Indiana Division of Mental Health and Addiction
Transformation Workgroup/Workforce Development Task Force

Recruitment and Retention Subcommittee

Report to the Transformation Workgroup

November 6, 2009

Mission Statement:

The goals of the recruitment and retention subcommittee were to determine the scope of behavioral heath workforce shortages in Indiana; to understand causes for these shortages; and to provide potential solutions. Toward these goals, the committee accumulated and compiled available pertinent data from various Indiana sources, and designed and conducted a Behavioral Health Workforce and Recruitment and Retention Survey of all major DMHA-supported behavioral health centers in Indiana. As reflected in the committee membership and in the work of data collection, key professional and training leaders were engaged in identifying ways to improve recruitment and retention difficulties. The resulting data and recommendations are presented in this report to the Workforce Development Taskforce of the Transformation Workgroup.

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1. Background

Among all parameters that determine the effectiveness of health care delivery, none are more important than the adequacy of size, quality, and expertise of the health provider workforce. Understanding workforce deficiencies and successfully addressing them is a key concern to all Indiana health care stakeholders, including those that provide health care funding, professional training, and delivery of clinical care. Behavioral health disorders collectively: 1) represent the leading root cause of premature medical illness and death in our society; 2) are major factors in the explosive growth of societal burdens of criminal justice, and incarcerations; and 3) are primary factors responsible for poverty and homelessness endemic to our cities. Thus, understanding the adequacy and quality of the behavioral health workforce is elemental not only in improving health care in our state, but the overall well-being of our society.

There is an emerging crisis in the professional workforce involving all sectors of the behavioral health field nationwide [Hoge et al. (2009) "A National Action plan for workforce development in behavioral health" *Psychiatric Services* 60:7:883-887]. The present report provides data characterizing dimensions of this crisis in Indiana.

1.1 Scope of the Clinical Problem in Indiana and Nationally

Behavioral health diseases, and specifically substance use disorders, collectively represent the #1 root cause of general medical illness and premature death in the United States (CDC, 1995-present). Even when excluding the impact of illicit substances, nicotine addiction (dependence), *a mental disorder described in the Diagnostic and Statistical Manual for Mental Disorders-IV*, is a leading risk factor for coronary heart disease (#1 leading proximal cause of death), and cerebrovascular disease (#3 leading proximal cause of death). It also is responsible for 50% of <u>all</u> cancer deaths (#2 leading proximal cause of death) and is related to 90% of non-cancerous pulmonary diseases (# 4 leading cause of death). Alcohol abuse and dependence, *which are also mental health disorders*, are responsible for the following common and often lethal conditions: 85% cases of chronic pancreatitis, 40% esophageal varices, 47% of gastroesophogeal hemorrhages, 40% of liver cirrhosis, 34% of drowning deaths, 32% of fall injuries, 42% of fire injuries, 47% of homicides and 23% of suicides (not attributed to alcohol as toxic cause of death), 48 % of all motor vehicle crashes involving drivers aged 20-44.

In a recent analysis of the causes of death (i.e. not deaths as reported by immediate cause but by underlying conditions leading to the immediate cause), reported by Mokdad et al [JAMA, 2004], the leading causes of death in America are ranked as follows:

1. Tobacco consumption
2. Poor diet/physical inactivity (obesity)
3. Alcohol consumption
4. Infections
5. Toxic agents
6. Motor vehicle accidents
7. Firearms
8. Sexual behavior
9. Illicit drug use

Considering this ranking, it is important to realize that not only do the #1, #3 and #9 causes directly reflect the impact of substance use disorders, but that many, if not all of the other causes, reflect the additional indirect impact of behavioral patterns, psychiatric or addictive disorders and their combinations. For example, in terms of #2 (obesity): appetite is controlled by a brain region called the hypothalamus; decision making leading to eating vs. engaging in physical activity is

controlled by the frontal cortex. In terms of #4 (infections) Endocarditis, HIV and Hepatitis B and C infections represent a significant fraction of this mortality; up to 1/3 of these cases are caused by I.V. drug use. In terms of #6, substantial proportions of car accidents are secondary to substance intoxication (as demonstrated by CDC data). For #7 (firearms), substantial proportions of firearm deaths, whether homicidal, suicidal, or accidental occur in the context of addictions or psychiatric conditions. For #8 (sexual behavior), impulsive sexual behavior leading to medical illness is a well-known component of several mental disorders including, but not limited to, bipolar disorder, and cluster B personality disorders and addictions.

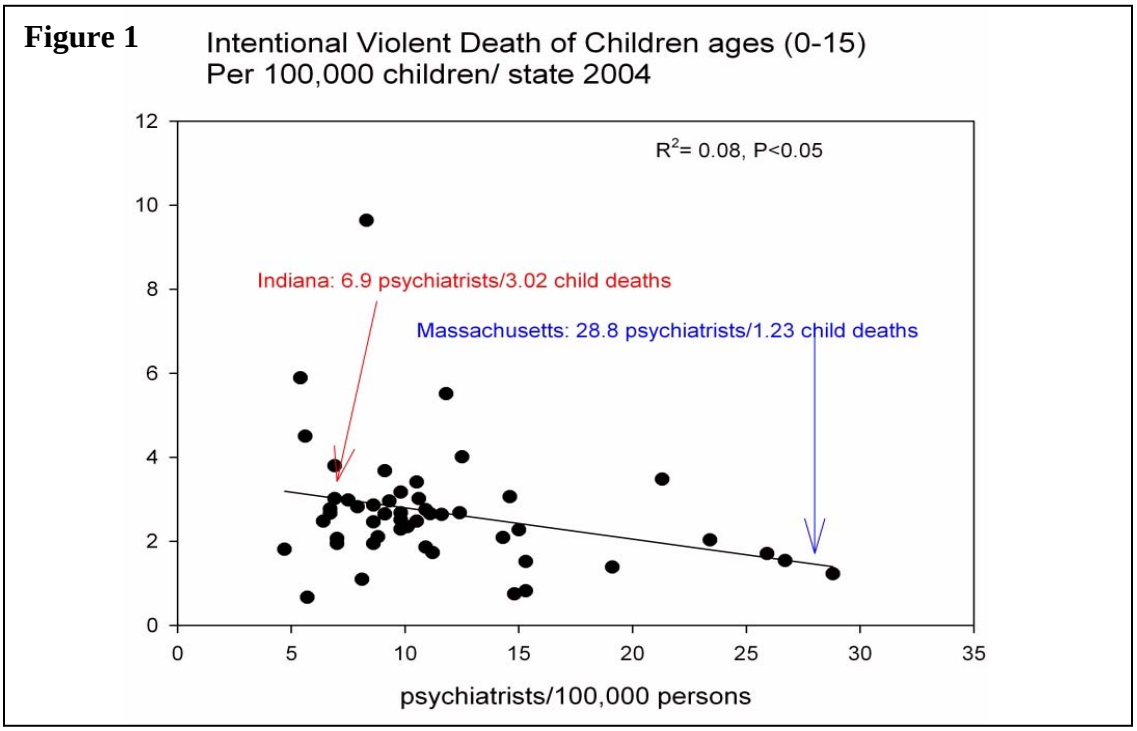
While these data depict morbidity and mortality trends due to substance disorders over the general population, an important aspect of this epidemiology is that substance disorders occur disproportionally within a minor fraction of the general population— those who also suffer with mental illnesses. In fact, mentally ill populations show two- to four-fold increases in the prevalence rates of addictions to nicotine, alcohol, cannabis, opiates, amphetamines, cocaine, and other addictive drugs. In clinical treatment settings spanning emergency rooms, outpatient clinics, hospitals, and payer sources, more than 50% of persons presenting primarily for addictions treatment have concurrent or recent history of psychiatric disorders, and more than 50% of those presenting primarily for mental health care have concurrent addictions of some kind. This major form of co-morbidity, frequently termed 'Dual Diagnosis,' is due to an extreme vulnerability to the addiction disease process, that is of a biological and non-volitional nature [Chambers et al, 2001 Biol psychiatry; Kessler, Biol Psychiatry,2004;O'Brien, Biol Psychiatry, 2004]. This vulnerability is so prevalent that much of the medical illness burden, early death and public health cost-burden of addictions are disproportionately carried by populations with mental illness. For example, with respect to rates of nicotine addiction in the general population, 50% of all cigarettes are smoked by persons with minor or major psychiatric disorders [Lasser, et al, 2000 JAMA].

These data on the impact of substance disorders as the leading root cause of medical morbidity and mortality, and its high prevalence in persons with mental illness, suggests that the behavioral health workforce (including physicians (psychiatrists), psychologists, nurses, social workers, case managers, and therapists) is the most critically important component of effective public health care delivery. Indeed, since leading evidence- based treatments for either mental disorders or addictions involve delivery of both pharmacological and psychotherapeutic modalities of care working in concert, this workforce (among all those in health care delivery) is best trained for, and should be adequately deployed for, the treatment of these disorders as either stand alone or co-morbid conditions.

