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Enhancing the capacity of our mental health workforce

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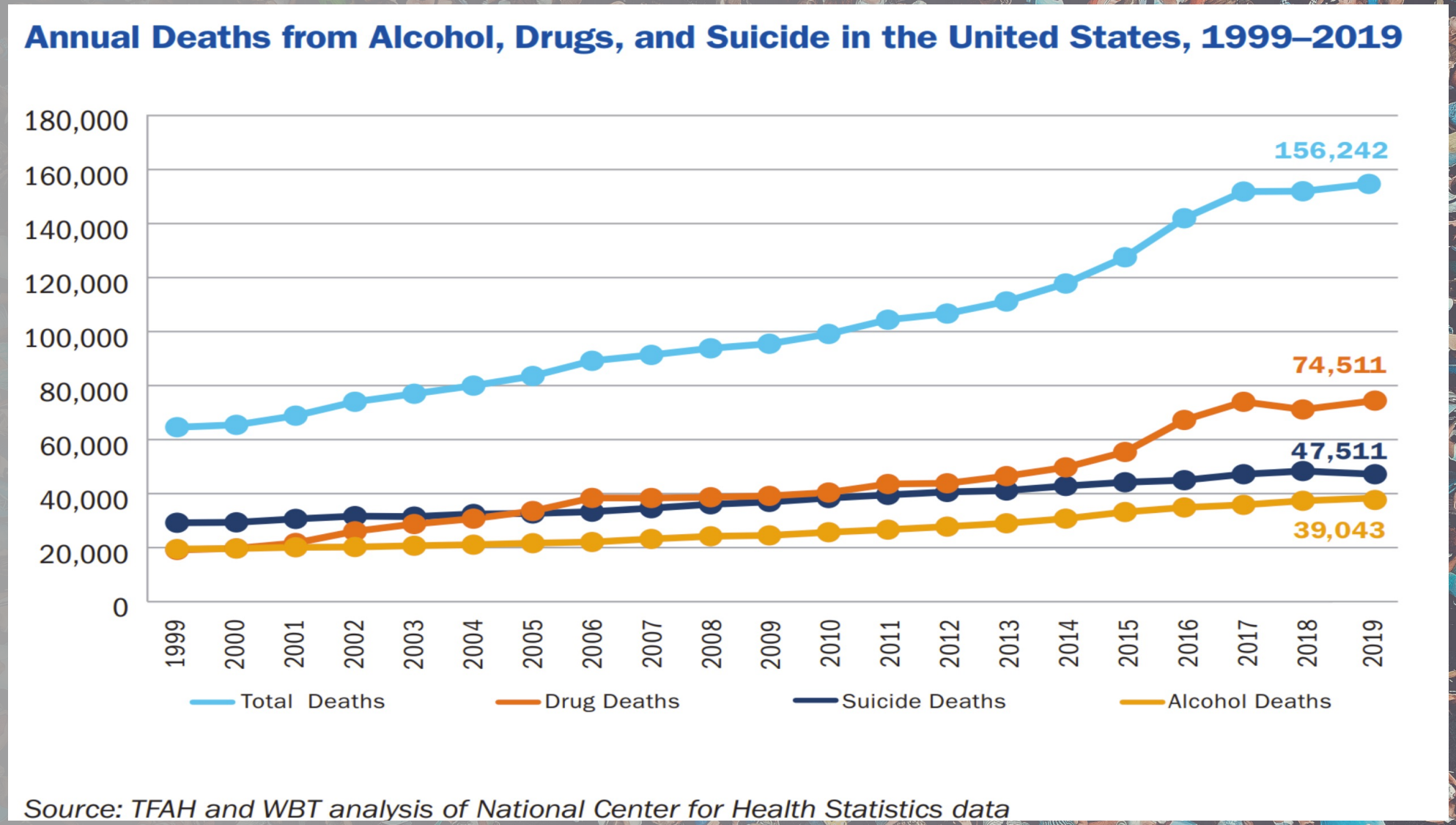
Well Being Trust

For workforce, “how do we get more?” is often answering the wrong question. The more accurate question is “how do we better use who we have?”

Let’s begin by answering the right question.

