HEALTHY MINDS
POLICY INITIATIVE

OKLAHOMA'S BEHAVIORAL HEALTH WORKFORCE: GREATEST NEEDS

December 2020

A 2020 report ranked Oklahoma ninth in the nation in workforce availability for the total number of mental health providers.[1] But a closer look reveals shortages in particular categories of behavioral health workers. For example, psychiatric prescribers are in short supply. And rural areas, as compared to metro areas, are experiencing significant shortages. In this brief, we reconsider the behavioral health workforce in Oklahoma by looking at workforce shortages among professionals grouped as "prescribers" (e.g., psychiatrists) and "non-prescribers" (e.g., psychologists, social workers) and focusing on providers working in community-serving or public mental health settings where services are accessible to individuals with a wide range of socioeconomic circumstances.

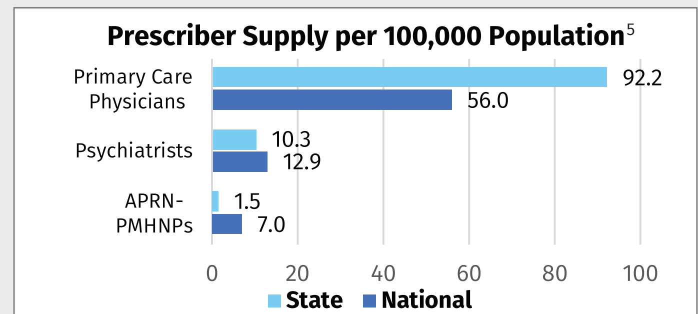
PRESCRIBING AND NON-PRESCRIBING BEHAVIORAL HEALTH PROFESSIONALS

PROVIDER TYPE	DEGREE AND TRAINING	SCOPE OF PRACTICE
PSYCHIATRIC PROVIDERS (PRESCRIBERS)		
Psychiatrist	Doctor of Medicine (MD) or Osteopathy (DO)	Primarily manage mental illness and substance use disorders through psychotropic and substance use disorder medications. Can provide psychotherapy but do not typically provide this service in community mental health settings.
Advanced Practice Registered Nurse – Psychiatric and Mental Health Nurse Practitioner (APRN-PMHNP)	Master's or doctorate	In OK can prescribe in collaboration with a physician (with some exceptions). May provide psychotherapy in community mental health settings.
PSYCHOSOCIAL BEHAVIORAL HEALTH PROVIDERS (NON-PRESCRIBERS)		
Licensed Psychologist	Doctorate (PhD or PsyD)	Have a doctorate in clinical, counseling or school psychology. Trained in the administration and interpretation of psychological and neuropsychological tests. Provide psychotherapy in many settings and may provide this service in community mental health settings.
Licensed Professional Counselor (LPC) **Licensed Clinical Social Worker (LCSW)** **Licensed Marriage and Family Therapist (LMFT)**	Master's level Two years of post-degree supervised clinical training	These master's-level clinicians provide most of the psychotherapy in community mental health settings. A licensed master social worker (LMSW) may provide services under LCSW supervision.
Licensed Alcohol and Drug Counselor (LADC)	Master's level 2,000 hours supervised experience	Provide counseling and treatment for substance use. May hold additional licensure in mental health counseling (LADC-MH).
Certified Alcohol and Drug Counselor (CADC)	Bachelor's level 4,000 hours supervised experience	Provide counseling and treatment for substance use.

PRESCRIBER SUPPLY AND SHORTAGES

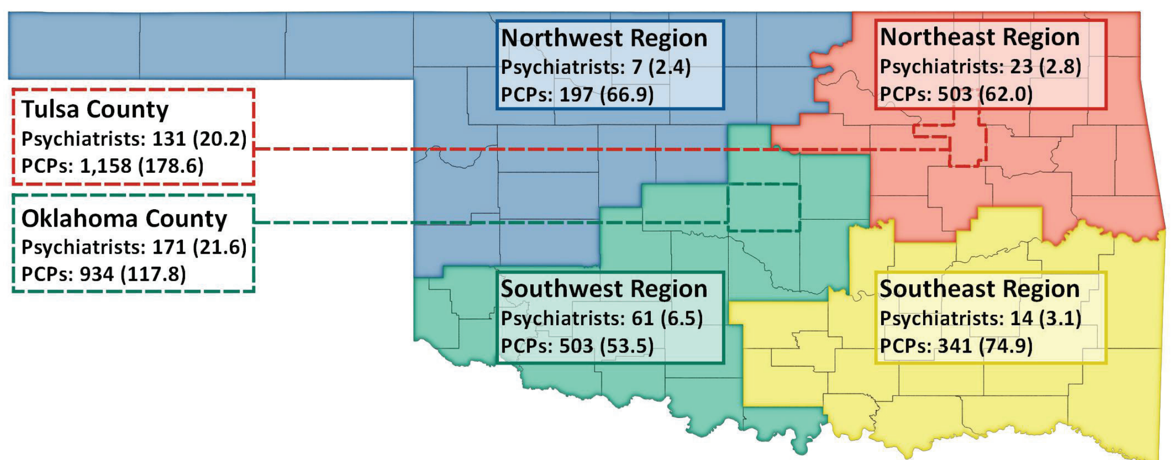
The supply of psychiatrists is limited by multiple factors. Training requirements include four years of medical school followed by four years of residency, creating a lag between expansion efforts and placing new workers. Nationally, an average of 1,798 newly board-certified psychiatrists will join the workforce each year through 2024. However, the number of psychiatrists retiring from the workforce will exceed the number joining it by a multiple of two.[2]