Several indicators suggest that deficiencies in the behavioral health workforce present in Indiana, while representative of national trends, are particularly severe. Because psychiatrists often work with or lead teams composed of many different types of behavioral health professionals, numbers of psychiatrists can serve as a proxy measure of the vitality of the entire workforce. Indiana has one of the lowest per-capita population ratios of psychiatrists in the United States, ranking at 43 in the year 2000. [USDHHS, HRSA, State Health Workforce profiles (2000)]. A useful and relatively specific indicator of the potency and vitality of the health care workforce toward maintaining a region's behavioral health is an examination of the mortality of children due to violent- perpetrated death by parents. This measure is valuable because the killing of one's own children is instinctually contrary to normal parental behavior and is almost always reflective of severe mental disorders and/or addictions that are not being adequately treated or addressed in the adult population. According to 2005 data from the CDC [CDC; www.cdc.gov/ncipc/wisqars], Indiana ranked #1 in the U.S. in terms of per-capita child abuse fatalities, # 1 in terms of preventable (abuse and neglect-related) related fatalities for children 0 to 1 years old, and #3 for children 0 to 4 years old. Most of these cases were perpetrated by immediate relatives and parents, and do not include abortions or peri-delivery complications giving rise to infant mortality. When examining rates of the perpetrated death of children age 0 to

15 years old, Indiana again ranks near the top of this list. Strikingly, in a comparison of this data among all the states combined with data on the number of psychiatrists per capita in the state population, there is a significant overall inverse linear relationship **(Figure 1:** Compiled from USDHHS, HRSA, State Health Workforce profiles (2000) and CDC data (2004)**).**

Figure 1



Other measures suggest inadequacies of the behavior health workforce in addressing addictive disorders in the general population and specifically within mental health populations. Indiana has consistently ranked among the top five states in terms of rates of nicotine addiction [2002 data; MMWR, CDC, behind Kentucky, Alaska, South Dakota, West Virginia]. As an indirect measure of the rate of consumption of an illicit substance, Indiana has also ranked similarly with respect to the number of methamphetamine labs discovered [behind Iowa, Arkansas, North Dakota;2004 data; National Clandestine Laboratory Database]. Meanwhile, according to estimates provided by the Indiana DMHA Task Force on Co-occurring Disorders (1999), a majority of 160,560 adults in Indiana with dual diagnoses (aged 18-24) who are living independently, receive no behavioral health treatment.

1.2 Under-production of behavioral health physicians in Indiana

Despite being the only institution that trains psychiatric physicians in Indiana, and being a core clinical department within the second largest medical school in the United States, the Department of Psychiatry at the Indiana University School of Medicine is undersized in terms of full time teaching faculty and number of residents being trained. Currently, the IU psychiatry residency program graduates approximately 5-7 psychiatrists per year and from 0 to 1 per year who become psychiatric addictionologists. This is for a state of 6.3 million people, in which at least one quarter (1.5 million) will suffer some form of addictive disease with or without a treatable co-morbid mental disorder. **Table 1A** compares Indiana and Connecticut in terms of behavioral health physician workforce production and related parameters of overall public health in these states. **Table 1B** compares the IU School of Medicine and Yale University School of Medicine in terms of the number of psychiatric residency slots, and related ratios relevant to the size and mission of the medical school.

Table 1A: Psychiatric Physician Production and Related Health Care Measures

	Indiana	**vs.**	**Connecticut**
Population (2005, Census bureau)	6.3 million		3.5 million
Number of psychiatry residency programs	1		2 (Yale + UCONN)
Number of new psychiatrists per graduating class	4-6		18-22 (Yale (14-16), UCONN (4-6))
Number of addiction psychiatrists graduating per year	0-1		2-4
Psychiatrists per capita (per 100,000)/rank (HRSA data, 2000)	6.9 (43rd)		23.4 (4th)
State ranking by population health (United Health Foundation, 2006)	33rd		5th
State assessments of Health Care quality (encompasses all specialties) (Commonwealth Fund report, 2007)			
Overall	38th		7th
Access	30th		7th
Quality	28th		4th
Avoidable hospital use/costs	33rd		25th
Equity	34th		7th
Rate of perpetrated violent death of children ages 0-4 (per 100,000) (CDC,2004)	4.65		2.84

Table 1B: Psychiatric Physician Production and related medical school measures

	Indiana University SOM	**vs.**	**Yale University SOM**
Number of medical students per graduating class:	275+		100
Approx number of graduating students considering career in psychiatry	2-4 (1-2% of total)		6-8 (6-8% of total)
Approx total number of Psychiatry residents at school (incl years 1-4)	20-24		60
Approx ratio psychiatry residents to medical students	0.07		0.60
Medical school rankings (U.S. News and WW 2008)	44th		8th

1. 3 Health Professional Shortage Areas in Indiana

The U.S. Department of Health and Human Services contracts with State Health Departments nationwide to analyze local districts within states to determine shortages of primary care physicians, dentists, or mental health professionals. For mental health care, a geographic region (e.g. a county) is declared a Health Professional Shortage Area (HPSA) if one or more of the following criteria is met:

1. General population: psychiatrists >30,000:1

2. General population: Core Mental Health Providers (CMHPs) (including psychiatrists, psychologists, social workers, psychiatric nurse specialists, marriage and family therapists)
   >9000:1

3. General population: CMHPs >6000:1 and general population: psychiatrists >20,000:1

4. Additional qualifying ratios based on poverty levels of a given region.

According to data provided by the Indiana State Department of Health, 36 of Indiana's 92 counties and a portion of Lake County, encompassing 40% of Indiana, was designated as a Mental Health Professions shortage area in 2009.

Section Summary

Addictions and dual diagnosis disorders are the central public health concern and present as the mainstream of clinical presentations in behavioral health care. However, Indiana's capacity to generate an adequate physician workforce in behavioral health care, as currently shouldered solely by the IU school of medicine, is deficient. Accordingly, large proportions of the state of Indiana represent health shortage areas in mental health care.

2. Physician Workforce in Behavioral Health in Indiana: Data from the DDPAT

In 2007, Indiana DMHA commissioned the design and implementation of a physician workforce study instrument that would characterize the physician workforce providing clinical care at DMHA-supported centers. Several design features of the study instrument (the Dual Diagnosis Physician-infrastructure Assessment Tool (DDPAT)) were aimed to provide information about institutional involvement and individual physician involvement and expertise in the care of patients with dual diagnosis disorders, since co-occurring addictions and mental illness characterizes the mainstream of cases treated by these centers. The goal of this study was to 1) develop a novel workforce instrument that may be useful to Indiana and other states in gauging the professional crisis in behavioral health care and dual diagnosis treatment; and 2) provide 'actionable intelligence' on the behavioral health physician workforce in Indiana to relevant stakeholders in behavioral health care in Indiana. The results of this study, as presented here, have been accepted for publication in *Psychiatric Services,* the leading and most widely circulated journal on Behavioral Health Care delivery in the United States *(Chambers, RA, Connor, MC, Boggs, C, Parker, G (in press) "The Dual Diagnosis Physician-infrastructure Assessment Tool (DDPAT: Examining State-Funded Facilities and Physician Workforce Attributes) Psychiatric Services*).

Method: All major clinical centers receiving significant funding from Indiana DMHA were assessed in the survey (30 Community Mental Health centers (CMHCs); 13 Addiction Treatment Centers (ATCs); 6 State hospitals) from February to October of 2007. The study instrument was deployed in two phases (each by phone contacts and web-based surveys): Phase 1 was a 10-part questionnaire directed to the administrative leadership of the centers (e.g. to characterize services provided by the centers); Phase 2 was a 10-part questionnaire directed to each of the individual physicians employed by the centers. The content of these phases addressed the following:

Phase I: Treatment Centers
1. Name of organization
2. Number of treatment sites
3. Type of treatment provided (inpatient and/or outpatient)
4. Primary treatment focus (mental illness, addictions or both (separately or integrated))
5. Specific addictions services (inpatient detoxification and/or outpatient opiate treatment)
6. Patient population (primarily children, adults, or both)
7. Number of unfilled physician positions (FTEs)
8. Number of individual physicians on staff
9. Names and contact information of physicians
10. Number of non-physician prescribers on staff

Phase II: Individual Physicians
1. Physician identifier code
2. Age
3. Clinical specialty by residency training
4. Primary clinical role (psychiatric care, general addiction, treatment of opiate addictions, combination of psychiatric illness and addictions, medical care)
5. Number of hours per week at this center
6. Site of residency training (in-state, out-of-state, other)
7. ABPN certification in psychiatry
8. ABPN certification in addiction psychiatry
9. ABPN certification in child psychiatry
10. ASAM certification

Results:

Participation:
All 49 (100%) treatment centers responded to Phase I, reporting a total of 286 physicians on staff, of whom 215 (75%) completed Phase II. Physician response rates ranged from >93% at state hospitals and addiction treatment centers to 67% at CMHCs**.** Four of 6 hospitals, 11 of 13 addiction centers and 8 of 30 CMHCs had 100% physician response rates.

Overall physician workforce shortages:
As a fraction of the total medical staff (of whom only half were full-time), the need for new full-time physicians in 2007 was 30%, 12% and 32% in state hospitals, CMHCs, and ATC's, respectively. These and related findings suggest the presence of a longstanding and chronically worsening inadequacy of production of new psychiatrists in Indiana. First, the total number of physician FTEs needed (55.9) state wide is more than nine times larger than the annual class size (6) of Indiana's only psychiatry training program, at the Indiana University School of Medicine. Second, only 27% of all surveyed physicians trained in psychiatry in Indiana, even though this school is the second largest medical school in the U.S. by medical student class size. Third, progressive decreases in the numbers of employed physicians in age groups below 50 years suggests chronically extinguishing production rates of new psychiatrists and/or rates of entry into public sector psychiatry **(Figure 2)**.

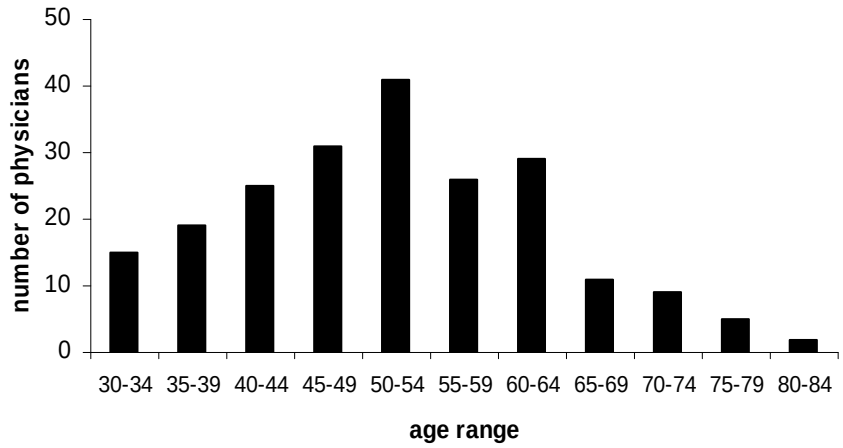


Figure 2. Age diagram of physicians employed at Indiana CMHC's, state hospitals, and addiction treatment centers. Approximately 90% of physicians were psychiatrists; other primary care doctors (internal medicine, family medicine, surgery) represented <10% of this workforce. Physicians aged 50-54 outnumbered those younger than 35 by nearly three-fold. About 4 in 10 (38%) were within a decade or beyond a retirement age of 65, but only 16% were aged 30-39. CMHCs employed 77% of this workforce, which was also the youngest cohort with a mean age of 51 years. Hospitals employed 7% of the workforce with the oldest cohort and mean age of 59.

