organizations and hospitals.<sup>3</sup> Mental health care in California is largely county-driven.<sup>4</sup> Previous studies have identified current shortages in the mental health workforce.<sup>3,5</sup>

There is expected to be an even greater need for mental health workers in the future given population increases and an expected increased demand for mental health services.

The purpose of this project was to assess the supply, demand, education, training, and diversity of California's mental health workforce. We explored related issues, such as recruitment, retention, and the stigma of working in the mental health professions. We examined the workforce implications of the education and training component (the "workforce component") of the Mental Health Services Act (the "MHSA") on adopting the wellness, recovery, and resilience model (the "recovery model") of care.<sup>6</sup>

## Research Methodology

California's mental health workforce was assessed using two approaches: stakeholder interviews and a review of literature and key reports. Voluntary one-hour telephone interviews were conducted with 16 key informants ("interviewees") to solicit their observations regarding predominant mental health workforce issues in the state. Informants representing various sectors of the mental health system included: representatives from the California Department of Mental Health, county administrators, community-based provider organizations, educators, field training supervisors, professional organizations, consumer advocacy groups, policy-makers, and other researchers. A list of general questions with additional inquiries was tailored to each interviewee. Project approval from the UCSF Committee on Human Research was secured to protect participants' rights.

## Key Themes Identified in Interviews

### *Financing of Public Mental Health and Impact on Models of Care*

Most interviewees reported that the mental health financing system in California is a critical, and limiting, factor in restructuring mental health services in the state. In California, public mental health services are funded by an array of federal, state, and local sources, most of which have stringent eligibility requirements.<sup>7</sup> Due to historical under-funding, in 1991 a new funding system, commonly known as "Realignment," was implemented. This transferred financial responsibility for most of California's mental health programs from the state to local

governments.<sup>4,8</sup> Counties were thus permitted to partake in the development and oversight of programs uniquely tailored to their constituents.

Only certain categories of providers can be reimbursed for mental health services under most public payment mechanisms. The federal Medicaid program, which provides medical benefits to certain groups of low-income people, is a major revenue source for county mental health departments. However, federal law establishes the general guidelines, and each state decides its own eligibility requirements and administers the public insurance program.<sup>9,10</sup> Reimbursement rates under California's Medicaid program (Medi-Cal) remain among the lowest in the U.S.<sup>11</sup> In addition, county-run psychiatric hospitals are closing and clients are being redirected to community-based programs.<sup>4</sup> These financing mechanisms inhibit the development of innovative models of care by limiting the type of providers who can be reimbursed for services.

To improve access to health care for underserved areas or populations, the federal government has supported the training of professionals and improving systems of care in rural communities since 1982.<sup>12</sup> In 1992, federal aid was extended to mental health professional shortage areas.<sup>13</sup> Hence, underserved areas and underrepresented populations may qualify for federal assistance in training more mental health care providers. Currently, California has 142 designated mental health professional shortage areas.<sup>14-17</sup> However, the type of providers trained with these resources is limited to just a few professions. Candidates must be licensed as one of the following mental health professionals: psychiatrist; clinical psychologist; clinical social worker; psychiatric nurse specialist; or marriage and family therapist.<sup>13,18</sup>

### ***Shortages of Some Types of Mental Health Providers***

Key informants overwhelmingly reported that California is suffering from a serious shortage of mental health care providers. Many acknowledged a particularly high vacancy rate for child psychiatrists, community-based counselors, and psychiatric nurse practitioners. In 2002, a legislative task force found that for core occupations, such as psychiatrists, psychologists, licensed clinical social workers, registered nurses, and psychiatric technicians,

vacancy rates were approximately 20-25 percent statewide.<sup>19</sup>

Factors contributing to shortages in mental health providers include the aging workforce as well as a maldistribution of the current workforce. Many informants reported that there will be a severe shortage in the mental health workforce after the retirement of the "baby boomer" generation in the next decades.

Interviewees reported that mental health providers are extremely scarce in certain predominantly Latino areas of Los Angeles. Some in need of mental health services are thus forced to seek less conventional means to address their needs, such as local churches or services across the U.S. border.

