
The Mental Health Workforce Shortage in Texas

**As Required By
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Executive Summary

It has been estimated that nearly 50 percent of all adults nationwide will experience mental illness in their lifetimes, and over 25 percent will experience mental illness annually (Hogg Foundation for Mental Health, 2011). In Texas, over 25 percent of surveyed adolescents reported negative emotional states within the previous 12 months and over 20 percent of adults reported poor mental health in the 30 days preceding the survey. Despite this established need, a mental health workforce shortage is evident nationwide.

The 83rd Texas Legislature passed a series of bills to help address the state's mental health infrastructure and payment and delivery systems. Among them was [House Bill \(H.B.\) 1023](#), which charged the Texas Health and Human Services Commission (HHSC) or an HHSC-designated health and human services agency with researching and analyzing the state's mental health workforce shortage. HHSC accordingly designated the Department of State Health Services (DSHS) with fulfilling H.B. 1023's requirements. Using existing information and data, DSHS conducted a review of the causes and potential solutions proposed for mental health workforce issues across Texas and the nation. The Department conducted a literature review and sought out information from stakeholders, including: the Statewide Health Coordinating Council, mental health care providers, advocacy organizations, and professional organizations. These efforts revealed five possible key themes for state consideration in policymaking:

1. **Increasing the size of the mental health workforce** – At its core, the mental health workforce shortage is driven by factors that attract and maintain individual practitioners. Chief among these factors, studies and stakeholders suggest that the fee-for-service payment system fails to provide adequate reimbursements for providers, especially in light of the extensive training necessary for practice. Furthermore, attracting more students to the mental health professions via exposure throughout their educational careers appears a worthwhile avenue to pursue. Finally, maximizing the capacity of the mental health workforce could benefit from ensuring all providers are able to responsibly treat patients within their scope of practice, with appropriate treatment tools available to them.
2. **Improving the distribution of the mental health workforce** – Access to care is differentially distributed across the state. Often, rural and border populations experience greater impacts from the mental health workforce shortage than do urban populations. One approach to consider is increased focus on targeted development and recruitment of rural mental health providers may be expanded to address these needs. Additionally, the state could consider methods to increase the practice of tele-mental health services.
3. **Improving the diversity of the mental health workforce** – Due to Texas' diverse population, cultural, ethnic, and linguistic barriers to mental health care are important considerations for minimization or removal. Evidence suggests that educational pipeline programs and the state's Joint Admission Medical Program have been successful. The expansion of such programs, aimed at producing mental health providers, is a possible consideration. Additionally, the state may consider policies that encourage international medical graduates to practice in the state, educational institutions equip providers with the necessary tools to treat our diverse population, and health workforce analysts have the data needed to inform planning.

4. **Supporting innovative educational models** – Recent health care system changes have challenged providers to be more innovative and efficient in their practice. These concepts include team-based care, patient-centered medical homes, and other innovations. The health education system will need to adapt its curriculum, produce more faculty with expertise in these new delivery models, and students with related clinical experience.
5. **Improving data collection and analysis** – Projects aimed at innovative delivery of mental care have already been initiated as part of the Medicaid 1115 Waiver Delivery System Reform Incentive Payment (DSRIP) program and as a result of Senate Bill 58, 83rd Legislature, authored by Senator Jane Nelson. These projects may shed light on mental health workforce implications and potential scalability. There is also a gap in knowledge about the mental health care needs of the state’s population and the actual capacity and productivity of its workforce. Additional data would help inform policymaking decisions.

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Introduction

[House Bill \(H.B.\) 1023, 83rd Legislature Regular Session](#), charged the Health and Human Services Commission (HHSC) with submitting a report to the Legislature providing policy recommendations for addressing Texas' mental health workforce shortage. HHSC subsequently delegated this task to the Department of State Health Services (DSHS). The recommendations included in this report were developed in consultation with programs within DSHS and HHSC, the Statewide Health Coordinating Council, and other nongovernmental entities with expertise in mental health workforce issues.

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Background

Nationally, 46.4 percent of adults experience mental illness at least once in their lifetime and 26.2 percent of adults experience mental illness annually. On an annual basis, 5.8 percent of adults in the U.S. experience a serious mental illness¹ (Hogg Foundation for Mental Health, 2011). Moreover, the aging of the U.S. population requires behavioral health service providers with special knowledge and skills (Hoge, et al., 2013).

Nationwide, 39 percent of persons with mental illness and 10.8 percent of persons with substance abuse issues receive needed mental health treatment (Hoge, et al., 2013). A national study conducted by the Center for Studying Health System Change found that 66.8 percent of primary care physicians were unable to refer their patients to high quality mental health specialists. This is a far higher rate of unavailability than those seen for other specialty referrals, nonemergency hospital admissions, or high quality imaging services (between 17 and 34 percent). The study attributed unavailability to either inadequate health insurance coverage or a shortage of mental health providers (Cunningham, 2009).

Workforce-based explanations for a lack of mental health and substance abuse providers at-large generally focus on insufficient numbers of mental health providers, high turnover (a national average of 18.5 percent annually), low compensation, minimal diversity, and the need for accelerated adoption of new evidence-based treatments (Hoge, et al., 2013).

Describing these shortages quantitatively can be problematic as relevant data have not been universally collected and there is no consensus regarding what constitutes adequate supply. However, efforts to describe the mental health workforce shortage should consider both the population's need for mental health services and the number of practitioners available to provide these services (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009). Finally, despite the Patient Protection and Affordable Care Act's (PPACA) effort at expanding access to medical care, populations living in areas affected by a mental health workforce shortage will likely continue to have insufficient access (Cunningham, 2009). This is in part due to the expectation that PPACA will raise demand for services and thus exacerbate the practitioner shortage (Kirch, Henderson, & Dill, 2012).

As a means of addressing the nation's mental health system problems, President George W. Bush convened the President's New Freedom Commission in 2002. The Commission's 2003 report called for the large scale transformation of the U.S. mental health care system into a consumer-centered system focusing on recovery and delivering excellent care without disparities. Such a transformation demands the vast expansion of the workforce through training and initiatives aimed at the redistribution of duties among providers (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009).

¹ A serious mental illness has been defined as one involving a serious attempt at suicide, substantial limitation of work capabilities due to mental or substance disorder, psychosis, bipolar I or II, substance dependence with serious role impairment, a seriously violent impulse control disorder, or any mental disorder resulting in 30+ days of limited capacity in the past year (Kessler, Chiu, Demler, & Walters, 2005).

Texas' need for mental health services

As noted above, one part of describing a workforce shortage involves demonstrating the needs of the population for mental health services. A standard definition of mental health need is not available locally or nationally.

Children and adolescents

As of February 2014, no reliable statewide survey data on mental health needs existed for children younger than high school age. However, data demonstrate conduct/oppositional defiant disorder (13 percent) and depression (11 percent) were among the most common diagnoses among children receiving services from DSHS' Mental Health and Substance Abuse Division.

Data from the DSHS Texas Youth Risk Behavior Surveillance System's (YRBSS) representative sample of 9th through 12th graders provide a baseline for establishing adolescent need for mental health services in Texas. Results from 2013 indicate that 28.3 percent of Texas' public and charter high school students reported feeling sad or hopeless almost every day for a two week period within the 12 months prior to being surveyed, similar to the national level. The proportion of females (36.8 percent) reporting these feelings was significantly higher than that of males (20.2 percent). Moreover, 16.7 percent of teens reported seriously considering a suicide attempt and 15.1 percent had a plan for how they would commit suicide. Rates for both of these measures were significantly higher among females than males. Finally, 10.1 percent of teens reported attempting suicide in the past year and 3.5 percent of teens had required medical intervention after doing so, with no significant differences between males and females. None of the above measures show any significant differences by race/ethnicity or grade level (Center for Health Statistics, 2013).

Adults

With respect to adults, DSHS' Texas Behavioral Risk Factor Surveillance System (BRFSS) reports that in 2012, 20.4 percent of adults reported having poor mental health for five or more days in the past 30 days. Additionally, the percentage of females (23.4 percent) reporting five or more days of poor mental health was significantly higher than that of males (17.3 percent). Significantly fewer college graduates reported poor mental health for five or more days (13.8 percent) than did those with some college education (21.9 percent), high school graduates (20.8 percent), and those with some high school education (25.7 percent). Likewise, the proportion of people with five or more poor mental health days was lower among those making more than \$50,000 annually (14.0 percent) than those making \$25,000 to \$49,999 (20.0 percent) and those making less than \$25,000 (29.2 percent) (Center for Health Statistics, 2012).

Texas' mental health workforce

In addition to patient need, a shortage of providers determines the insufficiency of the mental health workforce². The supply of providers can be conceptualized as being composed of two broad determinants. The first is the entire number of practitioners qualified to serve in mental health and the second is the number of these committed to providing patient care and the percentage of their productive time committed to doing so (Murphy, et al., 2012). The state's shortage of supply is expected to worsen as many of the most skilled practitioners are nearing

² Mental health provider data from DSHS' Health Professions Resource Center appears in Appendix 1. More information on these data can be found at: <http://www.dshs.state.tx.us/chs/hprc/health.shtm>

retirement age. At the same time, the state and the nation's educational institutions are not producing enough new graduates to meet predicted demand. Given the nationwide shortage, it is unlikely that Texas can meet its staffing needs by recruiting practitioners from other states (Thomas, Ellis, Konrad, & Morrissey, 2012) and the extent of the mental health shortage is expected to worsen as the workforce continues to age (Hogg Foundation for Mental Health, 2011).