Institutional Shortfalls in Dual Diagnosis/Addictions treatment:
Dual diagnosis presentations are mainstream in patient populations seeking treatment for either mental illnesses or addictions. While the majority of CMHCs (97%) reported providing treatment for both addictions and mental illness (either as segregated or integrated treatments), only a minority of hospitals (33%) and ATCs (33%) reported this dual diagnosis capability. Then, although CMHC's reported high rates of dual diagnosis capability, only about half of these centers (53%) actually provide inpatient detoxification service options; only 13% provide outpatient opiate maintenance therapy service options; and only one of 30 centers state wide provided both of these types of services. Since both of these treatment options (e.g. inpatient detox and outpatient opiate maintenance) are considered standard of care evidence-based treatment modalities for addictions, these findings suggests that center's definitions of dual diagnosis treatment capability does not often actually encompass provision of standard of care treatments for addictions. With respect to these addiction treatment options, ATC's actually provided fewer options overall compared to CMHCs. Moreover, physician involvement was sparse at most ATC's and non-existent at 4 of 13 centers surveyed, indicating that ATCs are least well equipped (and often not staffed) to provide standard of care/evidence based pharmacological and psychotherapeutic treatment services for addictions. As suggested in the physician workforce characteristics presented below, formal expertise in psychiatric addictionology was rare in the physician workforce, and when present, was not often being utilized in the care of dual diagnosis patients.

Shortages in physician expertise and involvement in Dual Diagnosis/Addictions treatment:
Physician staffing profiles (training backgrounds/certifications/specialties) according to treatment center type are shown in **Table 2.** Formal training in addictions indicated by certifications in addiction psychiatry (ABPN) or addiction medicine (ASAM) characterized only 3% vs. 5% of the entire physician workforce respectively. Then, of the three-quarters of all physicians surveyed who worked at CMHCs, only 30% described their primary clinical role as treating both mental illnesses and addictions, even though 97% of CMHCs reported dual diagnosis capability. Only a minority of addiction certified physicians (either ABPN or ASAM) identified their primary clinical role as treatment of both mental illness and addictions. The majority of ABPN-certified addiction psychiatrists (57%) were employed at the state hospitals, while the addiction treatment centers hosted the highest overall percentage of addictions-certified physicians (21%), even though only a minority of these centers reported dual diagnosis capability. Taken together, these findings suggest a disconnect between how centers report their dual diagnosis capability and levels of physician expertise and involvement in dual diagnosis care.

Section Summary

The DDPAT uncovered evidence for chronically worsening shortages of psychiatric physicians in behavioral health care in Indiana. Only a minority proportion of the physician workforce that works in Indiana was also trained in Indiana, suggesting the under-production of psychiatric physicians has been long-standing. Moreover, since nearly 40% of the workforce was within a decade of retirement, and given the low production of new psychiatrists ongoing in Indiana, these shortages are expected to get worse. With respect to treatment of dual diagnosis disorders, DMHA-supported clinical centers broadly lack sufficient institutional treatment programming and suffer from profound shortages of physician-based expertise in providing evidence-based, standard of care treatments for dual diagnosis patients, inclusive of both pharmacological and psychotherapeutic modalities.

Table 2. Physician staffing profiles by treatment center

	Hospitals (N = 35)		CMHCs (N = 166)		Addiction centers (N = 14)		All (N = 215)	
Mean age (years)	58.6 ±12.8		50.5±10.6		50.6 ±14.3		51.8±11.6	
	N	%	N	%	N	%	N	%
Clinical specialty								
General psychiatry	22	63	124	75	6	43	152	71
Child psychiatry	4	11	37	22	1	7	42	20
Internal medicine	3	9	1	1	0	---	4	2
Pediatrics	0	---	0	---	0	---	0	---
Family medicine	3	9	2	1	6	43	11	5
Surgery	1	3	0	---	1	7	2	1
Neurology	0	---	0	---	0	---	0	---
Emergency medicine	0	---	0	---	0	---	0	---
Other	2	6	2	1	0	---	4	2
Treatment Role								
Mental illness	19	54	112	68[a]	3	21	134	63
Addictions	1	3	1	1	3	21	5	2
Opiate addictions	0	---	1	1	0	---	1	<1
Mental illness & addictions	9	26	50	30	3	21	62	29
Medical care	6	17	1	1	5	36	12	6
Hours/week								
Full time (40+)	26	74	81	49	4	29	111	52
30-40	2	6	36	22	1	7	39	18
20-39	3	9	30	18	0	---	33	15
6-19	3	9	15	9	3	21	21	10
<6	1	3	4	2	6	43	11	5
Psychiatric residency								
Indiana	7	20	47	28	3	21	57	27
Out of state	21	60	116	70	4	29	141	66
Non-psychiatrist	7	20	3	2	7	50	17	8
ABPN certification								
General psychiatry	16	46	118	72	4	29	138	64
Child psychiatry	3	9	17	10	0	---	20	9
Addiction psychiatry	4	11	3	2	0	---	7 [b]	3
ASAM certification	0	---	8	5	3	21	11	5

[a] Missing case excluded; one CMHC physician did not respond to treatment role question.

[b] 4 of 7 with ABPN certification in addiction psychiatry were grandfathered in.

3. Spanning Behavioral health Professionals: the Recruitment and Retention Survey

Building on the investigative approach used in the DDPAT study, the Recruitment and Retention workgroup developed and implemented a new survey designed to assess workforce hiring and turnover conditions inclusive of the broad scope of professionals making up the entire behavioral health workforce. Much of the preliminary work in this effort was dedicated to determining a manageable list of discrete professional types. Behavioral health professionals can be titled and characterized by a wide variety of descriptors, including degree type, educational attainment, licensure, specialty or subspecialty certifications, role descriptions, and actual clinical/supervisory duties. In practice, we found that there is considerable heterogeneity of terminologies used to describe professional positions, and variance in how each of these descriptors relate to one another or actual clinical responsibilities. With these considerations in mind, the committee settled on the following list of 13 professionals, acknowledging that it is an imperfect list, and that some of the positions may be differentially interpreted by the specific centers:

--Psychiatrist (M.D. D.O.)
--Psychologist (PHD, Psy D (HSPP))
--Nurse (RN, LPN)
--APRN (Advanced Practice Nurse Practitioner or equivalent Rx capable)
--PA (Physician Assistant)
-- Case Manager (Associates or Bachelors Level)
--Social worker (Masters Level / LCSW)
--Mental Health Clinician (Associates or Bachelors Level)
--Mental Health Clinician (Masters Level (LMFT, LMHC))
--Substance Abuse Counselor (Associates or Bachelors Level)
-- Substance Abuse Counselor (Masters Level)
--Behavioral health technician/assistant (High school diploma or G.E.D)
--Pharmacist

With respect to these professional types, the Recruitment and Retention Survey was designed a 15 item questionnaire with mixed quantifiable and open-ended questions that address the following issues:

1) Types of Clinical Professionals in greatest need
2) Types of Diversity Professionals Needed
3) Types of Psychiatric Sub-specialists in greatest need
4) Difficulties in Recruitment
5) Current Methods of Recruitment
6) Potential Solutions to Recruitment Problems
7) Retention Difficulties
8) Future Challenges

Data collection for the survey was carried out by the membership of the recruitment and retention subcommittee in September and October of 2009. All major DMHA-supported clinical sites were assessed (27 CMHCs, 6 State hospitals, and 12 ATCs) for the 2009 survey, in addition to 5 'other' sites including community health centers that are not robustly funded by DMHA but which may have behavioral health missions. Each member of the investigative subcommittee was assigned 3 to 5 clinical sites to survey, typically conducted in face-to-face or telephone interviews with the administrative leadership and human resources staff of each center. Only selected results from the 5 'other' sites are presented here as they were not generally staffed by behavioral health professionals.

3.1 Types of clinical professionals in greatest need

Method: From the provided list of the 13 professional types, we asked centers to choose 3 that they most greatly need for achieving its clinical mission, and rank them as 1) highest need; 2) second highest need; and 3) third highest need. These choices were to be made independent from considerations about recruitment and retention difficulties.

Results:

CMHCs (N=27):

Psychiatrists, were most frequently selected as the highest profession in need (14/27). APRNs (nurses capable of prescribing psychiatric medications) were selected most frequently as the second highest profession in need (12/27), and social workers (Masters level LCSW) were selected most frequently as the third highest need (10/27).

State Hospitals (N=6)

Nurses (RN/LPNs) were most frequently selected as highest need (3/6). Behavioral health technicians/HS diplomas, were most frequently selected as the second highest need (2/6), while psychiatrists and pharmacists tied for being most frequently selected as third highest need (2/6 each).

ATCs (N=12)

Substance abuse counselors (Masters level) were ranked as both the greatest need (6/12), and second greatest need (4/12). Case managers (Bachelors or Associates) were selected most frequently as the third greatest need.

Other (e.g. community health centers) (N=5):

Social workers (Masters level / LCSWs) (3/5), psychiatrists (2/5) and Case managers (Bachelors or Associates), were most frequently ranked as the first, second, and third highest need professions respectively.

