Psychiatric Workforce Needs and Recommendations for the Community Mental Health System: A State Needs Assessment

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Similar to other states, Georgia is facing workforce challenges within its community mental health system. These issues may be exacerbated as implementation of the Affordable Care Act expands demand for behavioral health services. Georgia's Department of Behavioral Health and Developmental Disabilities commissioned a needs assessment to examine the shortage of prescribing providers (psychiatrists, advanced practice registered nurses, and physician assistants) in the state's public mental health system. A unique partnership of key stakeholders developed and conducted the mixed-methods needs assessment at six of Georgia's 27 community mental health centers serving more than 40,000 patients annually. The assessment documented challenges in recruiting and retaining psychiatrists and workforce shortages for all prescriber groups. The authors describe opportunities for optimizing the psychiatric workforce and training the next generation of community psychiatrists.

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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) have 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 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. The North Georgia Partnership for Behavioral Healthcare (NoGAP) comprises six of these CMHCs. NoGAP serves more than 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.

In April 2013, 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—DBHDD's commissioner and deputy commissioner, two NoGAP members, and an Emory University 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. We contacted the Georgia Board for Physician Workforce, which 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 semistructured hour-long interviews with 11 NoGAP administrators (one to three administrators

from each site) and two patient focus groups (six or seven participants in each). Patients were recruited from two ongoing research studies and provided additional consent. The moderator used semistructured 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 on 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 youths; these rates are lower than national estimates (2,3). Of the 19,830 physicians practicing in Georgia, 5.3% are psychiatrists and 34.9% are primary care providers. Almost half of the psychiatrists (47%) are age 55 or older, indicating that the psychiatric workforce could substantially turn over or shrink in the next decade. Most psychiatrists are male (65%), and over two-thirds are white. Only 12% of psychiatrists are black, compared with 31% of Georgia's population (4), which suggests the importance of increasing diversity in the psychiatric workforce.

Annually, more than 40,000 patients attend more than 115,000 appointments with NoGAP providers. Over half of the patients are female (55%) and 70% are white. A majority of patients are age 18–64, 12% are under age 18, and 3% are over age 65. Half of the patients are uninsured. The most common types of insurance are Medicaid (24%) and Medicare (14%). Of the 62 NoGAP psychiatrists, 77% (N=48) serve adults, 23% (N=14) serve children and adolescents, 37% (N=23) work full-time, and 36% (N=22) 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 has shortages of other mental health prescribers; only 3% of all APRNs and .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. In addition, retention was low among part-time psychiatrists. Rural CMHCs reported particular trouble hiring qualified psychiatrists. Once psychiatrists were hired, high caseloads, patients' complex psychosocial needs, and the need to adhere to CMHC procedures often 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 mental health 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 high recruitment costs and psychiatrists' fees, extra time for psychiatrist training and for communication with the contracting agencies, and disruptions in 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 with 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 a CMHC. Another theme was the importance of partnering with medical schools to train future psychiatrists in the array of services that 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 require a significant amount of a psychiatrist's time. For APRNs and PAs with limited psychiatric experience, additional supervision and training were 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 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 health 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 facilitates patient tracking and contributes to better outcomes. Health homes, which are a patient-centered strategy of 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 postresidency 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 the advisory board and assessment team centered on building workforce capacity in Georgia through increased training opportunities and 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. The following recommendations were included. First, develop a community psychiatry fellowship that will recruit psychiatrists committed to working in public psychiatry, train them to work effectively in and take on leadership roles in CMHCs, and connect them with available positions. Second, 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 to pursue a career at a CMHC. Third, develop psychiatric training and supervision opportunities for APRNs and PAs in traditional graduate school curricula and after graduation 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 the following. First, 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. Second, 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. Third, explore opportunities for greater collaboration and standardization across CMHCs. CMHCs could standardize service delivery and reimbursement methods to develop a consistent and comprehensive model of care.

Limitations of the 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. Also, we had small samples for the surveys, interviews, and focus groups. However, these results aligned with the state workforce data and literature review.

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. In addition, our needs assessment highlighted the importance of cultivating providers who are interested in and trained to practice in community settings.

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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