In addition to a shortage of providers, other sociodemographic factors contribute to the state's inadequate mental health workforce. For example, providers are not distributed evenly across the state resulting in differential access to care by region, especially in rural areas and along the border. Further, the provider workforce does not reflect the state's growing ethnic diversity resulting in the continued need for culturally competent mental health care.

A synthesis of workforce studies has identified five areas that may be targeted (Buerhaus & Retchin, 2013; Hogg Foundation for Mental Health, 2007). First, the state shortage of mental health providers may be addressed through improved employee recruitment and retention and the reorganization of service delivery. Second, there is a chronic maldistribution of the state's workforce requiring greater attention to the needs of rural and border areas. Third, the state's workforce will require greater cultural and linguistic diversity to serve its population. Fourth, the educational curriculum for health professionals should be reevaluated and updated in light of evolving advancements in health care. Fifth, there is currently an insufficient quantity and quality of data at the state and national level to fully inform workforce planning initiatives. A literature review reveals possible policy options for consideration in each of these five areas. The result of this literature follows, and is organized according to each of the five identified themes.

Section 1 – Increasing the size of the mental health workforce

As noted above, studies looking at the widespread and ongoing mental health workforce shortage have been centered on five categories of action. The first and most direct means of addressing the shortage is to increase the number of mental health care providers relative to the population. In this section are five core options that research suggests may improve the recruitment, retention, and deployment of mental health care providers.

Address payment disparities

In a response to DSHS' call for stakeholder recommendations, a consensus emerged among mental health advocacy groups, professional organizations, and health care providers: the payment/reimbursement system for mental health care services is insufficient and serves as a barrier to practice.

Among physicians, national studies have demonstrated that psychiatrists are significantly less likely to accept insurance than other specialty types and that the percentage of psychiatrists accepting insurance declined 17 percent between 2005-2006 and 2009-2010 (Bishop, Press, Keyhani, & Pincus, 2014). A health care staffing firm's 2012 national survey of physicians showed that just 57 percent of adult psychiatrists were then accepting new Medicare patients, lowest among all specialties. Further, just 47 percent of adult psychiatrists were accepting new Medicaid patients, second lowest among all specialties (Jackson Healthcare, 2012). The same report indicated that of physicians leaving the practice of medicine, over half do so for economic reasons. Data from a national survey of physicians listed psychiatrists as the specialty least likely to accept new Medicaid patients and demonstrated that they did so at a rate that was lower at a statistically significant level compared to other specialties (Decker, 2013). In Texas, 33.6 percent of adults with serious and persistent mental illness received services through the community health system, due in part to the shortage of physicians accepting Medicaid (Hogg Foundation for Mental Health, 2011). Studies commonly attribute payment disparities between mental health providers and other practitioners to differential reimbursement structures that fail to account for the increased amount of time that mental health providers spend with patients (Bishop, Press, Keyhani, & Pincus, 2014).

The Texas Medical Association, the Federation of Texas Psychiatry, and the Texas Pediatric Society (TMA, FTP and TPS) jointly authored a letter calling the issue of low reimbursement rates 'the elephant in the room' when addressing the mental health workforce shortage. The Hogg Foundation for Mental Health similarly indicates that without addressing reimbursement rates across mental health provider types 'the shortage is destined to continue and ultimately increase exponentially'. As the Texas Counseling Association (TCA) points out, current reimbursement rates for licensed professional counselors, clinical social workers, marriage and family therapists, psychologists, and psychiatrists often fail to match provider costs when providing individual therapy. This same call is repeated by the National Association of Social Workers – Texas Chapter (NASW-TC).

Several groups, including TMA, FTP, TPS, TCA, and others, have noted the complex administrative and bureaucratic procedures necessary to manage the reimbursement process. They suggest Texas should streamline its own processes and work to minimize the bureaucratic impacts of federal demands on the state's mental health workforce.

The Statewide Health Coordinating Council (SHCC) intends to consider payment and delivery system innovation in its forthcoming 2015 Update to the State Health Plan, to be presented to the Governor by November 1, 2014.

Expand practice incentives for mental health practitioners

Best practices in recruiting and retaining a workforce of specialists include early exposure to career opportunities in the field and the special populations served; mentoring by behavioral health specialists; training stipends; minority fellowships; loan repayment programs; and the development of career ladders. Paying wages commensurate with the education, experience, and responsibility required of such specialists appears to be a primary factor in the success or failure of recruitment and retention efforts (Hoge, et al., 2013). The Hogg Foundation for Mental Health (2011) has previously recommended that the state work to increase the number of intern sites across professions and address the problems of inadequate pay and reimbursement in the public system. TMA, FTP, and TPS suggest the introduction of a preceptorship program whereby medical students might interact and rotate with doctors in DSHS facilities. Some community mental health centers have also proposed stipend or subsidy programs to realize the potential these programs have in training and employing mental health care providers.

The SHCC has recommended revising the State's Physician Education Loan Repayment Program and Texas Higher Education Coordinating Board (THECB) rules to prioritize loan repayment funds for psychiatrists and primary care practitioners serving in state-supported living centers and state hospitals and those involved in patients' care after transition to community-based care from these facilities. Similarly, TMA, FTP, and TPS have supported expanded loan repayment and forgiveness programs that might be structured to attract psychiatrists to rural and other practice settings with less existing infrastructure and professional support. Likewise, the Texas Hospital Association (THA) has called for incentives to recruit potential mental health professionals at all levels into the field.

Additionally, the SHCC has recommended that DSHS work with THECB and other relevant stakeholders to research and analyze factors discouraging current and future practitioners from selecting psychiatry as their medical specialty. TMA, FTP, and TPS make a similar recommendation, suggesting DSHS employ surveys of medical students and psychiatrists to identify perceived barriers to practice.

Increase higher education funding for mental health fields

Nationwide, the robust expansion of graduate medical education has the most potential to bolster the supply side of the physician workforce strategies, yet the availability of funded residency slots remains a concern (Kirch, Henderson, & Dill, 2012). There has been no substantial increase in the number of graduate medical education residency training positions since the 1997 federal Balanced Budget Act (Kirch, Henderson, & Dill, 2012). Yet more residency positions in psychiatry are needed and their funding needs to be made more secure (Roberts, et al., 2013).

Within Texas, there is a ratio of 13,794.4 Texans per actively licensed psychiatrist. Texas' current workforce of 1,933 psychiatrists will have to grow significantly over the coming years. As of 2013, the State funded 469 psychiatric resident positions through ten universities across the state. While the number of such positions may require expansion in the future, 105 of these

positions were vacant (22.4 percent vacancy rate) as of September 2013. As Texas seeks to improve its practice environment and generate more medical students to the field of psychiatry, TMA, FTP, and TPS recommend continuing to invest in ensuring Texas has the highest quality and most attractive residency programs and facilities.

In addition to reinforcing Texas' mental health residency programs for physicians, stakeholders emphasize continued support for the education of all mental health providers as important. NASW-TC has drawn attention to the cost of education, the debt burden of mental health care graduates, and the relatively low pay of these providers. The Texas Association of Psychological Associates (TAPA) has also indicated the need to support public education programs.

As a result of federal funding mechanisms, rural community mental health centers often provide a narrow range of services in tightly defined catchment areas (Talbot & Coburn, 2013), but these might be expanded through the targeted use of internships and clerkships.

Initiate early recruitment practices

A review of educational pipeline programs targeted at minority students at an early age found positive outcomes for overall academic performance and enrolling in a health profession (U.S. Department of Health and Human Services, 2009). Locally, the Pathways Project, initiated by the Network of Behavioral Health providers in Houston, is engaged in identifying and implementing mechanisms to attract high school and undergraduate students to the health professions. This process begins with an awareness-building curriculum at the high school level and continues through special educational and experiential opportunities in post-secondary and graduate level educational programs. THA and NASW-TC support the expansion these types of programs.

Further, research has shown that targeting graduate medical and undergraduate pre-medical students with specialty clerkships and curriculum tracks is effective in recruiting students into residencies of that specialty (Grobler, et al., 2009). As noted above, TMA, FTP, and TPS suggest the introduction of a preceptorship program whereby medical students might interact and rotate with doctors in DSHS facilities.

Responsibly expand the practice capacity of APRNs and other practitioners

Following the Annapolis Framework (SAMHSA's Action Plan on Behavioral Health Workforce Development), expanding the capacities and roles of other health care providers could also help ease the shortage. Research has indicated that existing practitioners may be deployed to more fully use their training and that each profession should be granted a maximum amount of reasonable responsibility. A physician would then provide a leadership role while working as a member of the health care team, with well-specified and defined tasks for each profession (Gorman & Brooks, 2009). For example, research has indicated the increased use of nurse practitioners and physician assistants has great potential to significantly address health care workforce shortages (Kirch, Henderson, & Dill, 2012). Texas has incorporated these approaches, assigning physicians to supervise and delegate to advanced practice nurses and physician assistants serving on the health care team.