All Centers (N=50):

Psychiatrists were most frequently selected as the highest need (18/50), APRNs the second highest need (12/50) with case managers (Bachelors/Associates) and Social workers (Masters (LCSWs) tied for the third highest need.

Summary/Interpretation: Although psychiatrists were most broadly needed, the types of professionals needed varied considerably by center type. Prescribing professions (Psychiatrists/APRNs) were in greatest need at CMHCs, while hospitals needed more personnel for daily management of patients. ATCs, many of which have no or very little physician staffing, likely do not often see themselves as providing treatment following a medical model, and so are in need of specialists providing purely group or individual psychotherapeutic modalities of care.

3.2 Types of Diversity Professionals Needed

Method: Centers were asked to choose from, or write in needs in terms of professionals who represented specific diversity groups, or who are multilingual.

Results and Summary/Interpretation:

Across CMHCs, Hospitals, ATCs and community health centers, there was broad agreement for a high unmet need for greater numbers of professionals from the African American and Latino Communities. Need for other professional diversity group representation was also cited, or suggested such as for Asian, hearing impaired, Burmese, Somali, Chinese, Vietnamese, Amish, Women and Caucasian subgroups. However, overall ratings of 'high' or 'moderate' need for either African American or Latino professional representation was reported 10 to 20 fold more frequently than for these other diversity groupings. Notably, there were quite region specific needs for specific groups (e.g. Burmese representation was needed in one community that uniquely had a high Burmese immigrant population). Other notable features of this data included 1) an unmet need for more female clinicians in the addictions treatment area (reported by ATCs); and 2) more Caucasian clinicians needed as reported by public health centers. The significance of the latter reporting is unclear. It could be interpreted to mean that foreign (i.e. non-white/foreign national) professionals have traditionally been rather exclusively recruited to underserved rural areas. The high unmet need for African American and Latino professions was a problem across all professional disciplines (regardless of educational level), although the absolute highest rates of need was reported for Case Managers (Associates or Bachelors) and Social Workers (Master's level, LCSW).

The need for multilingual professionals across all treatment centers was by far most frequently reported for Spanish speaking professionals, garnering a 'high' need from 20 of 50 centers surveyed and a 'moderate' need from 20 other centers. Burmese and American Sign Language fluency were the only other two languages where a 'high' need was expressed (<3 centers reporting for each). Low frequencies of 'moderate' need were also reported for fluency in Chinese, Vietnamese, German, Somali, Croatian, and 'Eastern European' (<4 centers reporting for each).

3.3 Types of psychiatric sub-specialists in greatest need

Method: There are currently 5 forms of board certified sub-specialties in psychiatry requiring fellowship training after residency (Addictions, Child, Geriatric, Forensic, Clinical/Liaison (CL, e.g. psychiatrists who consult closely with primary care doctors). Centers were asked if each of these types of specialists were in 'high', 'moderate' or 'low' need.

Results:

CMHCs (N=27):

Child psychiatrists were most frequently selected as the highest need (16/27), addiction psychiatrists as moderate need (14/27) and both forensic and clinical/liason (CL) psychiatrists as lowest need (14/27) each.

State hospitals (N=6):

Geriatric and forensic psychiatrists were in greatest need (3/6 each), with CL psychiatrists (3/6) in moderate need, and addictions and child psychiatrists in lowest need (3/6 each).

ATCs (N=12):

Addiction psychiatrists were selected most frequently as in highest need (4/12) and moderate need (3/12) with forensic psychiatrists in lowest need (10/12).

Other (e.g. community health centers) (N=5):

Addiction psychiatrists were ranked most frequently both as highest in need (3/5), and moderately in need (1/5). Child, geriatric, forensic and CL psychiatrists were ranked equally as lowest in need.

All Centers (N=50):

Child psychiatrists were most frequently ranked as in greatest need (20/50), addiction psychiatrists in moderate need (20/50) and CL psychiatrists in lowest need (25/50).

Summary/Interpretation: Overall, need for child and addictions psychiatrists were in greatest need, especially for the outpatient missions in behavioral health. Hospitals were uniquely in need of geriatric and forensically-trained physicians, likely owing to the nature of their long-term stay hospital populations. The relatively low need for addiction psychiatrists in hospitals was likely not representative of the degree to which these populations suffer with co-occurring additions, but may reflect the fact that captive patient populations have relatively little opportunity to use substances and so addictions is not viewed as a major/acute clinical problem to be addressed in these settings. Notably, the IU Department of Psychiatry, with the exception of child psychiatry, is not equipped with sufficient infrastructure in terms of faculty depth or training stipends to produce these specialists in significant numbers. Of about 5-8 total resident/fellows graduating per year, 2-4 are child psychiatrists or triple boarded in child/adult psychiatry/pediatrics, and 0-1 are addictions or geriatric psychiatrists (e.g. often none/year). There is no viable CL training program at the IU School of Medicine..

3.4 Difficulties in Recruitment

Method: Recruitment difficulty was evaluated as an independent issue from either general need for a given type of professional, or difficulty in retention. Centers were asked to rank each of the 13 professional types as 1 (most difficult); 2 (moderately difficult); or 3 (easiest) to recruit. For each professional type that centers ranked as a 1 (most difficult), they were asked to choose up to three of 10 pre-provided reasons for this difficulty, with respect to this professional type. Finally, centers were asked to elaborate with open ended responses on reasons for recruitment difficulties.

Results:

CMHCs (N=27):

The top five most difficult to recruit positions:

Professional type	Mean Score
1. Psychiatrists	(1.41)
2. Social workers, Masters (LCSW)	(1.59)
3. APRNs	(1.84)
4. Substance Abuse Counselors, Masters	(1.92)
5. Nurses	(1.92)

Top 3 reasons for difficulty in recruiting:

Psychiatrists
1) too small a candidate pool for this type of professional (18 responses)
2) not interested in moving to our rural area (13 responses)
3) we can't offer competitive salary (8 responses)

Social Workers, Masters (LCSW)
1) too small a candidate pool for this type of professional (9 responses)
2) we can't offer competitive salary (5 responses)
3) tied: not interested in moving to our rural area/ competition with another employer near us (4 responses each)

APRNs
1) too small a candidate pool for this type of professional (12 responses)
2) not interested in moving to our rural area (6 responses)
3) we can't offer competitive salary (4 responses)

Difficulties in Recruitment (continued)

State hospitals (N=6)

Top five most difficult to recruit positions:

Professional Type	Mean Score
1) psychiatrists	(1.17)
2) nurses (RN/LPN)	(1.5)
2) pharmacists	(1.5)
4) psychologists	(1.67)
5) social workers, Masters (LCSW)	(1.83)

Top 3 reasons for difficulty in recruiting:

Psychiatrists

1) we can't offer enough job perks to be a competitive employer (4 responses)
2) too small a candidate pool for this type of professional (3 responses)
3) we can't offer competitive salary (3 responses).

Nurses

1) we can't offer enough job perks to be a competitive employer (3 responses)
2) competition with another employer near us (3 responses each)
3) we can't offer competitive salary (2 responses)

Pharmacists

1) we can't offer competitive salary (5 responses)
2) competition with another employer near us (3 responses each)
3) tied: too small a candidate pool/not interested in moving to our rural area (2 responses)

Difficulties in Recruitment (continued)

ATCs (N=12):

Top five most difficult to recruit positions:

Professional type	Mean Score
1) Substance abuse counselors masters	(1.83)
2) Social workers, masters (LCSW)	(2.18)
3) Mental Health Clinician, masters	(2.5)
4) Substance abuse counselors Bachelors/Associates	(2.67)
5) Psychologists	(2.7)

The top 3 reasons for difficulty in recruiting:

Substance abuse counselors, masters

1) too small a candidate pool for this type of professional (4 responses)
2) we can't offer competitive salary (3 responses)
3) educational requirements and experience requirements are often out of sync (2 responses)

Social workers, Masters (LCSW)

1) too small a candidate pool (2 responses)
2) four-way tie: can't offer enough job perks/can't offer competitive salary/educational requirements and experience requirements are often out of sync/ lack of our own recruitment capability (1 response each).

Mental Health Clinician, masters

1) all tied: too small a candidate pool/can't offer competitive salary/educational/experience requirements out of sync (1 response each)

Difficulties in Recruitment (continued)

Open ended responses:
The following responses were selected and paraphrased from the total pool of open-ended responses as those that do not reiterate the quantitative choice findings, and/or provide additional insights/perspectives. These have been listed according to recurrent themes evident in the response patterns.