Some key informants attributed current shortages to low enrollment in graduate-level mental health educational programs, while others posited that regional shortages are caused by poor workforce distribution. In California, providers tend to be concentrated in urban regions, such as Los Angeles and the Bay Area. A few interviewees stated that urban workforce clusters are a function of the greater availability of educational and job opportunities in large cities. The state's rural areas must compete for a limited supply of workers. Some interviewees observed that young people from underserved regions often relocate for school and do not return to their communities because of the appeal of urban life. Rural service areas must be more creative and resourceful in mental health service planning and service delivery. Technology has aided this problem somewhat with telemedicine.

### ***Telemedicine in Mental Health***

Telemedicine creates better access to mental health care in rural areas. High-tech equipment, including televisions and cameras, facilitate two-way conferencing between urban providers and rural clients. Telemedicine is ideal for many clients because it allows for personal space and more privacy.<sup>20</sup> Organizations, including hospitals, clinics, and insurers, are testing methods to incorporate these relatively new services into existing clinical, administrative, and billing systems.<sup>21</sup>

### ***Challenges in Recruitment, Retention, and the Stigma of Working in Mental Health***

The stigma associated with seeking mental health care is well known; the U.S. Surgeon General acknowledged that “stigmatization of people with mental disorders has persisted throughout history.”<sup>22,23</sup> Mental health providers have similar concerns about negative perceptions of their work. Interviewees reported that stakeholders in mental health should be more cognizant of this stigma and the need to promote a stronger public profile for workers in the mental health sector.

Other factors contribute to challenges in the recruitment of the mental health workforce. The greatest source of dissatisfaction among providers appears to be compensation. Nearly all key informants contended that public mental health workers are underpaid.

In addition, there is competition between sectors that hire mental health workers. The private sector and the California Department of Corrections and Rehabilitation tend to pay higher wages and salaries than the public mental health sector. For example, some interviewees reported that several psychiatrists recently resigned from county positions to work in the state prison system. Interviewees also reported that the salary differential between mental health care employees in the public and other sectors is generally around 20 percent.

A lack of public awareness of the range of mental health careers was mentioned by many interviewees. They recommended that active recruitment begin at earlier levels of education. For example, middle school students should be advised about job opportunities in the mental health care field, and career ladders could be stimulated by high schools working in partnership with community-based organizations. Interviewees further suggested that more scholarships and loan forgiveness programs are needed, such as the CalSWEC program at UC Berkeley, which provides stipends for students in social work masters programs in exchange for a commitment to work in the public mental health community after graduation.<sup>24,25</sup> Social workers account for a large proportion of all mental health professionals and are more likely to be employed by the county mental health system.<sup>26</sup> As elaborated in the next section, interviewees also stated that recruiters should

focus on targeting underrepresented populations.

### ***Lack of Workforce Diversity and Cultural and Linguistic Competency***

The California Census has been reporting rapid growth in underrepresented populations since the 1980's.<sup>27</sup> However, the demographics of students in California's mental health educational programs have not kept pace with the transformation of the state's population.<sup>3</sup> Likewise, current workforce demographics do not reflect the growing underrepresented communities served.

Interviewees reported that insufficient recruitment, coupled with consequent lack of visibility for several mental health professions, perpetuate racial and ethnic disparities. The U.S. Surgeon General confirmed that culturally, racially, and ethnically diverse communities have less access to mental health services and often receive a poorer quality of mental health care.<sup>22</sup>

Interviewees stated that the mental health workforce often lack cultural competency skills.<sup>i</sup> They noted that clients are less inclined to seek services where language barriers exist. By state mandate, “cultural and linguistically appropriate social services, including mental health services, are required for populations with so-called threshold languages, which are spoken by at least 3000 beneficiaries or 5 percent of a county's Medicaid population.”<sup>28</sup> Although interviewees asserted that workforce diversity is the foundation for culturally competent care, they recommended the inclusion of cultural and language competency skills training in programs for all providers. The literature concurs that cultural competency skills are necessary for effectively responding to clients' needs.<sup>29</sup>

Greater diversity among health professionals has been associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, and better patient-provider communication.<sup>30</sup> Non-English speaking clients tend to receive better care when their providers are fluent in the same language, particularly with regard to mental health services where communication is imperative.<sup>31</sup> Conversely, the absence of workforce cultural and language competency skills training obstructs access to care. Unfortunately, workforce projections indicate that shortages of

<sup>i</sup> For legal definition of cultural competence, see Cal. Admin. Code tit. 9 §3200.100 (2008).

diverse and culturally competent mental health care providers will continue to negatively impact California's mental health community.<sup>32</sup>

### ***Regulatory and Scope of Practice Limitations***

Interviewees noted that for several mental health professions, California's registration, certification, and licensing requirements differ from those of other states. Out-of-state mental health professionals often must complete duplicative education and training requirements in order to become licensed in California. This lack of professional mobility limits the ability of provider organizations to recruit from out-of-state as one avenue to address workforce shortages. Several interviewees discussed the benefits of consolidating California's multitude of mental health professions to standardize licensure requirements, which could reduce redundancy, public confusion, and frustration.