Specific to mental health, the SHCC and THA have recommended altering the Texas Administrative Code § 411.472 to allow advanced practice registered nurses (APRNs) in psychiatric hospitals, under physician supervision, to conduct initial psychiatric evaluations and subsequent required patient examinations during the patient's first week of inpatient hospitalization. Consideration may also be given to amending Texas Health and Safety Code §572.0025(f) to allow for APRNs to admit patients into psychiatric hospitals voluntarily. Similarly, Texas lawmakers may consider changes to the Health and Safety Code §576.024 that allow APRNs to order patient restraint or seclusion, as necessary. These amendments would allow APRNs, under the delegation and with the concurrence of the supervising psychiatrist, to work as extenders in psychiatric hospitals in a way that is similar to their roles in other medical settings. Furthermore, this change could ease psychiatrists' workload and allow them to serve more patients, especially in the state hospital systems. Another possible alteration to the Texas Health and Safety Code §574.025 would be to allow APRNs to testify as experts in the field of mental health when requesting an order of protective custody, temporary commitment, extended commitment or court ordered medication.

Another potential opportunity to improve the delivery of substance abuse services is the increased adoption of Person-Centered Recovery Planning and the utilization of laypersons with the lived experience of recovery in the care process. The shifting focus of client-patient interaction is also being addressed through the greater use of unlicensed, certified practitioners like certified peer specialists (Hoge, et al., 2013). Peer specialist and recovery coach efforts have thus far proven to promote better outcomes and reduce costs (Substance Abuse and Mental Health Services Administration, 2012). More than 20 states are now reimbursing certified peer specialists under Medicaid, while another 22 have indicated the intent to do so (Hoge, et al., 2013). Many mental health programs are not taking advantage of these professionals, due in part to limited employer awareness of the positive outcomes associated with their use. The Hogg Foundation for Mental Health (2011) has previously recommended that certified peer specialists be allowed to bill for their services.

TMA, FTP, and TPS support the expanded use of peer specialists as another member of the physician-centered, integrated care team. The Hogg Foundation, DSHS, and ViaHope continue to work together to promote the adoption of peer services in criminal justice facilities, emergency rooms, and community clinics, among other locations.

Section 2 – Improving the distribution of the mental health workforce across Texas

As shown by data on the distribution of health professionals in Texas (see Appendix 1), much of the state, especially rural and border areas, lack suitable levels of mental health professionals. With the changes contained in the Patient Protection and Affordable Care Act (PPACA), the existing health workforce shortage is likely to become more pronounced (Roberts, et al., 2013). Rural communities already lacking mental health professionals and primary care practitioners may find it more difficult to develop the multidisciplinary, integrated service models that may be optimal for people with comorbid conditions. As a potential solution, Talbot & Coburn (2013) have suggested multiple providers form networks that allow them to act as a single underserved site. Previous research on the mental health workforce shortage has shown that ameliorating policies should focus on 1) efforts to recruit health workers to these areas and retain them once they are practicing; and 2) provide the educational, regulatory, financial, personal, and professional support in which these practitioners can thrive (Dolea, Stromont, & Braichet, 2010). Targeted recruitment programs and the expansion of telemedicine and telehealth services are both policy options.

Targeted recruitment

In order to recruit and retain needed health care professionals to underserved areas, stable and rewarding personal and professional environments are necessities (Grobler, et al., 2009). Previous efforts at workforce recruitment have focused on temporary commitments from contracted providers, but research has shown that developing ‘home-grown’ providers – those who have spent prolonged periods in the community - might be a more sustainable strategy for rural workforce development (Talbot & Coburn, 2013). Specifically, professionals from rural backgrounds or who have served in rural areas in either residence or early in practice are more likely to engage in long-term rural practice. For example, over 2/3 of graduates of the Physician Shortage Area Program in Pennsylvania and Delaware have continued to practice in the same rural area for over a decade. Importantly, this program contains clinical rotations in underserved areas and appropriate educational preparation for rural practice, creating more interest in rural service (Dolea, Stromont, & Braichet, 2010). Further, it has been suggested that the location of university departments and/or teaching clinics in rural areas, the provision of rural clinical experiences for medical students, and rural and scarce skills allowances for practitioners can boost the workforce (Grobler, et al., 2009).

Identify disincentives and barriers to the practice of telemedicine/telehealth

Telepsychiatry and telehealth services offer an important link between underserved areas and the specialists who help promote positive health outcomes. Telepsychiatry has demonstrated diagnostic accuracy and service satisfaction relative to in-person practice (Chung-Do, et al., 2012). Further, telepsychiatry often links urban practitioners to rural populations, allowing specialists, primary care providers, and patients to interact and collaboratively develop treatment plans (Chung-Do, et al., 2012). Given this proven efficacy, the expansion of tele-mental health services may prove beneficial in increasing the geographic reach of the mental health workforce.

While current federal and state policy allow for the practice of telehealth and its payment reimbursement, there are very few tele-mental health providers and clients in Texas. The Texas Health and Human Services Commission reported 98 tele-mental health providers serving 9,748 Medicaid clients in 2011. These numbers represented a 113 percent and 128 percent increase

from 2009, respectively (Texas Health and Human Services Commission, 2012). Medicare and Medicaid reimburse the telehealth services of psychiatrists, nurse practitioners, clinical nurse specialists, physician assistants, clinical psychologists, and clinical social workers. Further, Texas Insurance Code, Chapter 1455 currently prohibits the denial of payment on the basis of services having been provided through telehealth technology.

In order to expand the use of telehealth services, other licensing boards might follow the example of the Texas Medical Board by establishing rules for out-of-state practitioners to practice telehealth in Texas. Recently, the Federation of State Medical Boards has been considering the implications of multi-licensing and it is thought that this would aid in access to telemedicine (with certain provisions). Finally, the SHCC has proposed removing rules from the Texas Administrative Code that affect where a patient may receive telehealth services and that require a third-party presenter at the patient site. Short of this, the SHCC recommends the facility fee for the patient site be reconsidered to include the necessity of presenters.

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Section 3 – Improving the diversity of the mental health workforce

Those patients with the least established links to the health care system are the first to suffer the effects of health care shortages (Kirch, Henderson, & Dill, 2012). Indeed, minority status is associated with negative social outcomes (less education, higher rates of uninsuredness, less English-language proficiency). These outcomes are subsequently linked to difficulties in accessing health services and receiving quality care, negatively affecting behavioral health. Previous studies have shown that higher percentages of whites in need of mental health services receive those services, while minorities have higher levels of mortality from substance abuse (Hoge, et al., 2013).

Given these outcomes, the low rates of diversity in the mental health workforce should be considered as minority practitioners are more likely to see minority patients than are white practitioners. It has also been shown that health care consumers have better therapeutic relationships and stronger retention rates when using a practitioner of their own race/ethnicity (Hoge, et al., 2013). This lack of cultural and linguistic diversity in the workforce results in a shortage of providers with the knowledge, training, and skills to serve people who speak languages other than English or of racial/ethnic minority populations (Hogg Foundation for Mental Health, 2011).

Targeted recruitment

Studies indicate that increased diversity in the workforce may be achieved through two means. First, efforts to recruit minorities into health professions training programs may be expanded. This effort would require accompanying efforts to improve the educational attainment of minorities at large (Gorman & Brooks, 2009).

A U.S. Department of Health and Human Services review of 24 scientific evaluations of educational pipeline programs found positive outcomes for racial/ethnic minorities and economically disadvantaged students for overall academic performance and enrolling in a health profession (U.S. Department of Health and Human Services, 2009). Key features of these programs include incorporating a range of health professions, a combination of academic support, professional opportunities, and sometimes financial support, and programs targeting students throughout the health education pipeline from kindergarten through 12th grade.

Currently, the Joint Admission Medical Program funded through THECB, supports economically disadvantaged undergraduate students and guarantees them admission to medical schools. Thus far the program has been successful in guiding students into Texas residency programs and producing primary care practitioners for the state. A coalition of mental health advocates and practitioners has supported the expansion of this program with the intent of attracting economically disadvantaged students into psychiatric practice.

Second, psychiatric care in the United States and Texas is and will continue to be dependent upon the services of international medical graduates, who make up nearly 30 percent of the workforce. These workers have diverse backgrounds and sensitivity to the experiences of minorities, including cross-cultural issues, the recognition of and respect for other ethnic groups, and tolerance of non-English language proficiency (Boulet, Cassimatis, & Opalek, 2012). Policy

consideration may be given to initiatives that encourage these individuals to practice in the state, especially in underserved areas.

Given Texas' changing demographics, the health professions require the capacity to effectively communicate and interact with their patients. A coalition of mental health advocates and care providers has called for professionals to strive to comply with the National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards). Further information on how to implement, advance, and sustain CLAS Standards are available at [the website of the Office of Minority Health, U.S. Department of Health and Human Services](#). TAPA draws attention to the certificate in Psychological Services for Spanish Speaking Populations currently offered by Our Lady of the Lake University in San Antonio as a successful and replicable model for encouraging health professionals to attain the necessary linguistic skills.