Based on the prevalence of mental illness and the treatment hours needed to treat each person with a mental illness, communities need 30.3 prescribers per 100,000 residents.[3] **Increasing the number of APRNs certified as psychiatric and mental health nurse practitioners (APRN-PMHNPs) could supplement the prescribing and diagnosing functions that psychiatrists provide**. Although APRNs have full practice authority in 28 states, allowing them to treat and prescribe without physician oversight, in Oklahoma they must collaborate with a physician to prescribe.[4] However, because of the small numbers of PMHNPs currently practicing in Oklahoma, increasing the number of PMHNPs collaborating with physicians is not sufficient to make up for the lack of psychiatrists. With appropriate supervision, consultation and training, primary care physicians (PCPs) can perform the initial diagnosis of a mental health disorder, prescribe psychotherapeutic medications and oversee subsequent medication management, particularly for patients with mild to moderate needs.



Many patients with mild and moderate behavioral health conditions receive medication management through a primary care physician; however, only half of the diagnosable mental health and substance abuse conditions are detected in primary care, and only half of those whose condition is detected receive any form of treatment.[6] Primary care physicians (PCPs) can vastly expand access to behavioral health treatment for thousands more Oklahomans each year, with support from embedded behavioral health specialists, nurse care managers and targeted psychiatric consultation for patients with the most serious behavioral health issues or those with complex chronic health issues (fewer than one quarter of all cases).[7] Oklahoma has far fewer psychiatrists than the state needs, but its supply of PCPs is very close to the estimated number (76) needed per 100,000 people for the projected 2025 population.[8,9]

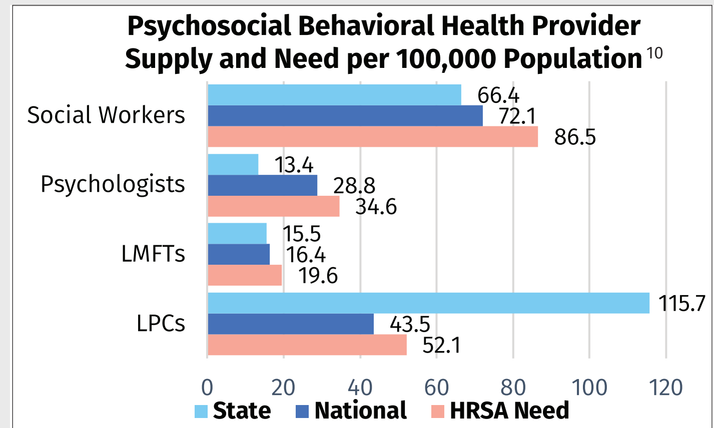
Number of Psychiatrists and Primary Care Physicians in Oklahoma
(figure in parentheses indicates number per 100,000 population)



PSYCHOSOCIAL BEHAVIORAL HEALTH PROVIDER SUPPLY AND SHORTAGES

Non-prescribers provide the bulk of psychotherapy, which, when evidenced-based, is highly effective in treating behavioral health disorders. To extend the diagnosis and treatment of these disorders beyond mental health settings, some of these providers could be reoriented to work in primary care settings, using brief interventions to serve patients through integrated care.

With the exception of LPCs, Oklahoma has shortages across all types of psychosocial behavioral health providers. The national counts of providers from the Bureau of Labor Statistics (BLS) are based on full-time workers, whereas state counts come from the number of individuals licensed to practice in Oklahoma. Because licensed providers may work part time or longer be active in the workforce, state licensing data may overestimate the supply of full-time providers.

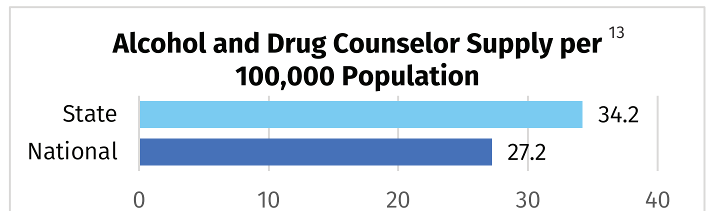


ALCOHOL AND DRUG COUNSELORS

Psychiatrists, social workers and other behavioral health professionals may be involved in addiction treatment, but **alcohol and drug counselors provide most of the front-line care in addiction services. Substance use treatment center administrators report that it is challenging to retain emerging behavioral health professionals because higher paying private practice opportunities lure them away after they secure their credentials**.