Interviewees reported that expanded regulatory scopes of practice for some mental health professions would increase multi-disciplinary collaboration, which would, in turn, increase workforce capacity. One example cited was the ability to prescribe medications to mental health patients. Proponents of Senate Bill 1427 attest that Californians would have more access to mental health care if other clinicians, such as psychologists and psychiatric mental health nurse clinical nurse specialists, were legally authorized to prescribe medications.<sup>33,34</sup>

Scheffler and colleagues forecast shifts in professional duties among psychiatrists, psychologists, and clinical social workers. They estimated that job opportunities, and thus, training programs, will continue to increase for non-physician mental health professions, especially where prescriptive authority is granted.<sup>35</sup>

### ***Overview of the Mental Health Services Act and Workforce Implications***

Most key informants agreed that their current workforce focus is on the California Mental Health Services Act (MHSA) and its emphasis on education, training, and a different model of care. The purpose of the MHSA is to "develop and maintain a competent and diverse workforce capable of effectively meeting the mental health needs of the public."<sup>36</sup> One of its goals is to reduce disparities experienced by specific racial/ethnic and cultural groups.<sup>37</sup> The

MHSA imposes a one percent income tax on personal income of over one million dollars. California counties are expected to use the funds to expand the availability and scope of mental health services with the creation of new programs.<sup>38</sup> As of June 2007, \$2 billion was generated.<sup>24</sup>

MHSA funds are not to be used to support existing programs. MHSA funds must support: 1) community services and supports; 2) workforce education and training; 3) capital facilities and technological needs; 4) prevention and early intervention; and 5) innovative programs.<sup>39</sup> The California Department of Mental Health is implementing each component through a sequential approach.<sup>40</sup>

MHSA workforce education and training funds are distributed to county mental health departments. To receive funding, counties must submit detailed proposals to the Department of Mental Health describing their prospective mental health programs. Each county must devise programs tailored to its constituents' evolving needs.

Applications must specify logistics, such as financing and operational structures, and counties must update workforce education and training curricula to incorporate the recovery model.<sup>39</sup> Prior to the MHSA, researchers at the University of California, Berkeley, compiled baseline properties of California county mental health departments. Subsequent assessments of each county's structure, finances, and expenditures can therefore be compared with previous data to measure progress.<sup>41</sup>

### ***The Wellness, Recovery, and Resilience Model***

The MHSA envisions education and training programs that include the recovery model of care. This model theorizes that personal empowerment is imperative to recovery and upholds the value of establishing meaningful social connections within the community.<sup>40,42-43</sup> There is a need to re-orient the current mental health system from its current focus on acute care and symptom reduction to a new focus on long-term recovery and full involvement in community life.<sup>42</sup>

In the recovery model, consumers and family members ("consumers") are an



integral part of the mental health workforce. Consumers include clients or clients' family members who are familiar with system structures and practices, and can be employed in non-licensed positions.<sup>43</sup> Consumer-run services include peer-support and self-help networks, drop-in centers, wellness programs, crisis and respite care, and hospitalization alternatives.<sup>44,45</sup>

Some examples of this model are already in practice. In 1990, the Mental Health Association of Los Angeles County pilot tested the Village Model, which advocates client empowerment by effective personal and financial management. It blends a range of approaches, such as psychiatric care, psychosocial rehabilitation, assertive case management, and client empowerment.<sup>46,47</sup>

### **Workforce Challenges in Transitioning to the Recovery Model**

Many interviewees reported that California's mental health infrastructure is in the midst of transformation. Decision-makers are confronted with the challenges of introducing recovery ideologies to the established service delivery structure. Those major challenges include reimbursement regulations, provider training, and cultural differences.

#### ***Reimbursement Structure is Established for a Medical Model***

Reimbursement for mental health care is largely positioned to pay for a traditional model of care, under which certain providers are allowed to bill insurers for discrete services. Generally, rehabilitative services under the recovery model are not covered or are limited by provider type or type of service. Most interviewees agreed that the structure of the current system impedes access to effective mental health care because it encourages the treatment of isolated symptoms, and discourages continuity of care.