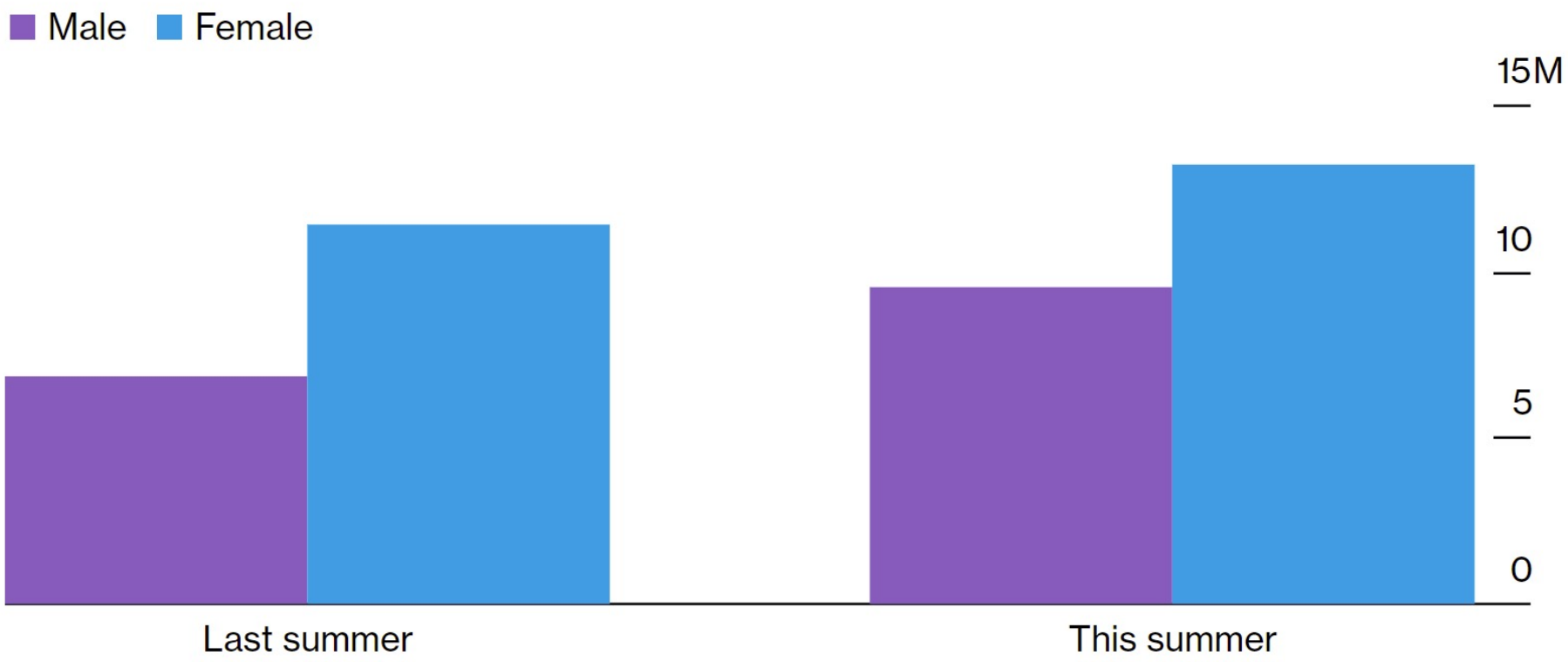
Our context



Source: TFAH and WBT analysis of National Center for Health Statistics data

Americans in Need

More people now say they need mental-health assistance -- but aren't getting it

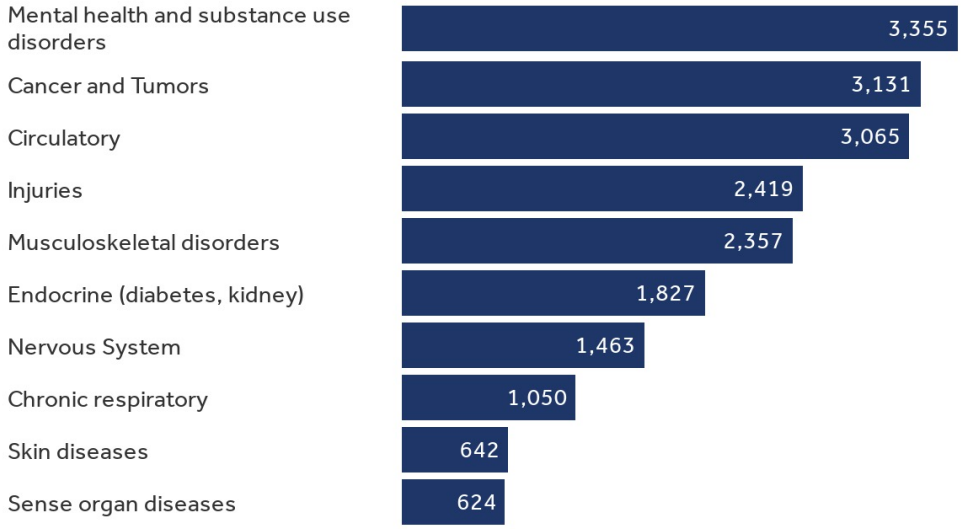


Source: U.S. Census Bureau
Note: Millions needed counseling or therapy but did not get it during the last 4 weeks

https://www.census.gov/data/tables/2021/demo/hhp/hhp34.html

Mental health and substance use disorders are the leading causes of disease burden in the US

Age standardized disability adjusted life years (DALYs) rate per 100,000 population, both sexes, 2015

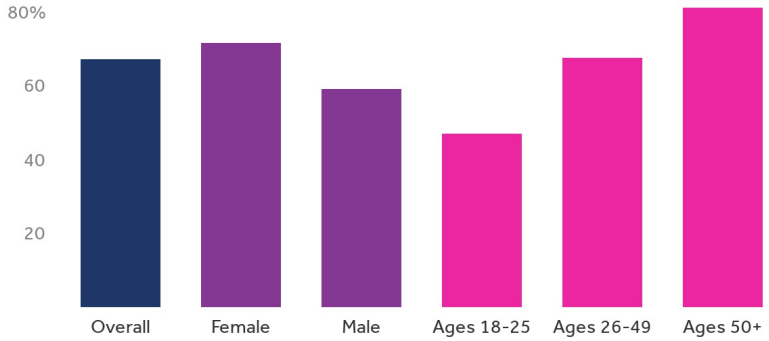


Source: Kaiser Family Foundation analysis of data from Institute for Health Metrics and Evaluation. Global Burden of Disease Study 2015 (GBD 2015) Data Downloads

Peterson-KFF Health System Tracker

A third of persons with 'major' depression receive no mental health care

Percent of adults with major depression who received mental health treatment, by gender and age, 2015



Source: Kaiser Family Foundation analysis of data from SAMHSA 2015 NSDUH (Accessed on July 27, 2017)

Peterson-KFF Health System Tracker

11m

People live in a mental health professional shortage area

$210B

Annual cost or economic burden of major depression

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The problem

- Fifty-five percent of U.S. counties have no practicing mental health clinician
- Seventy seven percent of people with mental health conditions report unmet mental health needs due to lack of clinicians.
- Not to mention there's a serious lack of diversity within the small workforce.