Nationally, 7.7 million adults reported the experienced co-occurring substance use and mental health disorders within a 12-month period prior to completing a national survey. And of these, 53% received neither mental health nor substance use treatment during that time.[11]

In Oklahoma, drug overdose deaths peaked at 899 people in 2016 (these deaths were attributed to both pharmaceutical and illicit drugs). In 2017, the Oklahoma Commission on Opioid Abuse was created to respond to the state's opioid epidemic, and in 2018, several pieces of legislation aimed at addressing the epidemic were signed into law. The Health Resources and Services Administration (HRSA) estimated that 32.6 addiction counselors are needed per 100,000 people.[12]



PEER RECOVERY SUPPORT SPECIALISTS

We also are looking into the role of peer recovery support specialists (PRSS), people with lived experience of mental illness and/or substance use disorders who have received 40 hours of specialized training and certification to provide recovery coaching and support. Research has shown that utilizing a peer recovery support specialist in client care has positive outcomes, including, but not limited to, increased social functioning, decreased substance use, reduced hospital admission rates and longer community tenure.[14] An average of 500 certified peer recovery support specialists are active at any given time across Oklahoma, but the lack of readily available workforce supply data make it difficult to estimate national and state comparisons.[15]

SUMMARY AND RECOMMENDATIONS

Oklahoma has significant current and projected behavioral health provider shortages, especially for psychiatrists—and especially in non-metro areas. To address these shortages, we recommend supplementing psychiatrists with APRN-PMHNPs and collaborating with primary care practices to expand integrated behavioral health care and vastly increase access to these services. Through integrated care, these physicians can take on many of the mild to moderate behavioral health issues, allowing psychiatrists to manage the most complex disorders.

Most integrated care models require extensive use of non-prescribing behavioral health workers as part of an integrated team. Our analysis shows that licensed professional counselors are in relatively abundant supply and could possibly fill this role, with appropriate training in evidence-based practices and brief psychosocial interventions. Psychologists and social workers are also well-suited to behavioral health consultant roles. Increasing the number of these providers should be pursued with this type of training in mind. Even without a full integrated team, primary care physicians can expand their capacity to identify and treat behavioral health conditions through enhanced screening and psychiatric consultation.

LOOKING AHEAD

As we continue to examine the behavioral health workforce, we will introduce potential policy solutions. These possibilities include, but are not limited to, creating a partnership dedicated to examining and monitoring behavioral health workforce data and focusing on solutions to shortages, increasing the number of psychiatry residencies in Oklahoma and expanding the state's current primary care physician loan repayment program to include psychiatrists and other needed mental health and addiction professionals. We will explore the creation of innovative public-private partnerships aimed to recruit and retain behavioral health professionals. And, finally, given the significance of primary care physicians' role in meeting behavioral health needs and addressing workforce shortages, we will consider ways to promote continued implementation of integrated primary care/behavioral health care models throughout the state.

NOTES

1 Mental Health America (2020). 2021, *the state of mental health in America*. https://mhanational.org/sites/default/files/2021%20State%20of%20Mental%20Health%20in%20America_0.pdf (Please see the Mental Health Workforce Availability table on page 32.)
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3 Estimate does not include prescribers needed for substance use disorder treatment. Konrad, T. R., Ellis, A. R., Thomas, K. C., Holzer, C. E., & Morrissey, J. P. (2009). County-level estimates of need for mental health professionals in the United States. *Psychiatric Services, 60*(10), 1307–1314. https://doi.org/10.1176/ps.2009.60.10.1307
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5 Regional counts of primary care physicians and psychiatrists were based on Oklahoma state licensing data. National counts of primary care physicians were based on BLS 2019 data. Estimates for APRN-PMHNPs in Oklahoma were only available at the state level. Beck, A. J., Page, C., Buche, J, & Gaiser, M. (2020). The distribution of advanced practice nurses within the psychiatric workforce. *Journal of the American Psychiatric Nurses Association*, *26*(1), 92–96. https://doi.org/10.1177/1078390319886366
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12 Health Resources and Services Administration. (2018).
13 The national count was based on full-time equivalents (FTEs). However, the state number includes all licensed/certified providers (including part-time and those not in the workforce) and may overestimate the FTE supply. Health Resources and Services Administration. (2018).
14 Substance Abuse and Mental Health Services Administration. (2017). *Value of peers, 2017* [PowerPoint presentation]. https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/value-of-peers-2017.pdf
15 Heath Hayes, ODMHSAS, (personal communication, September 15, 2020).