The Statewide Health Coordinating Council is legislatively charged to “ensure that health care services and facilities are available to all citizens in an orderly and economical manner”. DSHS, in the service of the SHCC, currently collects data on race/ethnicity from the relevant licensing boards. To assess the multilingual competencies of the health workforce, the SHCC recommends that the State allocate the necessary resources and amend the Health and Safety Code, Chapter 105 to direct the Health Professions Council and the Texas Department of Information Resources to collect linguistic proficiency data and provide it to DSHS for analysis. This recommendation is also supported by the Hogg Foundation. Using the newly collected data, DSHS, THECB, and impacted licensure boards would be able to assess the need for greater linguistic and cultural proficiency in the health professions. Remediation of deficiencies might occur through the incentivization of linguistically and culturally competent practice or through the identification and development of linguistically proficient para-professionals.

Section 4 – Supporting innovative educational models

Support integrated health and mental health practices

As the PPACA heightens the shortage of health professionals, leaders in health profession education must respond to this challenge (Kirch, Henderson, & Dill, 2012). Current and projected shortages suggest that the roles and activities of health care workers must likely be reorganized to maximize the productivity of the workforce (Buerhaus & Retchin, 2013). In the area of mental health workforce, this could include expanding the role of the lay workforce, such as certified peer specialists, family partners, and recover coaches (Buerhaus & Retchin, 2013).

One essential attribute of future health workers will be the ability to recognize and employ suitable innovations (Gorman & Brooks, 2009). The utilization of team-based care, collaborative care organizations, and medical homes have been cited as ideal models for improving outcomes and efficiency (Kirch, Henderson, & Dill, 2012). Medical, or health, homes have been presented as an appealing opportunity to offer integrated medical and behavioral health services (Beacham, Kinman, Harris, & Masters, 2011) while also potentially offering social service and housing programs (Mechanic, 2011).

Curriculum Changes

Higher education programs and accrediting bodies can meet emerging needs by updating their curriculum (Hoge, et al., 2013). Further, academic medical centers must embrace the innovation imperative and address the projected workforce shortages (Kirch, Henderson, & Dill, 2012). Rather than relying on tradition or incremental change, these efforts should continue to identify and employ ‘disruptive innovations’ that will spark true workforce growth and increased efficiency (Gorman & Brooks, 2009). It is known that programs will require additional faculty and greater leadership development among existing faculty to achieve the quality of education needed (Kirch, Henderson, & Dill, 2012), but they must also seek to align changing elements of the education system and health system with each other and with patient care needs (Gorman & Brooks, 2009).

Expanded Training in Clinical Settings

Within psychiatry, Roberts, et al., (2013) have suggested additional focus on the psychiatry curriculum and the development of more innovative teaching strategies to attract and prepare new workers. Specifically, these authors recommend expanded psychiatry clerkships and electives for medical students who have not yet chosen a specialty. Further, researchers have recommended that psychiatry residents and fellows receive specific training in telepsychiatry delivery, including such diverse topics as program sustainability, model of health service delivery, program infrastructure development, legal and regulatory issues, administrative strategies, technical applications, quality of service, and clinical outcomes assessment (Chung-Do, et al., 2012). THA supports similar efforts.

With respect to other physician types, it has been estimated that up to 70% of services sought from primary care providers are related to behavioral health conditions (Robinson & Reiter, 2007). Indeed, Texas Medicaid statistics have shown that roughly 66% of behavioral health prescriptions for children were written by physicians not identified as psychiatrists (Becker, King, Shafer, & Thomas, n.d.). Given the role primary care physicians often play in delivering mental health services, the American Academy of Pediatrics has recommended the inclusion of

child psychiatry and developmental-behavioral pediatric training in residency. This suggestion is in response to a study demonstrating that few primary care practitioners feel capable of diagnosing or treating psychopathology in children or adolescents. The Hogg Foundation has recommended ensuring educational requirements are aligned with workforce needs and that primary care physicians, including pediatricians, are comfortable in an integrated health care environment.

It has been suggested that nursing faculty should share and build new curricula for RNs entering psychiatric nursing (Delaney, 2012). For psychologists, a greater concentration of academic training and workplace experience should occur in the clinical psychological setting, including the expansion of rotations for psychologists in the primary care setting (Beacham, Kinman, Harris, & Masters, 2011). Further, doctoral psychology training programs may consider curriculum changes that: maximize the expertise of their faculty; provide greater teaching and supervisory remuneration; maximize the knowledge and skills of their students; and create and expand clinic relationships and affiliations.

Community health centers have been presented as offering an ideal place for psychological training in primary care behavioral health as these efforts would be available to patients with fewest resources and greatest needs (Beacham, Kinman, Harris, & Masters, 2011). 33.6 percent of adults who experienced serious and persistent mental illness received services through the community health system in 2010; this is due in part to the shortage of physicians accepting Medicaid (Hogg Foundation for Mental Health, 2011). As a result of federal funding requirements, rural Community Mental Health Centers often must provide a narrow range of services in tightly defined catchment areas (Talbot & Coburn, 2013). Indeed, mental health advocates and care providers have proposed expanding educational opportunities within public health settings, for example the state hospital system.

Incorporate training on interprofessional collaboration into education of health professionals

As policymakers, industry leaders, and health care professionals seek to better appropriate health resources, the use of collaborative health care teams and patient-centered medical homes has grown. This trend and underlying research has highlighted the benefits of training in interprofessional collaboration, specifically by providing health professions students greater opportunities to interact in their coursework and clinical experiences, as appropriate.

TMA, FTP, and TPS have suggested that as primary care providers are integrated into patient-centered medical homes, they may benefit from additional training on collaborative practice with specialty care providers and on the co-management of mental, physical, and social well-being.

According to the SHCC, the State should increase the availability of collaborative training by appropriating funds and directing the THECB to work with institutions of higher education to monitor and implement evidence-based programs to prepare future providers for practice. Concurrently, the SHCC recommends that state licensing boards and regulatory agencies examine and amend their policies that may deter the full implementation of these efforts, as necessary.

Section 5 – Improving data collection and analysis

Consider potential workforce impacts of Medicaid 1115 waiver DSRIP projects and SB 58 implementation

The Delivery System Reform Incentive Payment Program (DSRIP) has been funded with over \$11 billion covering almost 1,500 projects across the state. About 450 of these projects are related to mental health, with many acting to enhance the mental health workforce within specific geographic regions of implementation. Federally-required outcome evaluations do not specifically address how these projects might affect, directly or indirectly, the state's mental health workforce. For this reason, the SHCC and other stakeholders have recommended that HHSC and DSHS evaluate the potential long- and short-term impacts of these projects on the mental health workforce.

Expand data collection and analysis

As noted above, there is a lack of data to define the need for mental health services for the Texas population. Population need is dependent on prevalence of mental health illness, the distribution of risk factors, currently available social services, and other considerations. The main findings of recent systematic reviews on health workforce planning showed that there has been an absence of rigorously designed studies supporting the use of specific interventions addressing the shortage of health professionals (Grobler, et al., 2009; Buykx, Humphreys, Wakerman, & Pashen, 2010). Traditional planning has been insufficient in accounting for population need, models of health care delivery, and workforce productivity. Effective planning must involve the sustained investment on iterative collection of data on each of these elements (Murphy, et al., 2012). Definitions of workforce adequacy must consider population need and the available supply of mental health professionals (Thomas, Ellis, Konrad, & Morrissey, 2012).

Assessment of mental health service needs

The first requirement of assessing the suitability of a health workforce is to understand the needs of the population. Currently, sufficient demand models for Texas' mental health workforce do not exist, especially for small areas. These predictive models should consider the local morbidity of mental illness, mental health service utilization rates for both patients with serious mental illness and the population at-large, and the proportion of mental health needs currently being met by primary care providers (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009). Such a model is especially important as the U.S. and Texas work to address a chronic lack of health care accessibility (Buerhaus & Retchin, 2013). While the underpinnings of such a model are presented in Appendix 1, the currently available models fail to incorporate data specific to the mental health needs' of the Texas population.

In addition to these more traditional considerations, patient socioeconomic status and cultural and linguistic diversity affect the accessibility and suitability of health care (Terry, Terry, Hoang, & Hannah, 2013). Distinguishing between spatial (geographic) barriers to care and aspatial (social organizational) variables would allow for a more comprehensive description of patient need (Terry, Terry, Hoang, & Hannah, 2013; Wang, 2012). Measurements of shortage should conceptualize access using more nuanced means (Wang, 2012), including the prevalence of mental health disorders (variable by demographics), the extent of need among those in need, the extent to which Primary Care Physicians (PCPs) can meet mental health needs, and finally the

mismatch between the level of need and the services provided (Konrad, Ellis, Thomas, Holzer, & Morrissey, 2009).

Workforce development data

Second, greater consideration of factors affecting workforce development and distribution are needed. More and better data should be collected on the level of service provided for different levels of health and illness and the productivity of providers should be measured (Murphy, et al., 2012). Currently, there is no systematically and uniformly collected nationwide data on the mental health workforce (Hoge, et al., 2013) and data quality in Texas varies by the licensing board and profession. Thus, greater investments on the activity and productivity of health workers are needed to ascertain the effectiveness of staffing levels (Murphy, et al., 2012). Additionally, more extensive and complete minimum data requirements, including race, ethnicity, and languages spoken, when not already collected, would allow a better understanding of provider ability to meet population needs. “Without these statistics, it is challenging to identify a plan for developing the mental health workforce skills and abilities needed to meet the state’s increasingly diverse mental health needs” (Hogg Foundation for Mental Health, 2011).