Problems with sites of clinical mission:
---'Neighborhood where our institution is based is perceived as too dangerous'
---'Physical plant/infrastructure we work in is disgusting—a turn off to qualified professionals'

Problems with culture of clinical mission/professional support:
---'Over-regulation and excessive documentation requirements decreases staff to patient contact, reduces quality of care and demoralizes staff. Awareness of these problems endemic to public sector care turns off recruits'
---'Prospect of working with indigent, highly comorbid patients (e.g. with medical/psychiatric/addictions) is a turn off to many qualified professionals'
---'Clinical burdens out of proportion to professional resources creates expectation that professionals will take home work, or work after paid hours—this is a turn off for recruits'
---'Pushing people to work off hours has been a barrier to recruitment'
---'Top professionals unwilling to accept 6 months without a day off—only 2 weeks of vacation a year'
---'Psychiatrists don't like the 6 day work week of rounding and call'
---'Cannot afford health care benefits for our clinical staff—we only provide health care benefits for 4 out of 20 of our employees'

Problems with professional pools and competition
---'Very few APRNs are being produced that have behavioral health experience'
---'Difficulty in finding psychiatrists to adequately supervise APRNs'
---'Professionals (e.g. nurses) seem to avoid behavioral health field (e.g. go into purely medical disciplines) because pay scales are better, and lower stress in those jobs'
---'Not only are there too few psychiatrists trained in Indiana, but suspect that they are encouraged to go into either research careers or private practice"
---'In urban areas competition with other medical systems employers is intense, especially for nurses. With respect to pharmacists, cannot pay at the level of the CVS's located on every street corner"
---'The behavioral health care provider field is aging; very hard to find people to work with adolescents'

Problems with hiring process
---'As a state institution we are burdened by an inability to negotiate salaries at a local level and the hiring process is too long '
---'Slow hiring process in state government facility—candidates are not willing to wait for months'

Difficulties in Recruitment (continued)

Summary/Interpretation:

For CMHCs and State Hospitals, psychiatrists were rated as the most difficult of professionals to recruit. Non-prescribing professionals were rated as most difficult to recruit at ATC's as they may be less likely to see medical treatment for addictions as part of their mission and/or are not able to afford physician support, and so do not invest effort in recruiting these professionals. Across all treatment centers and professions, 'too small a candidate pool' was selected most frequently as the leading cause of recruitment difficulty. This cause was the leading cause with respect to the following 6 professional types: (psychiatrists, psychologists, APRNs', social workers (masters), substance abuse counselors (BS/Associates), substance abuse (Masters). The second and third leading causes of recruitment difficulty across all treatment centers (and professions) were 'not interested in moving to our rural area' and 'can't offer competitive salary' respectively. Interestingly, ATC's appeared at least quantitatively, to have the least general difficulty in recruiting, possibly due in part to not seeing themselves as needing to recruit from psychiatric and nursing disciplines, and/or the possibility that they may have a more natural recruitment pool from their own client base (e.g. recovered substance users turned professional clinicians). The open-ended commentaries elaborate on the nature of professional shortages, competition with non-behavioral health fields (especially in relation to nurses), and indicators of impoverished systems of care being a disincentive to new recruits.

3.5 Current Methods of Recruitment

Method: Centers were asked to provide staffing levels and estimate annual expenditures, and list top methods devoted to recruitment for open positions. Centers were also asked if their recruitment approaches involved some form of connection with Indiana-based professional training/educational institutions.

Results:

Human Resources Allocated to Recruitment

Total FTE's of dedicated HR/Recruitment staffing:

	Mean	SD
CMHCs	1.14	1.47
Hospitals	0.58	0.4
ATCs	1.83	4.50

Average annual expenses (last 5 years) for marketing and recruiting for open positions:

	Mean	SD	Min	Max	(Means x N)
CMHCs (N=27)	$57,222	$65,000	$0	$300,000	$1,544,994
Hospitals (N=6)	$55,083	$68,038	$1,500	$182,000	$330,498
ATCs (N=12)	$5,250	$14235	$0	$50,000	$63,000 .
					$1,938,492

Top methods of Recruitment

1) Internet job postings (52 responses)
2) Staff referral/word of mouth (36 responses)
3) Newspapers (30)
4) Headhuneters (20)
5) Job fairs (11)

% reporting recruitment involves regular contact with educational institution:

CMHCs	85%
Hospitals	100%
ATCs	75%
Other (community health centers)	63%

Summary/Interpretation:
There was considerable variance among centers in number of recruitment staff and expenditures made in recruitment, likely due to the variance in size among these centers. Hospitals reported less HR staffing for recruitment as the state takes on significant portions of this role on their behalf. Estimated annual expenditures dedicated to statewide recruitment were substantial, on the order of $2 million. A high number of all centers reported connectivity with training/educational institutions in their recruitment, with greatest advantage at hospitals, and least at public health centers.

3.6 Potential Solutions to Recruitment Problems

Method: Centers were asked to rate each of 7 possible provided solutions to ongoing recruitment problems on a 1 to 3 scale as (1) very helpful; (2) somewhat helpful and (3) not helpful. The ranking of these scores according to treatment center type are listed below. Each of the possible solutions is paraphrased here from their original form in the survey. Centers were then asked to elaborate with open ended responses in suggesting solutions for recruitment difficulties.

Results:

CMHCs

Rank	Solution	Score
1)	Offer job-related incentives (e.g. professional education loan repayment)	1.22
2)	Increase Indiana's home grown pool of professionals	1.26
3)	Devise new mechanisms of continuing education and promotion	1.67
4)	Clinical centers/DMHA/State/Universities to create Career Dev. Fund	1.78
5)	Offer non-job related perks (e.g. IU tuition discounts for children of employees)	1.89
6)	Facilitate greater connectivity of centers with educational institutions	2.04
7)	DMHA should provide centralized help in recruitment	2.37

State hospitals

Rank	Solution	Score
1)	Offer job-related incentives (e.g. professional education loan repayment)	1.00
2)	Devise new mechanisms of continuing education and promotion	1.33
3)	Facilitate greater connectivity of centers with educational institutions	1.5
4)	Offer non-job related perks (e.g. IU tuition discounts for children of employees)	1.5
5)	Clinical centers/DMHA/State/Universities to create Career Dev. Fund	1.5
6)	Increase Indiana's home grown pool of professionals	1.67
7)	DMHA should provide centralized help in recruitment	2.17

ATCs

Rank	Solution	Score
1)	Offer job-related incentives (e.g. professional education loan repayment)	1.5
2)	Increase Indiana's home grown pool of professionals	1.67
3)	Offer non-job related perks (e.g. IU tuition discounts for children of employees)	1.75
4)	Devise new mechanisms of continuing education and promotion	1.83
5)	Clinical centers/DMHA/State/Universities to create Career Dev. Fund	1.92
6)	Facilitate greater connectivity of centers with educational institutions	2.33
7)	DMHA should provide centralized help in recruitment	2.5

Potential Solutions to Recruitment Problems (continued)

Open ended responses:
The following responses were selected and paraphrased from the total pool of open-ended responses as those that do not reiterate the quantitative choice findings, and/or provide additional insights/perspectives. These have been listed according to recurrent themes evident in the response patterns.

Address problems with benefits packages or perks
---'Small agencies cannot afford to provide health insurance to employees, need to find a way to overcome this.'
---'Many professionals want only part-time work, but cannot offer health insurance benefits for part time employees'

Address problems with recruitment in rural areas:
---'Make rural areas more attractive to job applicants with higher salaries'
---'Home grown pool of behavioral professionals is so small, that often, viable candidates are from other countries. In particular, many are of Muslim faith—need to build mosques in rural communities in Indiana so we can actually attract behavioral health professionals'

Address problems with overly complicated rules of credentialing, licensure, etc
---'I simply wish policy makers would stop demanding narrower and narrower credentials to provide ever more tightly regulated services. There is a point when payers and regulators require so many licenses that no one is left to work'
---'decrease years of experience required to hire a nurse'
---'End the ridiculous 2-year licensing requirement for LMST's, LMHCs, LCSWs. We cannot hire unlicensed people so when these disciplines complete their schooling, they have not completed all requirements for joining the workforce. They should either be able to stay in school longer, during which they obtain their licenses, or be graduated in ready-to work status'
---'Silo-ing out of disciplines, training/licensure according to addictions vs. mental health care is not helpful given highly co-morbid population: social workers should be able to do addictions work, and addictions counselors should be allowed to do mental health work'
---'Grants require licensed staff—but can't find licensed staff right out of school'
---'Need legislative action to support agencies in allowing new MSW's and other staff pending licensure to be reimbursable'

Address problems with recruitment methodologies
---'Need a centralized website, for all DMHA supported centers to list their job openings. DMHA should do this. Indiana Council used to do it but can't afford it anymore'
---'Need sponsored website for posting all job openings and listing of candidates for all behavioral health professionals in Indiana'
---'We have so few behavioral health professionals trained in state- that we need some capacity to efficiently recruit from out-of –state'

Potential Solutions to Recruitment Problems (continued)

Support recruitment through supporting educational missions:

---'Need financial support for education occurring at centers, for example to assist with nurse recruiting, more behavioral health nursing instructors should be embedded in the centers, and provided along with training slots'

---'Need to expand psychiatry and APRN training slots at more clinical centers—we're competing for an impossibly small labor market'

---'Needs to be an expansion of joint academic and clinical appointments at treatment centers. There is no CMHC equivalent (that exists for hospitals with respect to medical residents) that actually reimburses the centers for professional training missions. This should be corrected. Small pools of trainees are due to few to no resources to support training stipends'

Need better pay across disciplines:

---'Need to pay more- salaries are too low'

---'Low salaries appear to be one of the most important issues'

---'Need more money to pay clinicians, recruit and retain, currently our clinicians in are the lower 1/3 of salary range in our region'

---'Anything done to increase pay would be helpful'

---'Need additional funding to pay competitive salaries for professional staff'

---'More money desperately needed to pay employees of sufficient professional expertise to perform the clinical mission. Our center struggles to meet financial needs of paying employees, not to mention support training and career development. Amount of money provided to us is hugely out of balance with the clinical need (e.g. taking care of addictions.)'

---'It would be helpful if federal and state funders would increase reimbursement rates to pay higher staff salaries. Increasing demands on staff to comply with documentation, billing paperwork etc, and the contingency of reimbursement on conducting these non-clinical activities is creating a system that rewards avoidance of clinical contact with clients. Higher re-imbursement rates would allow more hiring of staff, reduction of caseloads, reducing burnout, increasing quality of care'

---'Number one issue: have to find a way to make salaries and perks competitive with for profits organizations'

Professional Resource Sharing

---'Need to increase use of telemedicine to support psychiatric care in rural areas'

---'Centers need to engage in collaborative sharing of psychiatrists'

---'Need to introduce more family practitioners into the CMHCs, increase use of CMHC psychiatrists for consultation with family practitioners in public health centers'

Potential Solutions to Recruitment Problems (continued)

Summary/Interpretation: Offering of job-related incentives (e.g. loan repayment programs) was quantitatively viewed across centers as the best solution to recruitment problems. This may be seen as the most efficient way to increase the pool of new applicants, previously rated as the most comprehensive problem in recruitment. Similarly, directly tackling this problem via increasing Indiana's home grown pool of professionals, was also rated second most highly for CMHC's and ATCs. The notion of facilitating greater connection between the centers and educational institutions was not ranked particularly high, possibly due to the centers already feeling like they have established connectivity with these institutions. However, in the open-ended responses, it seemed clear the centers wish for more support for taking on training missions within their own walls. The idea of DMHA taking on centralized authority in recruitment for the centers was consistently viewed unfavorably, possibly due to a suspicion of centralized government power and/or inability of DMHA to attend to local/specific needs. However, the idea of DMHA supporting a central website listing both job openings and applicants available to all DMHA supported centers was suggested in the open ended responses.

