BEHAVIORAL HEALTH NEWS

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FROM THE LOCAL, STATE, AND NATIONAL NEWS SCENE

SUMMER 2019

http://www.mhnews.org/

The Behavioral Health Workforce "Crisis": Past, Present, and Future

By
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"The Workforce Crisis Today" is first on the list of possible topics for this issue of *Behavioral Health News.* That's interesting because the workforce "crisis" is anything but new.

For example, when I first entered this field during the height of deinstitutionalization in New York—the early 1970s—there was a vast shortage of English-speaking psychiatrists in the state hospital system. Having the proper credentials was good enough at the time. Never mind being able to communicate with one's patients; there was paperwork to be signed.

Fortunately, progress has been made. The problem now is finding psychiatrists who speak languages other than English and who have real clinical and cultural competence, especially regarding kids and older adults.

Of course, it was even worse in the years before deinstitutionalization. Staff-patient ratios in state hospitals were often 1 staff to 8 patients. And the quality of the staff—the attendants and others—was often abysmal. Some were lovely, caring people, no doubt, but some were abusive in the extreme and clinically incompetent. Now a minimum is more like two staff per patient. And abuse, especially the officially sanctioned abuse of the old days such as harsh restraint and punitive seclusion has been significantly reduced if not eliminated. Much better.

How did they manage in the old days? The patients did much of the work. They cleaned the hospitals, cut lawns, cooked meals, chauffeured the hospital directors, and so forth. Not to mention the never mentioned therapeutic services they provided to their fellow patients on the wards. An underground of peer services goes back a very long time.

So, to say it again, a mental health workforce crisis is not new. And since the beginning of the community mental health movement, many somewhat successful efforts have been made to address both the shortage of mental

health personnel and their limited clinical, cultural, and—I would add—generational competence.

These efforts fall into three broad categories—education and training, recruitment, and de-professionalization (a positive in my view).

Education and Training

I will not say much about education and training. Professional schools, particularly, have increasingly provided education in "evidence-based" practices that probably have better outcomes than intuitive clinical practice. And training programs abound. In New York, for example, social workers—who provide most the nation's mental health services—now are required to get continuing education credits. New training is flourishing, much of it on-line, just one example of how new technology can contribute to improved professional—and paraprofessional quality.

Recruitment

Recruitment, of course, is key to increasing the size of the mental health workforce. And critical to this is **HIGHER PAY**—especially for "lower level" staff. It is appalling that residential counselors and case managers without a master's degree can sometimes make more money flipping burgers at MacDonald's than they can providing vital services for people with serious mental illness. And it is appalling that some social workers and mental health counselors with master's degrees have to moonlight as servers in restaurants to get by. And **the indifference of government, which relies on professionals and paraprofessionals working in not-for-profit organizations to fulfill its obligations to people with behavioral health conditions, is sad in the extreme.**

But pay is not the only way to attract people to vital jobs. Loan forgiveness, in a nation in which most people go into debt to get an education, is frequently on the recruitment agenda. Unfortunately, it's on the recruitment agenda for every vital, but not terribly popular, job, creating huge competition for the little money that is made available to help people pay off their loans.

Beyond the money issues, recruitment depends on creating the sense that work in the field of behavioral health opens up a range of professional and career opportunities—that include increasing pay over time, the expectation of promotions to supervisory and management positions if desired, and access to experiences that add value to the work professionals do such as participating in research, attending conferences, publication, etc. Unfortunately, such opportunities often require very high levels of education and jobs devoted less to service than to academics, so they are effectively closed off to the very workers for which the system has a crying need.

In addition, the mental health professions face a problem of social status. I don't want to overstate this. There are some high-status roles, being a psychotherapist, for example. But psychiatry is apparently a lower status role among physicians, and social work, for sure, doesn't get the kudos it deserves.

How to increase the social status of behavioral health work is a tough question. I have always thought it would be useful to have positive images in the movies and on TV. But it strikes me that psychiatrists and social workers, among others, are often ridiculed in the popular media. We need far better public relations!

De-professionalization

Finally, the shortage of professional staff has been, and can continue to be, addressed by "unbundling" functions and thus de-professionalizing them. For example, in the medical world in general, there are now nurse practitioners, physician assistants, and administrative staff who have taken over part of the workload of physicians.

In psychiatry there has been a vast change since I entered the field 50 years ago. Then, psychiatrists not only did diagnosis and treatment planning; they also did virtually all of the individual treatment while social workers handled families and life planning. Now, most treatment is provided by social workers. Psychiatrists still do some treatment—especially in private practice—but in organizational settings such as clinics, psychiatrists more and more oversee treatment, handle difficult diagnostic questions, prescribe and monitor medication, and do assessment of homicidal and suicidal risk. Quite a change!

Social work has also changed. Many years ago, it created a Bachelor's in Social Work degree (BSW) so as to step down some of the work that social workers previously had done—especially case management and dealing with the concrete needs of people having a tough time managing to lead safe and satisfying lives. Whether this was a wise change is still open to debate, but it has unquestionably been a way to provide more service to more people.

Can more functions of psychiatrists and other professionals be unbundled and turned over to other professional or paraprofessional staff? I have no doubt that this is possible. For example, I believe—and this is very controversial—that psychologists, nurses, social workers, and mental health counselors can all be trained to prescribe psychiatric medications and that, with appropriate training, they can be relied on to sign off on treatment plans that now call for psychiatrists. This would not be a total response to the lack of psychiatrists in many locales in the United States, but it would help.

Looking Ahead

Prediction is notoriously uncertain and arrogant. But here's a few stabs at how the behavioral health workforce will evolve.

First, there will be continuing unbundling/de-professionalization of roles.

Second, this will include increasing use of peers to provide services hitherto not seen as part of their bailiwick.

Third, technology will be used in increasingly innovative ways, not just to provide communication with traditional providers but also to provide innovations that will be therapeutic in effect and designed to address the social determinants of behavioral health conditions.

And fourth, old people—like me—will increasingly be seen as being able to provide help and not only as people in need of help. We can become a vital part of the mental health workforce both as paid, experienced workers and as volunteers.

Details, of course, need to be filled in. Another time, perhaps.

(Michael B. Friedman, MSW has been working in the field of mental health for over 50 years—as a direct practitioner, an administrator, and largely as a mental health advocate. He taught health and mental health policy at Columbia School of Social Work for twenty years. He has just moved to Baltimore to spend more time with his grandchildren, who are, of course, cuter than most. He will also continue writing and will take on new adventures yet to be determined. He can be reached at mbfriedman@aol.com.)