Interviewees reported that only certain mental health professionals, such as psychiatrists, psychologists, psychiatric nurse practitioners, and licensed clinical social workers, are eligible for direct Medi-Cal reimbursement for their services, while other providers, such as marriage and family therapists, are not. This impedes implementation of the recovery model and interdisciplinary care models. Interviewees argued that more professions need to be

eligible for reimbursement in order to make the recovery model financially viable for the mental health care delivery system.

#### ***Misalignment between Training and the Recovery Model***

Interviewees contended that there should be greater congruence between professional education programs and the recovery model. They believe that most training programs inadequately prepare the workforce for recovery-oriented practices.<sup>48,49</sup> While counties are making efforts to restructure services to focus on a recovery model, educational curricula and clinical training experiences need to be revised.

Some key informants specified that students need more preparation for community-based work in the public sector, since many educational programs currently focus on preparation for private practice. Academic programs often neglect aspects of social rehabilitation that are inextricably tied to recovery, such as lifestyle management and economic self-sufficiency. Furthermore, interviewees commented that faculty members have few incentives to change their curricula.

Some informants, however, were skeptical of the recovery model because "we're steering away" from traditional methodologies. They contend that one single model cannot be appropriate for all clients.<sup>50</sup> However, the literature suggests that for some clients, the recovery model could be successfully utilized with other service delivery models, such as the medical model.<sup>51</sup>

#### ***Challenges in Inclusion of Consumers and Family Members***

Interviewees reported that counties and community based provider organizations are currently discussing ways to create positions for consumers in the workforce. They agree that organizations should be directly "hiring consumers to work as staff...because they have life experience that is unlike that of traditional professionals..." The very presence of consumer staff can stimulate hope and images of successful recovery.<sup>51</sup>

Interviewees reported a lack of clarity among provider organizations regarding what services consumers are legally authorized to provide. Key informants identified an urgent need to create clear job descriptions, training curricula, and career tracks for consumers in the workforce. An

equally important issue was how consumers' services might be reimbursed or what funding is available to compensate consumers in the workforce.

Although interviewees overwhelmingly agreed that "the consumer is the guide to recovery and we should be honoring them," there is still not a great deal of awareness or acceptance of the model. A 2002 U.S. Surgeon General's Report on Mental Health did not mention the inclusion of consumers in the workforce. Furthermore, a few informants reported that the majority of "client-run clinics" are predominantly managed by clinicians, rather than consumers. These interviewees recommended including consumer input at high management levels.

### **Detailed Application Process for MHSA Funds**

Several interviewees perceived the application requirements to secure MHSA funding for new programs as cumbersome. To receive funding, each county must prepare a three-year plan for its funding allocation which is then subject to state approval.<sup>52</sup> Each application must include a workforce needs assessment "identifying its shortages in each professional and other occupational category in order to increase the supply of staff..."<sup>40,53</sup> The California Department of Mental Health provides a handbook to aid counties in assessing mental health workforce needs, which in part requires providing reasonably accurate estimates of the county's publicly-funded mental health workforce in terms of nine criteria.<sup>54</sup> Interviewees reported that the application and review process can be very lengthy. Most California counties are still in the process of submitting these applications.<sup>55</sup>

### **Summary**

The mental health workforce is challenged to provide needed mental health services to a growing and increasingly diverse population in California. Severe shortages of some categories of providers, maldistribution of the existing workforce, and limitations in scope of practice and financing, further strain an already fragile delivery system. The infusion of new funding in the form of the MHSA, along with changes in consumer demand, call for greater transition to models of care emphasizing wellness and recovery. The workforce needs further preparation to deliver services under

these models. Educators must address the current misalignment between education and training and the new models of care.

Interviewees had several general recommendations to address the challenges in the mental health workforce. These included more funding for training, more loan forgiveness for students, revised curricula and field training for professional programs, and more training programs to prepare consumers for the workforce.

Solutions to offset the state's provider shortage must be considered at the cultural, historical, institutional, political, regulatory, and socio-economic levels. Our assessment found that MHSA programs have unprecedented opportunities to improve access to mental health care. Measurement criteria for follow-up reassessment must be developed to determine whether the state is successful in creating a more robust workforce that is diverse and prepared to utilize the recovery model of care.

### **Notes**

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