As a whole, the open-ended responses elaborated on a wide range of problems which need to be addressed in recruitment. One of the most frequent themes was the need for better pay in proportion to the work loads, which was not a solution directly suggested in the quantitative portion of this survey. Personnel sharing was proposed as a method to spread expertise of psychiatrists over a broader area (or number of centers), although a barrier to this may be the inability of centers to provide health benefits to such shared or part time employees. Addressing problems with overly complicated rules of licensing and credentialing, was a major theme that seems related to calls for both ending the segregation of professional expertise along addictions vs. mental health care lines, and a need for allowing centers to more directly take on educational missions for trainees.

3.7 Retention Difficulties

Method: Retention was addressed as an issue independent from issues in recruitment and general need for professional types. Difficulty in retaining personnel as employees was ranked from 1 (most difficult); 2 (moderately difficult); 3 (easiest) among 13 professional types across all surveyed centers. From those professional types ranked as 1 (most difficult) to retain, centers were asked to choose up to 3 of 6 pre-provided reasons for these retention difficulties. Finally, centers were asked to elaborate with open ended responses on reasons for retention difficulties.

Results:

CMHCs

Top five most difficult to retain positions:

Professional type	Mean Score
1. Case Managers, Bachelors or Associates	(1.92)
2. Behavioral Health Technician, HS diploma	(1.96)
3. Social Workers, Masters (LCSW)	(2.0)
4. Nurses	(2.19)
5. Psychiatrists	(2.41)

Top 3 reasons selected for difficulty in retaining:

Case Managers, BS or Associates:
Three-way tie:
1) professional frequently experiences 'burnout' (5 responses)
1) professional role is seen as a 'stepping stone' (5 responses)
1) center de-funding/increasing case loads destroys job satisfaction (5 responses)

Behavioral Health technician, HS diploma
1) professional, once hired, not prepared or educated for role (5 responses)
1) professional role is seen as a 'stepping stone' (5 responses)
2) professional frequently experiences 'burnout' (4 responses)

Social Workers, Masters
1) center de-funding/increasing case loads destroys job satisfaction (7 responses)
2) professionals expect more raises/promotions than we provide (5 responses)
2) professional frequently experiences 'burnout' (5 responses)

Retention Difficulties (continued)

State hospitals (N=6)

Top five most difficult to retain positions:

Professional Type	Mean Score
1) Nurses	(1.67)
2) Behavioral Health Technician (HS diploma)	(1.67)
3) Psychiatrists	(2.00)
4) Pharmacists	(2.17)
5) Social Workers, Masters	(2.33)

Top 3 reasons selected for difficulty in retaining:

Nurses

1) professional frequently experiences 'burnout' (3 responses)
2) personal problems that interfere with reliability/professionalism (2 responses)
2) center de-funding/increasing case loads destroys job satisfaction (2 responses)

Behavioral Health Technician (HS diploma)

1) personal problems that interfere with reliability/professionalism (3 responses)
1) professional, once hired, not prepared or educated for role (3 responses)
3) professional frequently experiences 'burnout' (2 responses)

Psychiatrists

Only one reason was suggested
1) professionals expect more raises/promotions than we provide (1 response)

Retention Difficulties (continued)

ATCs (N=12)

Top five most difficult to retain positions:

Professional Type	Mean Score
1) Substance Abuse counselors (Associates or Bachelors)	(2.58)
1) Social Workers, (Masters, LCSW)	(2.58)
1) Mental Health Clinician (Masters level (LMFT, LMHC)	(2.58)
2) Case Manager (Associates or Bachelors)	(2.67)
2) Substance Abuse counselors (Masters)	(2.67)

Top 3 reasons selected for difficulty in retaining:

Substance Abuse counselors (Associates or Bachelors)
No reasons were specified.

Social Workers, (Masters, LCSW)
1) professional frequently experiences 'burnout' (2 responses)
2) three way tie (1 response each): professional role is seen as a 'stepping stone'; professionals expect more raises/promotions than we provide; center de-funding/increasing case loads destroys job satisfaction

Mental Health Clinician (Masters level (LMFT, LMHC)
Two way tie for first only (1 response each)
1) professional frequently experiences 'burnout'
1) professionals expect more raises/promotions than we provide

Retention Difficulties (continued)

Open ended responses:
The following responses were selected and paraphrased from the total pool of open-ended responses as those that do not reiterate the quantitative choice findings, and/or provide additional insights/perspectives. These have been listed according to recurrent themes evident in the response patterns.

Turnover is actually not a problem in and of itself at our center
---'With the down economy our retention has been unusually good'
---'In general, turnover occurs in entry level positions, not necessarily a problem there.
---'We have very little turnover'
---'We don't have significant turnover'
---'We don't have difficulty in retaining people'
---'Retention is not an issue at our organization'

Nature of Burnout and job dissatisfaction:
---'Higher education does not prepare new hires for the problems in real world mental health care: the education creates an expectation that they are going to help people but does not prepare them to be overwhelmed with paperwork and productivity expectations'
---'Must find ways to reduce the documentation required.'
---'Low reimbursement and high productivity pressures prompt college, masters, and even higher educated people to seek less challenging work in government agencies'
---'Increasing demands for productivity (billable services) interferes with collegiality, team spirit, and informal consultation that once characterized the mental health center environment and compensated for the low salary'
---'Increasing burdens for documentation, authorizations, leaves clinicians feeling disillusioned, frustrated, constrained'
---'Job loads impair work/life balance. Too many staff have to work late unpaid, or take work home; resources to help them with this balance, e.g. with child care, are non-existent.'
---'Bureaucratic crap' drives PhD's and masters providers into private practice.'
---'Incessant documentation requirements; stifling/restrictive treatment models'
---'There is an escalating level of violence in the adult units which is causing nurses (particularly female nurses) to seek employment elsewhere. Nurses can work anywhere so are not limited to the psych arena as some of the other disciplines might be.'
---'Cannot compensate adequately for the intensiveness and responsibility of the work-load'
---'Employees get tired of working evening hours'
---'Our electronic medical record and related IT systems have severe issues'

No mechanisms for merit based promotions or perks
---'Positions within our center are perceived as stepping stones to jobs elsewhere (outside our center), there is little in the way of long-term career trajectories we can offer
---'Resource impoverishment creates inability to recognize and reward excellence and hard work. No available incentive for good work supports mediocrity. No means to reward quality and quantity of work.
---'Professional culture values time-in-position over talent'
---'Need more of a merit based system or raises/promotion and demotion. The state employment system severely limits ability to reward excellence and eliminate incompetent or dangerous staff. Paperwork required to exercise promotion/demotion is too complicated and laborious. Career advancement tracks are often non-existent.
---'Salary negotiations are not available to internal candidates'

Retention Difficulties (continued)

Summary/Interpretation: In comparison to recruitment difficulties, retention problems appear to present differently qualitatively and in severity. In contrast to recruitment problems which appeared to weigh heavier in higher educated professionals, retention problems impact lower educated positions most severely. Also, the severity of overall retention problems may be less of a problem than overall recruitment because 1) severity scores for leading problem professionals mentioned were less extreme for retention than recruitment; 2) centers may see lack of retention in certain cases as a natural mechanism of either individuals progressing along career paths, or weeding out incompetence; and 3) in the open-ended responses, several centers reported that retention was not a major problem. Nevertheless, many centers listed several non-prescribing professional types (nurses and masters level professionals) as significant retention problems citing job dissatisfaction and burnout as important causes. Impoverished clinical resources along with too large caseloads were frequent concerns in the open-ended statements along with statements describing the high degree of documentation and paperwork that impedes contact time with clients.

3.8 Future Challenges

Method: Centers were asked to provide open-ended descriptions of concerns not already covered by the survey that are seen as significant future challenges to their workforce integrity and clinical missions. The following responses were selected and paraphrased from the total pool of open-ended responses. These have been listed according to recurrent themes evident in the response patterns.

Results:

Emerging problems with licensing of professionals:

---'Future recruitment of licensed addictions clinicians is a concern. These people are already difficult to recruit, and now the state's requirement that they be licensed will only exacerbate the problem'

---'Increased licensure requirements, training requirements, and more detailed job descriptions add up to ever more escalating costs for us while creating even more silo-ing of treatment options for clients'

---'I wish it wouldn't take so long to get social workers and other masters level clinicians licensed. We hire MSWs, provide years of clinical supervision and support, and then they leave for better paying jobs or private practice once they're licensed.

---'I'm concerned about the move toward more required licensure and certifications. These people are harder to recruit and more expensive. We should be allowed some kind of waiver on these requirements or reimbursed for the added expense of supervision of trainees to meet these licensure/certification requirements.

---'Push toward more licensure will be a major challenge, the advent of peer counselors will add a new dynamic of competition with paid/trained professionals.

---'Many workers will not be eligible for the new license requirements for addiction professionals'.

Need cross training of professionals/combat services in silos.

---'Need adequate training and continuing education of integration of Mental illness and substance abuse and physical health treatments

---'Lack of substance abuse licensed counselors in CMHCs will only reduce third party payers on claims… leading us to be even more financially unviable.'