The SHCC has recommended that HHSC and DSHS collect and analyze data from the Department of Criminal Justice, the Juvenile Justice Department, and other relevant agencies as a means of fully defining the state’s workforce shortage and designing effective policy solutions. Specifically, the SHCC calls on the Legislature to provide HHSC and DSHS access to data related to mental health services need and direct these agencies to develop statistical models to measure and predict workforce shortages. TMA, FTP, TPS, the Hogg Foundation, and NASW – TC also support the expanded collection and analysis of data on mental health need and/or provider supply.

Conclusion

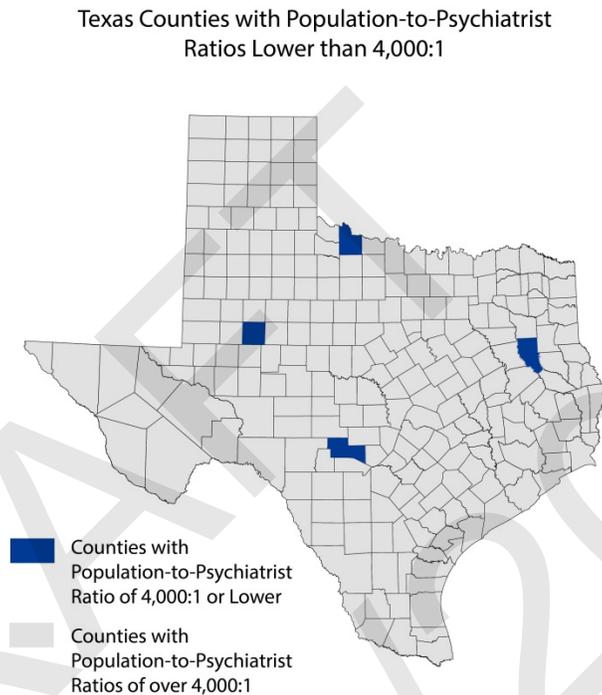
The mental health workforce shortage is a pervasive issue with multiple causes and many potential solutions. In passing [House Bill \(H.B.\) 1023](#), the 83rd Texas Legislature called on HHSC to provide policy options for its consideration. Research, analysis, and input from mental health providers, advocates, and other stakeholders, revealed five themes for future policymaking efforts: increasing the size of the workforce; improving the distribution of the mental health workforce across Texas; improving the diversity of the mental health workforce; supporting innovative education models; and improving data collection and analysis.

DRAFT
8/18/2014

Appendix A: Texas' Mental Health Workforce

Psychiatrists

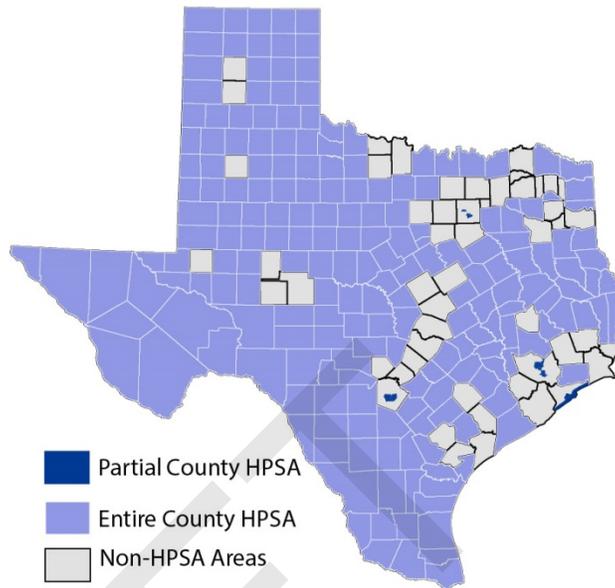
The most common method for measuring health workforce adequacy is to compare the size of the population and the number of health care providers. Cunningham (2009) has noted that the greater the ratio of population to psychiatrists, the less likely that a patient can obtain a quality psychiatric referral. Further, Cunningham suggests that a population-to-psychiatrist ratio of greater than 4,000:1 would likely impact the availability of mental health care, a threshold met by only four counties in Texas.



A statistical model accounting for patient need estimated that a national ratio of persons per psychiatrist not exceeding 3,681:1 was ideal, though provider need specific to Texas was not calculated (Konrad, Ellis, Thomas, Holzer, & Morrissey, 2009).

By comparison to these models which directly consider patient need, the federal Health Resources and Service Administration's (HRSA) threshold for designation of a geographic area as a Health Professional Shortage Area (HPSA) for mental health is a ratio of 30,000 people to one psychiatrist. HPSA designations allow doctors and facilities to receive incentives meant to attract practitioners. In high needs areas (defined by HRSA as areas with high proportions of youth, elderly, low-incomes, or people with alcohol/substance abuse problems) the ratio required for federal designation is 20,000 people to 1 psychiatrist. The Primary Care Office within DSHS currently uses these population-to-psychiatrist measures to apply for mental health HPSA designations.

Texas Counties with
Mental Health HPSA Designations



As of November 2013, 207 of Texas' 254 counties had whole or partial county Mental Health HPSAs and 241 counties had whole or partial county designation or at least one site-designated HPSA.³ Thus using the most lenient federal standard for HPSA designation, the vast majority of Texas counties lack a sufficient workforce of psychiatrists.

In addition to concern about the total number of psychiatrists, there is also a shortage of pediatric and geriatric psychiatrists. Only six states are considered to have an adequate supply of child and adolescent psychiatrists (Hoge, Stuart, Morris, Flaherty, Paris, & Goplerud, 2013), there is a national shortage of 22,000 child and adolescent psychiatrists and 2,900 geriatric psychiatrists, and only 325 new child psychiatrist graduates are produced nationally each year (Roberts, et al., 2013). The Institute of Medicine concluded that there was a major shortfall for professionals treating the mental health of aged populations. Currently, there are fewer than 1,800 geriatric psychiatrists in the US. By 2030, the national ratio of elderly persons with mental illness or substance abuse issues to geriatric psychiatrists will be 6,000:1 (Hoge, Stuart, Morris, Flaherty, Paris, & Goplerud, 2013).

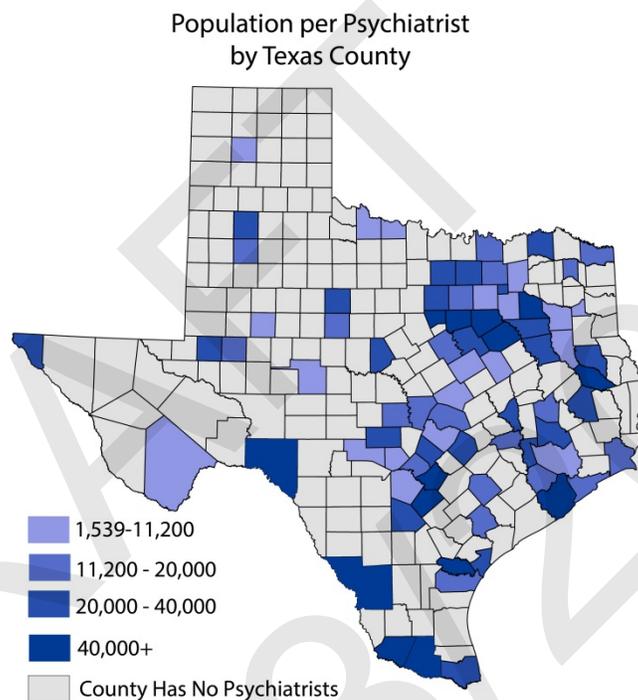
As of September 2013, 1,933 psychiatrists were actively licensed and offering direct patient care in Texas. Using 2013 population projections,⁴ this yields a ratio of 13,794.4 Texans per psychiatrist. However, Texas' five most populous counties (Harris, Dallas, Tarrant, Bexar, and Travis) had roughly 43.4 percent of the population and 63.0 percent of the state's psychiatrists

³ HPSA site designations allow for a single site, such as a clinic, to benefit from HPSA designation based on either an insufficient number of physicians serving the same population as that site or a disproportionate share of low-income users being provided services at that site.

⁴ All population is based on the 2012 projections of the 2013 Texas population offered by the Texas State Data Center: <http://txsdc.utsa.edu/Data/TPEPP/Projections/Data.aspx>

(9,507:1 ratio) while the remainder of the state had a ratio of 21,081:1. Border and rural areas generally have far fewer psychiatrists per capita.⁵

Geographic Designation	Population per Psychiatrist
Metropolitan, Non-Border	12,032
Metropolitan, Border	29,849
Non-Metropolitan, Non-Border	30,219
Non-Metropolitan, Border	126,821
Texas	13,794



In 2013, 2,798,583 Texans (10.5 percent of the population) lived in counties with no psychiatrists, while 5,512,060 (20.7 percent) lived in counties eligible for designation under the most utilized federal guidelines as a mental health professional shortage area (ratios of 30,000:1 or higher). By comparison, 99.4 percent of Texans lived in counties with ratios higher than those recommended by the academic literature (Cunningham, 2009; Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009).

From 2008 to 2013, there was an average annual growth of 3.64 percent among Texas' active psychiatrists. However because of the state's growing population, the ratio of population to psychiatrists improved by an average of 1.6 percent annually over these five years.

