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.
Annual Deaths from Alcohol, Drugs, and Suicide in the United States, 1999–2019

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

A third of persons with ‘major’ depression receive no mental health care
11m
People live in a mental health professional shortage area

$210B
Annual cost or economic burden of major depression
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

<table>
<thead>
<tr>
<th>Supply</th>
<th>Adult Psychiatrists</th>
<th>Child &amp; Adolescent Psychiatrists</th>
<th>Nurse Practitioners</th>
<th>Physician Assistants</th>
<th>Psychologists</th>
<th>Social Workers</th>
<th>Marriage &amp; Family Therapists</th>
<th>Addiction Counselors</th>
<th>Mental Health Counselors</th>
<th>School Counselors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated supply, 2017</td>
<td>33,650</td>
<td>8,090</td>
<td>10,450</td>
<td>1,550</td>
<td>91,440</td>
<td>239,410</td>
<td>53,080</td>
<td>91,340</td>
<td>140,760</td>
<td>116,080</td>
</tr>
<tr>
<td>New entrants, 2017-2030</td>
<td>10,270</td>
<td>5,000</td>
<td>9,520</td>
<td>1,770</td>
<td>49,400</td>
<td>367,520</td>
<td>39,190</td>
<td>33,300</td>
<td>72,860</td>
<td>158,440</td>
</tr>
<tr>
<td>Attrition b, 2017-2030</td>
<td>(14,850)</td>
<td>(2,810)</td>
<td>(2,770)</td>
<td>(350)</td>
<td>(29,670)</td>
<td>(82,760)</td>
<td>(18,080)</td>
<td>(28,030)</td>
<td>(45,150)</td>
<td>(52,640)</td>
</tr>
<tr>
<td>Change in work patterns c</td>
<td>(2,050)</td>
<td>(450)</td>
<td>(300)</td>
<td>(80)</td>
<td>(7,730)</td>
<td>(10,800)</td>
<td>(1,540)</td>
<td>(2,730)</td>
<td>(4,150)</td>
<td>(3,750)</td>
</tr>
<tr>
<td>Projected supply, 2030</td>
<td>27,020</td>
<td>9,830</td>
<td>16,900</td>
<td>2,890</td>
<td>103,440</td>
<td>513,370</td>
<td>72,650</td>
<td>93,880</td>
<td>164,320</td>
<td>218,130</td>
</tr>
<tr>
<td>Total Growth, 2017-2030</td>
<td>(6,630)</td>
<td>1,740</td>
<td>6,450</td>
<td>1,340</td>
<td>12,000</td>
<td>273,960</td>
<td>19,570</td>
<td>2,540</td>
<td>23,560</td>
<td>102,050</td>
</tr>
<tr>
<td>% growth, 2017-2030</td>
<td>-20%</td>
<td>22%</td>
<td>62%</td>
<td>86%</td>
<td>13%</td>
<td>114%</td>
<td>37%</td>
<td>3%</td>
<td>17%</td>
<td>88%</td>
</tr>
</tbody>
</table>

## Demand

<table>
<thead>
<tr>
<th>Demand</th>
<th>Adult Psychiatrists</th>
<th>Child &amp; Adolescent Psychiatrists</th>
<th>Nurse Practitioners</th>
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<th>School Counselors</th>
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</thead>
<tbody>
<tr>
<td>Estimated demand, 2017</td>
<td>38,410</td>
<td>9,240</td>
<td>10,450</td>
<td>1,550</td>
<td>91,440</td>
<td>239,410</td>
<td>53,080</td>
<td>91,340</td>
<td>140,760</td>
<td>116,080</td>
</tr>
<tr>
<td>Projected demand, 2030 d</td>
<td>39,550</td>
<td>9,190</td>
<td>12,050</td>
<td>1,670</td>
<td>95,600</td>
<td>268,750</td>
<td>57,970</td>
<td>105,410</td>
<td>158,850</td>
<td>119,140</td>
</tr>
<tr>
<td>Total growth, 2017-2030</td>
<td>1,140</td>
<td>(50)</td>
<td>1,600</td>
<td>120</td>
<td>4,160</td>
<td>29,340</td>
<td>4,890</td>
<td>14,070</td>
<td>18,090</td>
<td>3,060</td>
</tr>
<tr>
<td>% growth, 2017-2030</td>
<td>3%</td>
<td>-1%</td>
<td>15%</td>
<td>8%</td>
<td>5%</td>
<td>12%</td>
<td>9%</td>
<td>15%</td>
<td>13%</td>
<td>3%</td>
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## Adequacy of Supply, 2030

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</tr>
</thead>
<tbody>
<tr>
<td>Total Projected Supply</td>
<td>(12,530)</td>
<td>640</td>
<td>4,850</td>
<td>1,220</td>
<td>7,840</td>
<td>244,620</td>
<td>14,680</td>
<td>(11,530)</td>
<td>5,470</td>
<td>98,990</td>
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</table>

**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.
Why the workforce shortages?

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

### Vital Community Conditions
- Belonging & Civic Muscle
- Thriving Natural World
- Reliable Transportation
- Lifelong Learning
- Meaningful Work & Wealth
- Humane Housing
- Basic Needs For Health & Safety

### Coverage
- Affordability
- Comprehensiveness
- Parity

### Engagement
- Health Systems
  - Primary Care / Emergency Department / Hospital
- Workplace & Unemployment
  - Employees / Employers
- Judicial System
  - Diversion / Treatment / Re-entry
- Whole Community
  - Students / Teachers / Programs

### Outcomes
- Improved community conditions
- Increased affordability and available access to care
- Advanced integration
- Structures for evidence-based care
- Individual and family reported outcomes
- Enhanced efficiency
- Smarter use of technology
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)
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?
What are the range of mental health services?

I. Psychosocial barriers to care
II. Medical health problems requiring behavioral or psychological intervention
III. Mental Health and Substance Use Problems
IV. Multimorbid Mental and Physical Health Problems
V. Severe Mental Health

Examples

• [www.makehealthwhole.org](http://www.makehealthwhole.org)
• Created a statewide set of competencies for mental health clinicians working in primary care
The future workforce

- Accreditation standards
- Incentives
- Team-based learning and training
Redesign the workforce

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.
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.
The community

• Peer support services
• Community Health Workers
• Promotoras
Redefining mental health care

1. What?

2. Where?

3. Who?

4. How?

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/