---'need to promote integrated care models in professional training'

Aging workforce:

---'Worsening shortages of psychiatrists, particularly child psychiatrists'

---'Broad and severe professional shortages are looming. The entire workforce is aging and we are not replacing them. The average age in our workforce is 47- the average age of nurses and psychiatrists is in their 50's'

---'I'm very concerned about the number of people choosing to be psychiatrists. This is a low-paying specialty and so why would medical students choose it, especially in light of the debt they carry from medical school"

---'Aging workforce, particularly professionals with higher degrees is a grave concern (e.g. the average age of our nurses is 54.

---'Severe nursing shortage and physicians shortage in the next decade'

---'Aging workforce in psychiatry and need to keep trained psychiatrists in Indiana, requires that we enlarge our candidate pool.

---'For small towns, physicians are retiring without replacements'

Future Challenges (continued)

Will generally need higher education for the workforce:

---'Increases need for licensed professionals in the future because of MRO clinical option (Medicare and Medicaid), and increased need for evidence based professionals'

---'As of 7/1/10, there will be a move away from a service model to a more protocol driven treatment (trying to move the system to a recovery model); all this may change types of professionals needed-potentially will need more masters levels/less BA level personnel'

---'We lose masters level staff and case managers to school systems where they make more money and work less time, need to reverse this trend.

---'Recovery model involves expectations of higher professionalization of the clinical staff (e.g need more masters and doctoral level trained clinicians)'

Worsening systems dysfunction:

---'The Managed Medicaid bureaucracy, the dumping of clients off Medicaid (Medicaid 'Modernization'); DMHA registration/assessment instruments; pending MRO revisions will all be sources of time consumption, distraction and stress'

---'Due to MRO changes, a decline in re-imbursement will obviously affect programs and services we provide, leading to a decrease in staff we employ, causing ever more difficulty in recruiting…'

---'Behavioral health as a field has grown increasingly unattractive: increasing work loads, diminishing treatment resources, increasing paperwork, all leads to decreased effective interactions with patients.

---'The physical plant of our building is a turn off: potential employees have to ask themselves if they want to work in a slum.'

--- 'Pay scales are based on state norms rather than local city or rural environment'

---'Major budget Hoosier assurance; access to recovery, out of pocket client fees: all these sources of funding are at risk and dwindling. We are not paid for number of clients served, increasingly expected to do more with less.

---'So many of our clients are just out of jail and are immediately employable on paper, but not able to get jobs or benefits'

---'Clinical demands are ever increasing with respect to both prescription drug abuse and methamphetamine—these problems are eating up our communities and yet we are giving increasingly fewer resources to address them'

---'The complexity of reimbursement rules and the regulatory web is creating the need for administrative staff then counselors who actually interact with clients'

--- We are expected to meet department of corrections half-way and yet have been provided no resources to do it. There is huge uncertainty in the funding of treatment for unemployed clients with felony records who have no means of payment.

--- Funding for behavioral health care is far to unstable, inconsistent from year to year- too dependent on phasic grants and contracts'

Future Challenges (continued)

Generalized Fear about the economy and health care reform:

---'Can't attract high paid professionals to our region because it is so economically dependent on the depressed auto industry'

---'National health care reform is a concern'

---'Poor local rural economies and public schools with low marks impairs our ability to hire highly trained professionals.'

---'Disproportionate Share Hospital (DSH) funds (often brought in by psychiatric and obstetrics) is now in jeopardy. If and when this happens, hospitals will have to eliminate psychiatry, which even now is a major financial drain due to predominance of Medicaid clients, or patients who have no insurance.

---'The state of the economy is a major concern, impact of health care reform on behavioral health is an uncertainty'

Section Summary

The recruitment and retention survey of 2009 confirmed findings from the 2007 DDPAT survey suggesting that behavioral health care in Indiana is facing a general crisis of psychiatric physician supply, especially of child and addiction psychiatrists. In addition, however, the 2009 survey also indicated a concurrent crisis relative to a much broader array of behavioral health professionals, including nurses and masters levels clinicians (e.g. social workers and therapists). Taken together, these findings suggest a generalized inadequacy in the behavioral health workforce that may most directly result from the inadequate supply of new professionals trained in these fields. Retention appeared to be less of a problem, especially for professionals with high educational attainment, although certain positions (e.g. nurses) do represent a problem. Feedback from the centers depicts a rather grim picture of workforce conditions in public behavioral health related to the interactive effects of chronic de-funding and worsening economic difficulties, problems with morale, stigma (suffered by both the clients and the professionals who provide care), and the highly regulated/documentation based culture of behavioral care which distracts from client contact, and ironically quality of care and productivity. It should be noted that feed-back about workforce conditions came not from the clinicians who are directly impacted, but by the administrative leadership of centers who represent them.

4. Rates of Turnover Among Professionals

The Indiana Council of Community Mental Health Centers (ICCMHCs) conducted a Compensation and Benefits survey of CMHCs from January to April of 2009, in which 97% of Indiana CMHCs reported. This survey examined rates of compensation and annual turnover rates among various professional types in the behavioral health workforce. Compensation packages ranged considerably based on geographic region and individual role descriptions (e.g. presence of specific administrative/supervisory roles in addiction to clinical line work). Summary findings from this survey are provided below:

Hourly Compensation (means)*

	Geographic region of Indiana		
Professional type/degree	Northern	Central	Southern
Psychiatrist (M.D./D.O.)	$82	$109	$88
Licensed psychologist (Ph.D)	$29	$33	$32
Licensed Social Worker (M.S.W)	$21	$25	$20
Licensed counselor (Masters)	$20	$22	$26
Nurse (R.N)	$23	$28	$20
Case Manager (B.S/B.A)	$14	$15	$14
Behavioral Assistant (H.S/GED)	$9	$10	$9

* lists compensation rates for part-time personnel as a gauge of comparative salary levels, independent from benefits packages that may vary widely between centers for full time staff.

Annual Employee Turnover Rates**

	Geographic region of Indiana		
Professional grouping	Northern	Central	Southern
Masters, PHDs, MDs, APRNs	15%	25%	13%
Bachelors/RN/LPNs	29%	30%	16%
Associates/H.S./GED	26%	30%	24%
Administrative (regardless of degree)	11%	20%	11%
Clerical/support staff	14%	22%	12%

** % turnover calculated as: (employees terminated during period/ ((employees at beginning of period) + (employees hired during period))

Section Summary

Compensation rates are generally highest in the central Indiana region which is also the most urban of regions (i.e. Indianapolis metro area). Psychiatrist salaries are comparable to that of other high need primary care physicians in short supply (e.g. general internal medicine, family medicine, pediatrics) which collectively represent the lowest paid physician specialties. In general, masters and nursing levels salaries are lower than for medical care settings or in private institutions. Consistent with findings in the recruitment and retention survey, annual turnover rates are generally higher in professional groups with lower educational attainment and in professionals not in supervisory roles. Also, the central region experiences higher turnover rates regardless of professional grouping, likely due to increased competition among employers for professionals in the urban setting (e.g. for nurses), also consistent with findings from the recruitment and retention survey.

5. Workforce Projection Data

The Indiana Department of Workforce Development has supplied occupational projections specific to several types of behavioral health professionals. Source data and modeling approaches are derived from both state and federal workforce data bases. The following table presents employment numbers in 2006 (inclusive of both public and privately employed professionals), and workforce projections a decade later (2016). The modeling and assumptions informing workforce projections are complex and tailored somewhat to each profession (e.g. incorporating economic projections, population growth projections). However, they generally indicate what will be needed if the recent status quo of current workforce densities for Indiana are to be maintained (e.g. the projections do not necessarily assume current workforce shortages).

Occupational title	degree	2006 employment	2016 projection	(2006-2016) new entries *	2007 annual wage
Psychiatrists	M.D.	497	561	154	$121,577
Psychologists	PhD	108	120	29	$82,972
Marriage and Family Therapists	MA	407	526	200	$37,706
Social Workers (Mental Health & Addictions)	MA	2,250	2,809	1,033	$34,448
Mental Health Counselors	MA	1,677	2,031	332	$34,133
Nurses***	RN	54,428	68,511	23,067	$54,398
Addictions Counselors	BA/BS	1,016	1,264	449	$37,399
Behavioral Health Aids/Assistants	HS/GED	772	807	104	$23,263

*new entries needed suggests numbers of new professionals needed to enter the workforce to meet the 2016 projection, while making up for sources of attrition such as professionals moving away, retirement or death. These numbers do not necessarily account for workforce shortages or aging trends described in the other sections of this report.

** annual wages in 2007 are state median wages

***these numbers reflect the nursing workforce involved in all health care disciplines. The data base does not tease out nurses working in behavioral health; the size of this minority of the nursing workforce is unknown.

Section Summary/Interpretation

With the exception of psychiatrists, which are trained only at the IU School of Medicine in Indianapolis, the rates of production of all other behavioral health professionals in Indiana (and a listing of all institutions where they are trained) were not known by the committee at the time of this report. Notably, at a production rate of 6 new psychiatrist per year, Indiana has a current capacity to produce only 60 new psychiatrists in 10 years, or <39% of projected needs, even without accounting for current workforce shortages.

6. Summary of Findings

Converging data from various Indiana sources presented in this report suggests the emergence of a growing crisis in the behavioral health workforce in Indiana. These findings are consistent with national trends but may represent particularly severe conditions in Indiana, especially in comparison to states with larger urban populations and/or East coast regions where behavioral health care has traditionally occupied a larger 'footprint' within the medical treatment culture and academic training/institutions.

Although considerable portions of this report focus on the psychiatric physician workforce where workforce shortages appear particularly severe, it must be understood that the vitality of the psychiatric physician workforce is an indicator of the status of the entire behavioral health workforce, since the training infrastructures and knowledge bases that generate these professionals, and treatment systems that employ them, are interdependent among the disciplines. Accordingly, the recruitment and retention survey shows evidence of shortages and professional stress across all disciplines in behavioral health emerging in parallel to that occurring with respect to psychiatric physicians. In addition, data contained in this report indicate that behavioral health workforce problems are not limited only to inadequacy of size of the work force or insufficient generation of new professionals, but also extend to the qualities and cultures of the training and clinical responsibilities of these professionals, and the systems in which they provide care. Specifically, these cultures of training and care delivery are not appropriately designed or equipped to address the clinical populations they are charged to care for because of the longstanding and pervasive division or 'silo-ing' of mental illness vs. addictions care lines.