⁵ Texas' border counties are defined using the 1983 La Paz Agreement. Metropolitan and non-metropolitan counties are defined using the federal Office of Management and Budget's 2013 designations. For an accounting of each county, see Appendix 1.

In addition to an overall shortage in 2013, the existing psychiatric workforce differed demographically from the population at-large. The composition of Texas' population was estimated to be 43.4 percent whites, 39.1 percent Hispanics, 11.5 percent African-Americans, and 6.0 percent from other ethnicities. Yet 65.5 percent of the psychiatric workforce was white, with just 5.3 percent African-American and 9.7 percent Hispanic representation. 19.5 percent of the workforce was classified as being of another ethnicity, potentially through their status as an international medical graduate.

Texas faces the additional challenge of an aged psychiatric workforce. Nationwide, psychiatry is one of the top three specialties in terms of the number of practitioners over the age of 55 (Roberts, et al., 2013). Texas' 2013 data indicate that 473 of the state's 1,933 active psychiatrists (24.26 percent) were 65 years of age or older. An additional 532 were between the ages of 55 and 64, meaning that over half of the workforce (51.99 percent) would be 65 or older and of retirement age by 2023.

In 2013, only 681 graduates from US medical schools⁶ matched into psychiatric residencies nationwide. This number represented roughly half of the filled psychiatric residencies, with the remainder being filled by international medical graduates (Roberts, et al., 2013). Given this heavy reliance on international psychiatric residents, psychiatric care is expected to maintain reliance on international medical graduates for the foreseeable future (Boulet, Cassimatis, & Opalek, 2012). In 2013, 29.8 percent of Texas psychiatrists reported graduating from a medical school outside of the U.S. with the most prevalent source countries being India (8.4 percent), Pakistan and Mexico (4.0 percent each).⁷ Compared with graduates of U.S. and Canadian medical schools, a greater proportion of international medical graduates specialize in primary care, locate in areas of need, and care for poorer patients. Further, international medical graduates are more likely to live in areas with lower median incomes and greater proportions of people living in poverty, providing a gap-filling and safety net role (Boulet, Cassimatis, & Opalek, 2012). Among Texas psychiatrists, international medical graduates are more likely than US-trained practitioners to practice in border areas (8.5 percent vs. 2.7 percent) and slightly less likely to practice in rural areas (4.0 percent vs. 5.2 percent). Among psychiatrists under 40 years of age, international medical graduates are more likely than US-trained practitioners to practice in rural (7.3 percent vs. 3.3 percent) and border (7.3 percent vs. 4.8 percent) areas.

2013 data from the Texas Higher Education Coordinating Board showed that there were 361 psychiatric residencies in the state. In 2008 there were 316, indicating a roughly 3.1 percent average annual growth over the past five years. Among specialties, there were 304 general psychiatric residencies, 53 child and adolescent psychiatry residencies, three addiction psychiatry residencies, and one geriatric psychiatry residency in 2013.

Type of Psychiatric Residency	2008	2013	Percent Change over 5 Years
General	263	304	+15.6 %

⁶ Graduation from a US or international medical school does not necessarily indicate citizenship or residency status. However, the academic literature does use this measure as a proxy for reliance on foreign-born workers and available data necessitates the use of this measure.

⁷ Among all direct patient care physicians in Texas, 25.1 percent graduate from medical schools outside of the US.

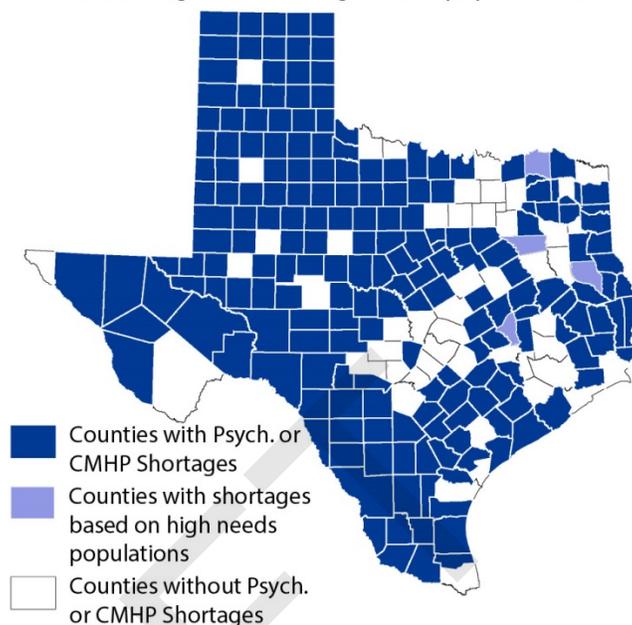
Type of Psychiatric Residency	2008	2013	Percent Change over 5 Years
Child/Adolescent	47	53	+12.8 %
Addiction	1	3	+300 %
Geriatric	5	1	-80 %
Total	316	361	+15.5 %

Other mental health professions

The federal provider ratios listed above account only for the number of psychiatrists serving a population. However, an alternative federal means for designating shortages in the mental health professions is to consider both psychiatrists and other related occupations, such as clinical psychologists, psychiatric nurses, clinical social workers, licensed professional counselors, and marriage and family therapists (Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009). The federal HPSA designations including these core mental health providers (CMHP) require a population to CMHP ratio of 9,000:1 including psychiatrists or 6,000:1 CHMP excluding psychiatrists and 20,000:1 for psychiatrists. Incorporating these definitions, 23.3 percent of the 2013 Texas population lived in 199 different counties with mental health workforce shortages.

Finally, areas with greater than 20 percent of their population at or below the federal poverty level, high proportions of underage or geriatric populations, or levels of alcohol/substance abuse in the top quartile of national, state, or regional prevalence may be designated HPSAs with unusually high needs for mental health providers. In these areas, a population to psychiatrist ratio of 20,000:1, a population to CMHP ratio of 6,000:1, or a 4,500:1 population-to-CMHP (excluding psychiatrists) ratio and a 15,000:1 population-to-psychiatrist ratio are eligible for designation. This broader definition drew four more counties into the shortage, resulting in 203 counties and over 6.6 million Texans (24.9 percent) experiencing whole county shortages.

Counties with Psychiatric or CMHP Shortages
(including areas with high needs populations)

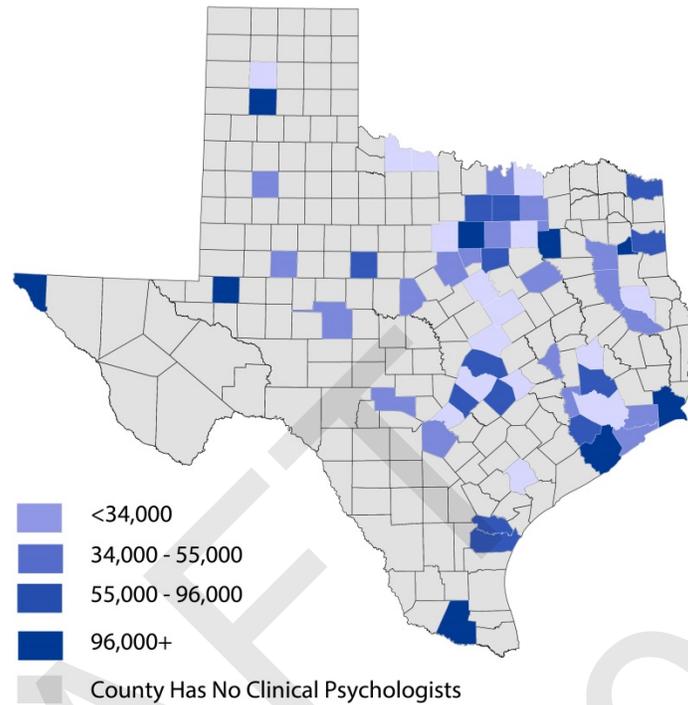


Clinical psychologists

As of September 2013, there were 566 actively licensed psychologists in Texas indicating a clinical specialty. This provided a ratio of 47,111 Texans per clinical psychologist in the state. Over two-thirds (67.84 percent) practiced in Texas' five most populous counties (Harris, Dallas, Tarrant, Bexar, and Travis). These five counties had a combined ratio of 36,236 persons per clinical psychologist while the remainder of Texas had 86,277 persons per clinical psychologist. There were no practicing clinical psychologists in any of the rural border counties.

Geographic Designation	Population per Clinical Psychologist
Metropolitan, Non-Border	40,031
Metropolitan, Border	159,193
Non-Metropolitan, Non-Border	123,622
Non-Metropolitan, Border	-
Texas	47,111

Population per Clinical Psychologist
by Texas County



Data to calculate annual growth rates of clinical psychologists were unavailable, but data did show that 21.0 percent of Texas' clinical psychologists were 65 or older while another 27.2 percent were between 55 and 64 years of age. A sizable proportion of the profession (48.2 percent) will be of retirement age by 2023.

Data for race/ethnicity were not available for clinical psychologists.