  - "According to a 2004 study, non-Hispanic Whites accounted for 76% of all psychiatrists, 95% of psychologists, 85% of social workers, 80% of counselors, 92% of marriage and family therapists, and 90% of psychiatric nurses in marked contrast to the composition of the U.S. population, which is nearly one-third Latino, African American, Asian American, or Native American/Pacific Islander and also undergoing growth."

Exhibit 1. Projected Supply and Demand for Behavioral Health Occupations in the U.S., 2017-2030

	Adult Psychiatrists	Child & Adolescent Psychiatrists	Nurse Practitioners	Physician Assistants	Psychologists	Social Workers	Marriage & Family Therapists	Addiction Counselors	Mental Health Counselors	School Counselors
Supply [a]										
Estimated supply, 2017	33,650	8,090	10,450	1,550	91,440	239,410	53,080	91,340	140,760	116,080
New entrants, 2017-2030	10,270	5,000	9,520	1,770	49,400	367,520	39,190	33,300	72,860	158,440
Attrition [b]*, 2017-2030*	(14,850)	(2,810)	(2,770)	(350)	(29,670)	(82,760)	(18,080)	(28,030)	(45,150)	(52,640)
Change in work patterns [c]	(2,050)	(450)	(300)	(80)	(7,730)	(10,800)	(1,540)	(2,730)	(4,150)	(3,750)
Projected supply, 2030	27,020	9,830	16,900	2,890	103,440	513,370	72,650	93,880	164,320	218,130
Total Growth, 2017-2030	(6,630)	1,740	6,450	1,340	12,000	273,960	19,570	2,540	23,560	102,050
% growth, 2017-2030	-20%	22%	62%	86%	13%	114%	37%	3%	17%	88%
Demand										
Estimated demand, 2017	38,410	9,240	10,450	1,550	91,440	239,410	53,080	91,340	140,760	116,080
Projected demand, 2030 [d]	39,550	9,190	12,050	1,670	95,600	268,750	57,970	105,410	158,850	119,140
Total growth, 2017-2030	1,140	(50)	1,600	120	4,160	29,340	4,890	14,070	18,090	3,060
% growth, 2017-2030	3%	-1%	15%	8%	5%	12%	9%	15%	13%	3%
Adequacy of Supply, 2030										
Total Projected Supply (minus) Demand	(12,530)	640	4,850	1,220	7,840	244,620	14,680	(11,530)	5,470	98,990