Understanding the underlying causes of the behavioral health workforce crisis as a confluence of long-term dynamics occurring on both the national and state levels is important to generating new solutions. Although this report did not aim to directly explore these overarching issues, it is worthwhile to consider them briefly here as a context for which both short- and long-term recommendations may be made. To the extent that the behavioral health workforce crisis represents a view of a collapsing field, the forces driving this collapse are decades old, and may be attributed to multiple inter-related dynamics: 1) failure to understand and anticipate neurobiological vulnerability to addictions in mentally ill populations; 2) predominant societal views of drug-abuse related behavior as a moral/criminal problem rather than a biomedical disease process; 3) under-resourcing of outpatient centers to effectively engage and treat what turned out to be largely dual diagnosed outpatient populations;4) diversion of societal funds directed to feed, clothe, house and provide health care for the mentally ill to both legal and illicit recreational drug economies; 4) vast increases in the size and cost of the criminal incarceration industry, due in part to criminalization of de-institutionalized mentally ill and/or drug abusing populations; 5) vast increases in the cost of newer psychiatric medications, significantly out of proportion to additional clinical benefits; 6) vast increases in the cost of general medical care, due to a medical treatment culture which reimburses primarily for delivery of medications and procedures, rather than professional expertise in clinical decision-making and patient contact; 7) evolution of the American medical professional training system as a market economy that preferentially supports the training of medical professionals in numbers proportional to professional income potential, rather than clinical or public health care needs.

In sum, the behavioral health workforce crisis may be viewed as symptomatic of a professional field under extreme stress, due to the explosive growth of societal resources diverted away from it, to closely related fields on its boundaries: criminal justice and general medicine. Yet, it becomes clear that a tremendous opportunity presents itself for a re-vitalization of the behavioral health field especially with respect to the integrated treatment of co-occurring mental illness and addictions, leading to more efficient, more humane, and more effective treatment of the clinical and societal problems of common interest to all of the criminal justice, behavioral health and public health fields.

7. Recommendations

Increase understanding of, and facilitate relationships between training institutions and behavioral health employers

1. Further DMHA-supported study of behavioral health professional training and development in Indiana. As comprehensively as possible, define all training/educational centers in Indiana where behavioral health workforce personnel are produced in Indiana (e.g. across all disciplines), determine recent rates of graduation of personnel from those centers entering behavioral health, obtain reports describing didactic and practical training experiences provided by these centers with respect to both mental health and addictions curriculums.

2. Indiana DMHA to create and maintain a common website listing all job openings for all professional types at all DMHA supported clinical centers in Indiana. Website should feature information provided by the centers about their communities and facilities. Indiana DMHA to identify and work with all educational/professional training institutions in Indiana to encourage newly-trained professionals to post their own candidacy descriptions on the same website.

Expand production of needed behavioral health professionals in Indiana

3. Legislative action and funding allotments provided for professional educational loan repayment programs, across multiple behavioral health disciplines. Multiple slots are provided annually for each behavioral health professional type, and apportioned according to clinical need in Indiana. Awards should be attached to contract obligations to work at *any* Indiana DMHA-supported institution for a minimum of 4 years post-graduation from professional training, and repaid annually during this service. Selection of candidates for loan repayment awards to be based solely on academic achievement in undergraduate/ and or professional training (e.g. not on the basis individual financial need/training institution, or nationality). DMHA to administer this program, but appoint an independent multidisciplinary selection committee comprised of academic leaders state wide. A preliminary example of professional types and annual numbers that could be supported by this program:

   --Psychiatry residents subspecialty/fellowship training in Addictions (4 positions)
   --Psychiatry residents subspecialty/fellowship training in Child Psychiatry (2 positions)

   --Behavioral health nurses (RNs/LPNs) (4 positions)
   --Behavioral health APRNs (2 positions)

   --Masters level therapists and/or social workers (6 positions)
   --Behavioral health pharmacists (1 position)

   --Offer one additional award for each position listed above that stipulates identification of the candidate with African American or Latino Diversity groups, and/or fluency in Spanish (up to 6 positions).

   Market this programming primarily to undergraduate/professional schools within Indiana and secondarily to out of state students.

4. Legislative and/or DMHA action to allocate additional resources specifically designed to increase production of, attract, and maintain the careers of behavioral health professional leaders in rural/underserved areas in Indiana. This may include a) creation of a new faculty position with IU Department of Psychiatry (as a joint position with new IU school of Public Health) who will be an academic leader in rural psychiatry; b) creation of programming to support annual salary bonuses for new professionals that choose to serve in rural/underserved areas of Indiana; c) creation of loan repayment programs (open to all qualified candidates), requiring service at designated rural treatment centers for at least 4 years.

5. State action to support/require IU School of Medicine to gradually increase number of annual psychiatry resident training slots to 12 /year. Expand medical student training and exposure to behavioral health and addictive disorders at IU School of Medicine.

6. Legislative and/or DMHA action to allocate protected resources directly to behavioral health treatment centers state wide for supporting professional clinical training missions at those centers.

7. Create new mechanisms to facilitate early education and career development of behavioral health professionals from the African American and Latino communities, and those that are fluent in Spanish. For example, The Crispus Attucks Magnet School in Medical Sciences is adjacent to the IUPUI /IU medical school campus. As a member of the Indianapolis Public School system, this school serves a relatively high density of minority students, and those of economically disadvantaged backgrounds. These represent exactly the diverse communities from which new generations of behavioral health professionals need to be recruited from, mentored and supported in their educational development. New programming supported by state and university stakeholders should devote professional time and resources to facilitating greater connectivity between IU School of Medicine/Nursing and Social Work/and Crispus Attucks. State supported scholarship programs supporting full tuition reimbursement for undergraduate and/or professional training schools should be specifically awarded to Crispus Attucks graduates. Existing programs may be used in a supervisory or consultative role, to accomplish these goals. The Indiana Area Health Education Center (a program of Indiana University Medical School), is both federally and state funded, and has six sites across Indiana. Their mission is to bring minorities to rural and underserved medical sites and to bring more minorities into the medical (including behavioral health care) field.

Transform and build professional training infrastructure that matches clinical needs of mainstream populations with co-morbid conditions

8. Ensure and eventually require cross training in addictions and mental health care for *all* behavioral health professionals/abolish segregated licensure and certifications along mental health/substance abuse treatment lines. Simplify behavioral health licensure categories to levels of educational attainment.

9. Support a new initiative to make fellowship training at IU Dept. of Psychiatry in addictions psychiatry mandatory for residents not otherwise committed to pursuing sub-specialty training or fellowships in other areas (e.g. in child, forensics, geriatrics). Taking this action is needed to provide adequate mental illness and addictions cross-

training in new psychiatric physicians in sufficient numbers that would begin to address clinical needs state wide. Committing to this step could garner federal granting support, and greatly increase the national reputation of IU School of Medicine/Indiana in the behavioral health field. Pathways to this approach include loan repayment incentives (recommendation # 3) and development of academic/training infrastructure (recommendation #10)

10. Creation of an Indiana Dual Diagnosis Gambling Addiction Treatment Excellence Center as a DMHA contract with IU School of Medicine/Department of Psychiatry. This center to be created via a special endowment provided by state (DMHA)/private/university systems and based in Indianapolis with proximity to DMHA and IU Department of Psychiatry. This contract will support new faculty and staffing infrastructure necessary for creating a new center of excellence focused on clinical care, research and professional training. Staffing appointments will be multidisciplinary (e.g. psychiatry/psychology/nursing/social work) and will be faculty members of the IU Department of Psychiatry, IU School of Nursing, and IUPUI School of Social Work. This core faculty will also be responsible for directing education in addictions and dual diagnosis curriculums in all of these departments, and for the psychiatric addictions training program at the IU Department of Psychiatry. The center will be physically based in one of the Indianapolis area CMHCs and will be hosted by and highly collaborative with the center. However, faculty funding will significantly allow research and training missions to occur independent of clinical/billing pressures requiring high patient volume and case loads. The center will be attached to a set of 8-12 step down, partially supervised overnight stay beds, for purposes of clinical observation/ detoxification/ education and research. The center will be primarily supervised and obligated to the primary stakeholders (DMHA/IU Department of Psychiatry). The goals of the center will be 1) act as a primary Indiana center for revitalization and production of the next generation of behavioral health professional trained in a state-of-the-art integrated dual diagnosis care treatment model; 2) act as an exemplary/model and consultative outreach program in dual diagnosis care for eventual adoption by all DMHA supported clinical centers state wide; 3) become a nationally recognized translational/clinical research center in the area of dual diagnosis and pathological gambling. Special emphasis of research missions will include understanding neurodevelopmental basis of dual diagnosis disorders and interface between criminal justice/ pathological gambling and dual diagnosis disorders.

11. Indiana DMHA to physically merge ATCs with CMHCs. Reformulate (CMHCs+ATCs) as Behavioral Health Treatment centers, that have the capacity to provide fully integrated care for both addictions and mental illness. Require all funded centers to provide a full array of evidence based- addiction and mental health treatments, including options for short-term detoxification and outpatient opiate maintenance therapy (with buprenorphine). Require expert cross-training in both addictions and mental health care in the majority of the professionals staffing these centers.

12. Strengthen ties between community health centers and behavioral health treatment centers via professional workforce sharing agreements (e.g. psychiatrists at behavioral health centers perform part time/on site clinical consulting at community health centers; primary care physicians perform part time/on site clinical care and consulting at behavioral health centers).