Psychologists (All)

HRSA definitions allow for only clinical psychologists to be considered as CMHPs. However, Texas' 2013 total psychology workforce was substantially larger than the clinical subset described above. In fact, there were 7,243 persons eligible to practice under at least one of the state's four license types in 2013. This number includes 3,009 specialists in school psychology, 1,041 licensed psychological associates, and 4,176 licensed psychologists.⁸

Geographic Designation	Population per Psychologist (All)
Metropolitan, Non-Border	3,190
Metropolitan, Border	10,428
Non-Metropolitan, Non-Border	7,618
Non-Metropolitan, Border	20,024
Texas	3,681

⁸ A single practitioner can be licensed under multiple license types.

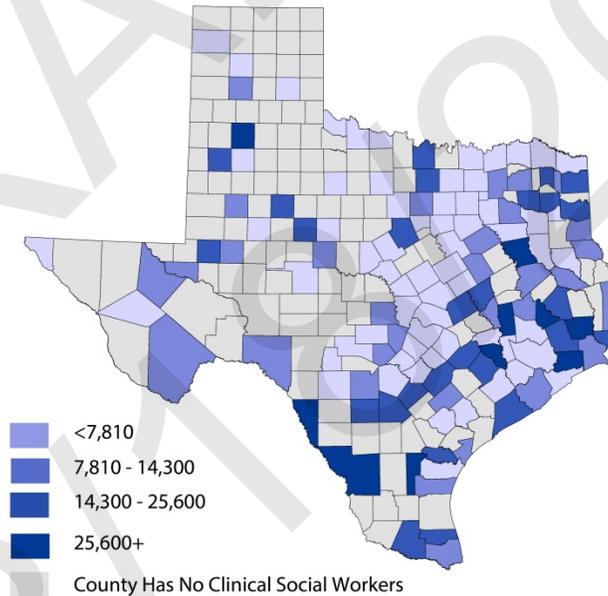
Among those licensed to practice psychology, 16.4 percent were 65 years old or older and 24.7 percent were between 55 and 64 years of age, percentages slightly lower than those of clinical psychologists.

Clinical social workers

Clinical social work is the use of social work knowledge and skills to apply professional theory, knowledge, and methods to restore social, psychosocial, and bio-psychosocial functioning. In September 2013, there were 6,316 licensed clinical social workers in Texas. 4,119 (65.2 percent) of these were in the state’s five most populous counties while the remainder were in Texas’ other 249 counties, with corresponding population-to-provider ratios of 2,809:1 and 6,870:1, respectively.

Geographic Designation	Population per Clinical Social Worker
Metropolitan, Non-Border	3,642
Metropolitan, Border	9,950
Non-Metropolitan, Non-Border	11,056
Non-Metropolitan, Border	23,779
Texas	6,316

Population per Clinical Social Worker
by Texas County



The number of clinical social workers in Texas increased at an average annual rate of 4.3 percent from 2008 to 2013, yet the effective annual growth rate was only 2.3 percent when population growth is considered.

In the case of clinical social workers in 2013, 19.1 percent were 65 or older while 29.5 percent were between 55 and 64. Thus, 48.6 percent of clinical social workers will be of retirement age within the following decade. Race/ethnicity data were not available for clinical social workers.

Social workers (All)

HRSA definitions allow for only clinical social workers to be considered as CMHPs. However, Texas’ total social worker workforce is also larger than the clinical subset described above. In fact, there were 18,785 social workers in 2013.

Geographic Designation	Population per Social Worker (All)
Metropolitan, Non-Border	1,300
Metropolitan, Border	2,076
Non-Metropolitan, Non-Border	2,158
Non-Metropolitan, Border	4,476
Texas	1,420

When considering all social workers, 11.3 percent were 65 years old or older and 23.4 percent were between 55 and 64 years of age. These percentages are lower than those of clinical social workers.

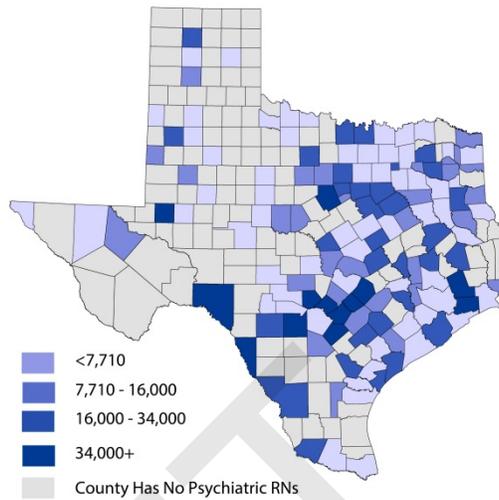
Psychiatric nurses

Nationally, there has been a shortage of psychiatric/mental health nurses since the 1980s. The 2004 National Survey Sample of Registered Nurses showed that younger nurses preferred clinical over psychiatric/mental health settings, that fewer total younger nurses were entering the workforce, and that psychiatric/mental health nurses were older than the workforce at large (Delaney, 2012). As of September 2013, there were 188 clinical nurse specialists (CNS) in Texas⁹ specializing in psychiatry/mental health. These 188 CNSs would be recognized as CMHPs for mental health HPSA designations. There are an additional 274 nurse practitioners with psychiatric/mental health specialties. There are a total of 5,657 registered nurses (RN), including CNSs and NPs) reporting psychiatric/mental health/substance abuse as their practice specialty.

Geographic Designation	Population per Psychiatric RN
Metropolitan, Non-Border	4,499
Metropolitan, Border	7,003
Non-Metropolitan, Non-Border	4,525
Non-Metropolitan, Border	47,558
Texas	4,714

⁹ The Texas Center for Nursing Workforce Studies, housed within DSHS’ Center for Health Statistics, conducts ongoing research on the state’s nursing workforce shortage. More information on this element can be obtained at www.dshs.tx.us/chs/cnws/.

Population per Psychiatric RN
by Texas County



Among clinical nurse specialists and nurse practitioners specializing in psychiatry or mental health, 52.6 percent were aged 55 or more years and 20.6 percent were already 65 or older. Among all registered nurses with psychiatric specialties, 47.4 percent were 55 or older and 13.5 percent were 65 or older.

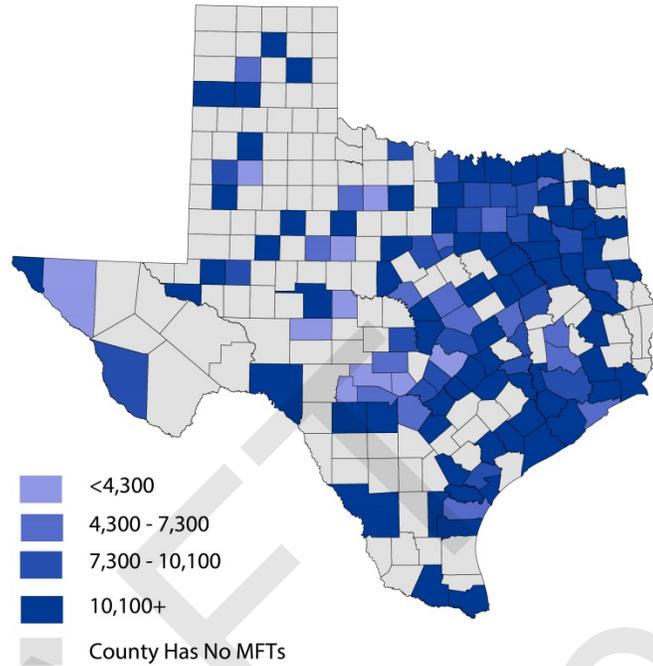
The vast majority of clinical nurse specialists and nurse practitioners with a psychiatric focus were white (72.3 percent), with African-American (10.4 percent) and Hispanic (10.0 percent) the next most common categories. Among registered nurses with a psychiatric focus, 60.8 percent reported being white, 18.3 percent reported being African-American, and 10.2 percent reported being Hispanic.

Marriage and family therapists

There were 3,062 marriage and family therapists (MFTs) practicing in Texas as of September 2013, giving a ratio of 8,708.2 persons per MFT. Within the state’s five most populous counties the population to MFT ratio was 6,442:1 while it was 11,923:1 in the rest of the state, comprising proportions of 41.35 percent and 58.65 percent, respectively.

Geographic Designation	Population per MFT
Metropolitan, Non-Border	7,435
Metropolitan, Border	32,269
Non-Metropolitan, Non-Border	19,998
Non-Metropolitan, Border	95,116
Texas	8,708

Population per MFT
by Texas County



In 2013, 27.7 percent of MFTs were 65 or older and another 31.8 percent were between 55 and 64 years old, meaning that 59.6 percent of the workforce will be of retirement age by 2023. Finally, average annual growth of the MFT workforce in Texas has been 1.8 percent from 2008-2013. Yet when considering population growth, there has been just 0.2 percent average annual growth.