Notes: All numbers reflect full time equivalent (FTEs); Numbers presented are rounded to the nearest ten and may not sum due to rounding; Negative numbers are in parenthesis;

[a] For all professions except psychiatrists, the model assumes that demand and supply are equal in 2017.

[b] Includes retirements and mortality.

[c] For example, changes from full-time to part-time hours, or vice versa.

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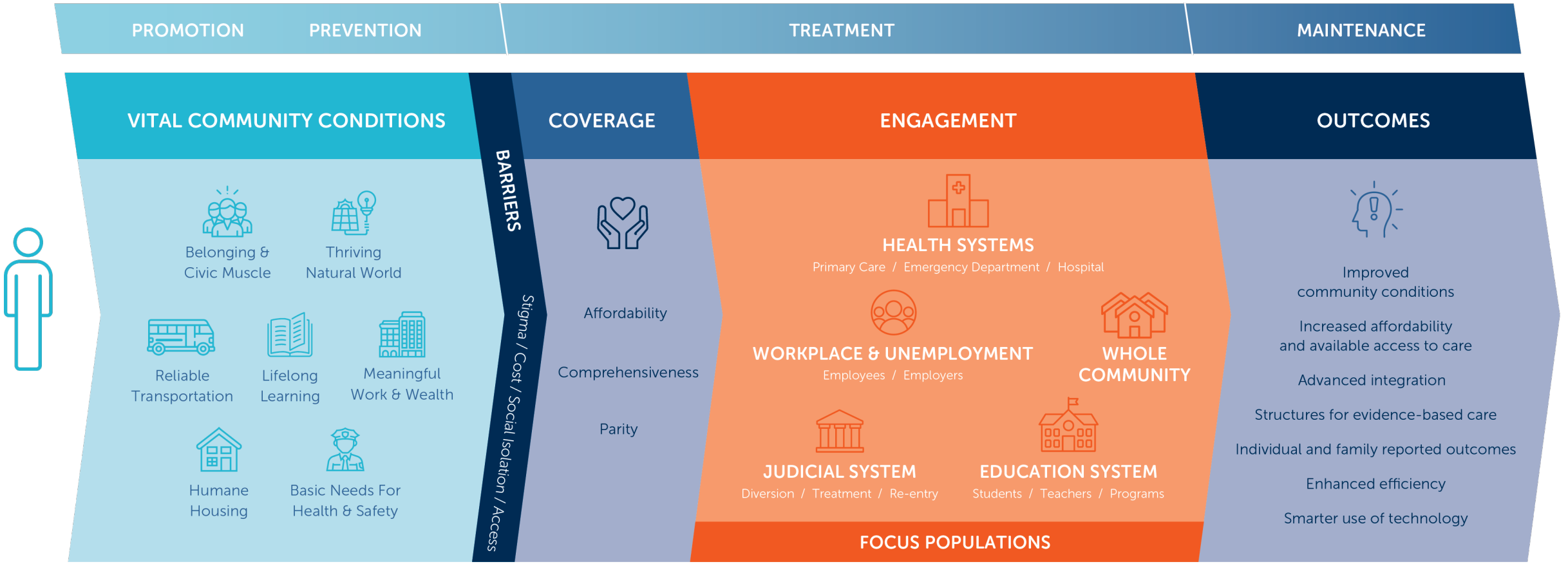
Why the workforce shortages?

- Aging workforce
- Low salaries
- Lack of resources
- Fewer people entering into the profession

Framework for excellence in mental health and well-being

The framework for excellence in mental health is a guide for changemakers at every level of society who seek to improve mental health outcomes and promote well-being for millions of Americans.



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A clear taxonomy for getting workforce right

- **The current workforce** (who's out there doing what, for whom, now?)
- **The future workforce** (pipeline – how can we get more trained to work in settings where people are)
- **The community workforce** (the unlicensed workforce e.g. peer support services)

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The current workforce

- How do we better assess who is doing what, where, and for whom?
- Can we “retread” the current workforce to be better positioned to address mental health and addiction needs?

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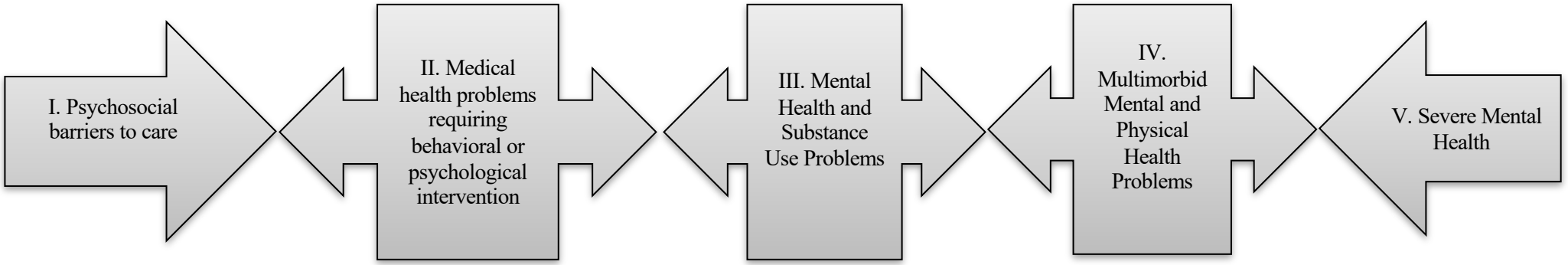
What are the range of mental health services?



Miller, B. F., Brown Levey, S., Payne-Murphy, J. C., & Kwan, B. (2014). Outlining the scope of behavioral health practice in integrated primary care: Dispelling the myth of the one-trick mental health pony *Families, Systems & Health*.

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Examples

- www.makehealthwhole.org
- Created a statewide set of competencies for mental health clinicians working in primary care

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The future workforce

- Accreditation standards
- Incentives
- Team-based learning and training

Redesign the workforce

Figure 1: Framework for Mental Health and Addiction Workforce (Revised from WHO) World Health Organization. (2009). Improving health systems and services for mental health (978 92 4 159877 4). WHO Press. https://www.who.int/mental_health/policy/services/mhsystems/en/

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The community workforce: Central to any meaningful redesign of health care is a discussion of our workforce. Who is doing what, to whom, where, and at what cost?

Most policy solutions tend to focus on the supply of our workforce:

How many clinicians do we have and where are they located?

The answers to these questions often leave decision makers wanting more, because the answers tend to always be the same:

We need more trained experts and we need them everywhere, especially in places they are not.

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Task shifting

- Task shifting is a common practice in other countries. By training community leaders to address basic mental health issues through evidence informed practice, we begin to “shift” the services back into the community.
- It requires a consistent mechanism to provide this training
- To achieve the promise of community-initiated care, we need a reliable training hub wholly committed to identifying leaders, training them in these skills, and assuring ongoing quality and outcomes consistent with the training.

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The community

- Peer support services
- Community Health Workers
- Promotoras

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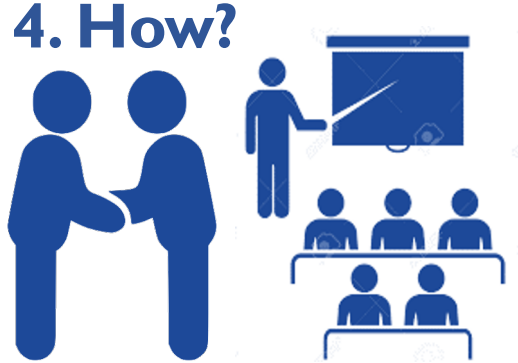
Redefining mental health care

1. What?

2. Where?

3. Who?

4. How?



Kohrt et al. 2018, *Int J Environ Res Public Health.*

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Implications for mental health care in the US

- Community initiated and community led care can add value to the mental health ecosystem
- Global experience can guide on what could work
- Integration of CIC can decrease the pressure on clinical care
- CIC can also decrease the cost of mental health care
- Administrative and financing barriers are substantial

Thank you!

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https://mentalhealth411.substack.com/