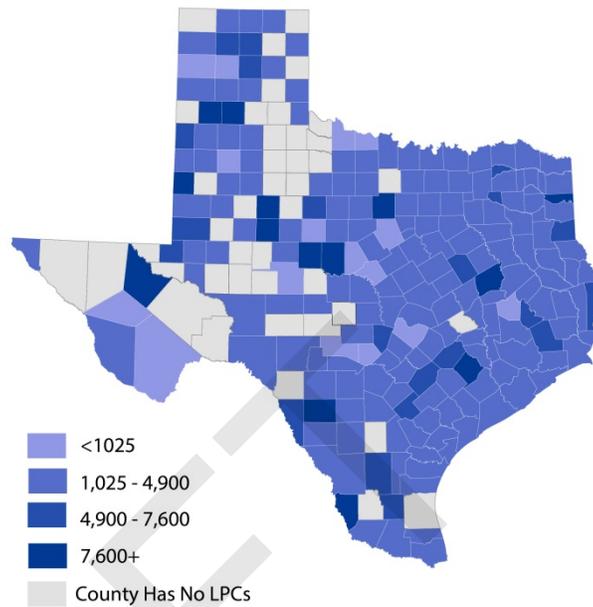
Licensed professional counselors

Licensed professional counselors (LPCs) are licensed by DSHS and perform a wide range of counseling services that utilize wide-ranging methods and strategies to help clients achieve mental, emotional, physical, moral, social, educational, spiritual, and/or career development and adjustment (Title 22, Texas Administrative Code, Chapter 681).

In September 2013, there were 18,641 licensed professional counselors (LPCs) in the state, giving a population to provider ratio of 1,430. The five most populous counties had a population to provider ratio of 1,221 while the rest of Texas had a ratio of 1647.1.

Geographic Designation	Population per LPC
Metropolitan, Non-Border	1,290
Metropolitan, Border	2,674
Non-Metropolitan, Non-Border	2,190
Non-Metropolitan, Border	3,963
Texas	1,430

Population per LPC
by Texas County



This field has had average annual growth of 5.47 percent from 2008 to 2013 and yearly growth over 5.5 percent from 2009 to 2013. Moreover, only 14.9 percent of the workforce was over 65 years old and just 22.9 percent was 55 to 64 years of age, meaning just 37.8 percent will be eligible for retirement by 2023.

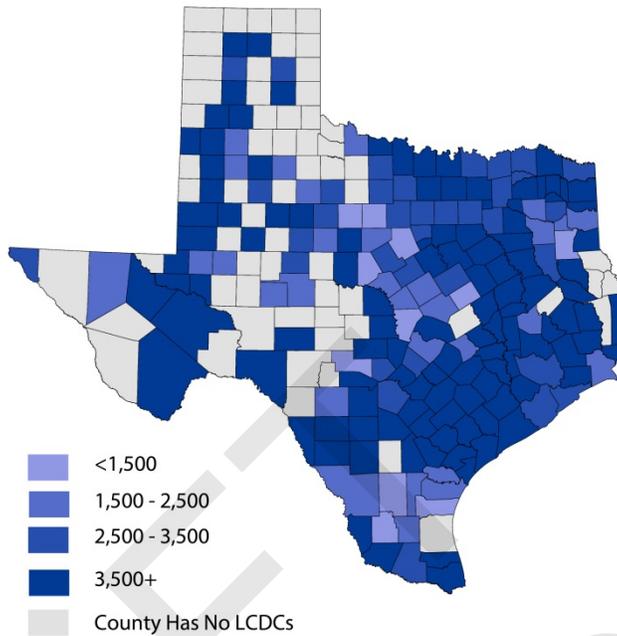
Licensed Chemical Dependency Counselors

Licensed chemical dependency counselors are licensed by DSHS and provide clients with a planned, structured, and organized chemical dependency program designed to initiate and promote a person's chemical-free status or to maintain the person free of illegal drugs (Title 25, Texas Administrative Code, Chapter 140).

There were 8,743 licensed chemical dependency counselors (LCDCs) in Texas in September 2013, with 3,974 of these (45.5 percent) practicing in Texas' five most populous counties. The corresponding population-to-provider ratios were 2,912 in these most populous counties and 3,165 in the rest of the state.

Geographic Designation	Population per LCDC
Metropolitan, Non-Border	2,986
Metropolitan, Border	3,069
Non-Metropolitan, Non-Border	3,421
Non-Metropolitan, Border	4,816
Texas	3,050

Population per LCDC
by Texas County



LCDCs have shown average annual growth of 4.7 percent from 2008 to 2013 with growth above 4.5 percent each year between 2009 and 2013. However, the population-to-LCDC ratio had lower average annual improvement of 2.5 percent over this period. In September 2013, 11.6 percent of the workforce was 65 years of age or older and 25.9 percent was between 55 and 64, totaling 37.5 percent eligible for retirement within ten years.

Community health workers/Promotores

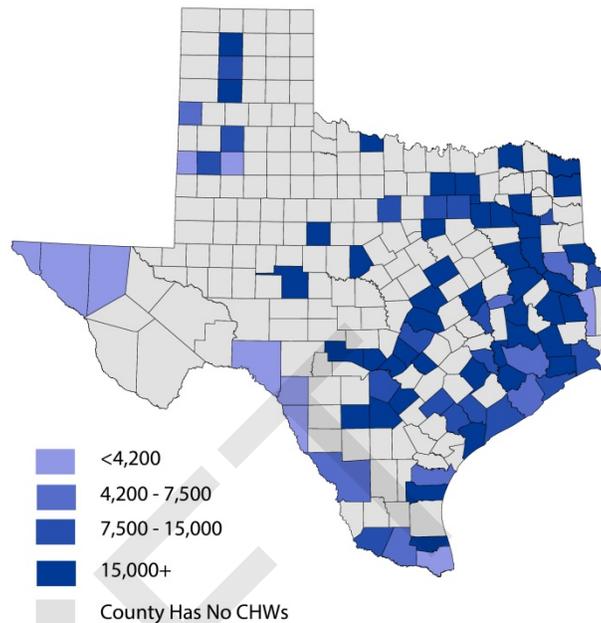
Community health workers (CHWs), or *promotores*, are certified by DSHS. These practitioners serve as liaisons between health and social services and community members, helping to bridge ethnic, linguistic, and socioeconomic divides. CHWs help community members access services and build capacity through a variety of activities.¹⁰

In 2013, there were 2,406 certified CHWs in Texas and annual growth was above 20 percent each year from 2009 to 2013. Over this same period, the ratio of population to CHW has improved an average of 22.4 percent

Geographic Designation	Population per CHW
Metropolitan, Non-Border	11,910
Metropolitan, Border	4,805
Non-Metropolitan, Non-Border	39,416
Non-Metropolitan, Border	6,137
Texas	11,083

¹⁰ More information on CHW duties and certification can be found at: <http://www.dshs.state.tx.us/mch/chw.shtm>

Population per CHW
by Texas County



Certified peer specialists

A growing national and state trend involves people in recovery from mental illness acting as certified peer specialists (CPS) to provide support to others in treatment. DSHS has helped fund ViaHope, an organization that provides training and certification to CPSs. According to ViaHope, there were 333 CPSs in January 2014 and the organization had conducted 19 total trainings in Austin, Dallas-Fort Worth, San Antonio, Houston and one in East Texas.

Certified family partners

Similar to CPSs, certified family partners (CFP) are parents or guardians experienced in raising a child with mental or emotional issues who are certified to help other parents navigate the system of care. ViaHope also runs the CFP training and certification program. This program has produced 99 CFPs as of January 2014.

Substance abuse recovery coaches

Serving as a recovery coach (RC) is a form of strengths-based support for persons with substance use disorders or in recovery from alcohol or other drugs and who may also have other mental health issues. These trained individuals offer shared living experiences to assist persons with active addictions as well as persons in recovery.

DSHS' Substance Abuse Program Services program developed the Recovery Coach Training of Trainers curriculum with the assistance of four non-profit organizations. These organizations assist trained individuals in obtaining paid or volunteer positions as RCs in places like treatment centers, hospital emergency rooms, and community and faith-based organizations. Using the DSHS curriculum and funding, these four organizations trained over 100 individuals in Fort Worth, San Antonio, Corpus Christi, and Beaumont. These 100 RC trainers have since trained

over 300 individuals as recovery coaches as of February 2014. This ongoing training process provides a supportive workforce for the healthcare industry.

Through DSHS' Substance Abuse Program's Texas Recovery Initiative, RCs have the opportunity to become certified as a Substance Abuse Peer Recovery Support Specialist through the Texas Certification Board of Addiction Professionals (TCBAP) upon meeting TCBAP requirements.

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Appendix B: Stakeholder Feedback

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Appendix C: List of Acronyms

BRFSS: Texas Behavioral Risk Factor Surveillance System

CFPs: Certified family partners

CHWs: Community health workers

CLAS Standards: National Standards for Culturally and Linguistically Appropriate Services

CMHP: Core mental health providers

CPSs: Certified peer specialists

DSHS: Department of State Health Services

DSRIP: Medicaid 115 Waiver Delivery System Reform Incentive Payment Program

FTP: Federation of Texas Psychiatry

HHSC: Health and Human Services Commission

HPSA: Health Professional Shortage Area

HRSA: Health Resources and Service Administration

LCDCs: Licensed chemical dependency counselors

LPCs: Licensed professional counselors

MFTs: Marriage and family therapists

NASW-TC: National Association of Social Workers – Texas Chapter

PPACA: Patient Protection and Affordable Care Act

RC: Recovery coach

SHCC: Statewide Health Coordinating Council

TAPA: Texas Association of Psychological Associates

TCA: Texas Counseling Association

TCBAP: Texas Certification Board of Addiction Professionals

THA: Texas Hospital Association

THECB: Texas Higher Education Coordinating Board

TMA: Texas Medical Association

TPS: Texas Pediatric Society

YRBSS: Texas Youth Risk Behavior Surveillance System

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