



Workforce Series: Rural Behavioral Health

Recruitment and Retention of Quality Health Workforce in Rural Areas: A Series of Policy Papers on the Rural Health Careers Pipeline, Paper #5.

I. Background

Approximately 62 million people, or 20-23% of the United States' overall population, live in rural areas, distributed over 75% of the country's land mass^{1,2,3,4,5}. Of those, recent estimates indicate that 16-20 percent or "at least 15 million rural residents struggle with significant substance dependence, mental illness, and medical-psychiatric comorbid conditions."⁵ The term "Behavioral Health" was first used in the 1980's to name the combination of mental health and substance abuse. Because both mental health and substance abuse issues need to be addressed through specific policies designed for rural populations, this policy brief will generally use the broader term of behavioral health. While recent studies indicate that the prevalence and incidence of behavioral health problems are similar in rural and urban areas, a notable exception is the significantly higher rate of suicide and suicide attempts in rural America. For rural elderly residents in some regions, the rate is 3 times higher than the national average in non-rural settings. In addition, rural residents experience many more obstacles to obtaining behavioral health services, which results in distinct mental health disparities. "The mental health needs of rural America are immense, and it is increasingly recognized that the implementation of adequate services in non-metropolitan areas is a critical national health imperative"⁵.

II. Status of Behavioral Health and the Associated Workforce in Rural America

Who are the health care professionals that we should be talking about when we address the issue of rural behavioral health care? The following is a list of those who are trained in mental health care and /or substance abuse and those who may not be trained, but will likely be called upon to deal with people requiring such care:

- Psychiatrist
- Primary Care Physician
- Adolescent Psychiatrist
- Psychiatric Physician Assistant
- Psychiatric Nurse Practitioner
- Psychologist
- Social Worker
- Substance Abuse Counselor
- Marriage/Family Therapist
- Emergency Room Nurse
- Emergency Room Physician
- Emergency Medical Technician
- Case Manager
- Counselor
- Behavioral Health Aide

Since more research has been done on the issue of rural physician practice than other health professions, it is helpful to examine there and extrapolate that information to all types of behavioral health providers. Only 9-11% of physicians practice in rural America^{1,2,3,4,5,6,7,8}. The more specialized the medical discipline, the less likely the physician will be in a rural setting^{9,10}. In particular, psychiatrists are less likely to practice in a rural area. This can be seen in the disproportionate number of vacant psychiatrist positions in federally funded Rural Community Health Centers⁷ and the marked disparities in the number of practicing psychiatrists between rural and urban areas^{11, 12}.

Although national data suggest that the prevalence of clinically defined behavioral health problems among the adult population is similar in rural and urban settings^{13, 14}, the availability of behavioral health services is limited for people living in rural and frontier communities^{1,2,5,6,15,16,17,18,19,20}. The majority of Mental Health Professional Shortage Areas (MHPSAs) are in rural counties. “Among 1,253 smaller rural counties with populations of 2,500 to 20,000, nearly three-fourths of these rural counties lack a psychiatrist, and 95 percent lack a child psychiatrist” (6 p.97, 18). An estimated 2/3 of U.S. patients with clinical symptoms of mental illness receive no care. Of those who receive formal treatment, approximately 40% receive care from a mental health specialist and 45% from a general medical practitioner^{21,22}. Due to the lack of specialty behavioral health care, primary care caregivers provide a large proportion of behavioral health care in rural America^{6,18,19,23,24,25,26,27}.

Many factors influence the delivery of rural behavioral health care. These include dual and overlapping relationships, caregiver stress and isolation, limited availability and access to behavioral health resources, stigma, and economic issues.

The most commonly cited variable is that of overlapping, (dual) relationships^{28,29,30}. The geographical and social structure of rural communities creates multiple relationships. A behavioral health professional might be called upon to treat a neighbor or find that his/her knowledge of a particular patient’s case impacts on interactions with in other settings. For example, a social worker who is also a member of the town’s school board, discovers during a family meeting that a schoolteacher has missed many teaching days because of a significant alcohol problem. The presence of alternative clinicians and facilities in urban areas fosters clearer and separate personal and professional boundaries^{5,6,28,29,30,31,32,33,34}.

Because there are few mental or behavioral health professionals, if any at all, in small rural communities, everyone tends to know the resident as a behavioral health provider in addition to his/her other roles in the community^{23,31,32,35,36,37,38}. A rural behavioral health provider is likely to be isolated from other behavioral health professionals and thus have limited opportunities to discuss ongoing issues³⁹. Combined with immense clinical responsibilities, these factors may lead to increased caregiver stress^{5,28}.

Stigma regarding mental illness and substance abuse is particularly significant in rural settings^{6,40,41}. Living in a small, isolated rural community where everyone knows each other heightens the stigma. As a result, a patient may refuse to go to the behavioral health provider’s office because everyone will recognize his truck. Rural residents may be uncomfortable with the prospect of disclosing information to a behavioral health care provider or not seek necessary care^{6,23,41,42,43,44,45,46}, leading to under-diagnosis and under-treatment of behavioral health disorders. Such stigma can also undermine the quality of care as well as the provider-patient relationship⁵. Cultural, religious, and personal values of rural residents influence health care decision-making. These values include self-reliance, self-care, a strong work ethic, and a unique perception of health and illness. Rural residents may be more likely to make use of informal supports such as neighbors, family, churches, and other community groups³⁰. While this may apply in certain urban neighborhoods, it can be characteristic of entire rural communities^{5,28,47}. Behavioral health professionals trained only in urban settings may be poorly prepared to understand these rural cultural characteristics.

Decreased population density impacts on rural behavioral health care because of the distance patients may need to travel to access other mental health professionals and facilities^{5,6,30}. Distance to such services can be problematic due to the lack of public transportation, challenging roads, and environmental and climatic barriers such as mountain ranges or extreme weather conditions³². When rural patients need to be admitted or transferred to an urban facility, prohibitive obstacles might be faced, such as distance, reluctance to receive care in a “far away” and unfamiliar city, and knowing that one’s family and friends might be less able to travel to provide support^{5,28,30,48}.

Economic factors influence rural behavioral health care. Rural populations have a lower income per capita², and in most rural areas, a higher percentage of people living below the poverty level compared to their urban counterparts^{49,50}. In 2000, the prevalence of rural children living in poverty in “non-metro areas” ranged between 18-23%⁵¹. Rural residents, under the age of 65, are more likely to be underinsured and uninsured⁵².

General health status is poorer in rural areas. Although the rural population has about the same age-adjusted mortality rate as the urban population¹, rural residents experience higher rates of infant mortality⁵³ and morbidity^{54,55}. Rural communities have a higher proportion of vulnerable residents, specifically children (5-17 years old) and the elderly (65+), who require more health services⁵⁶. In addition, those living in rural and remote frontier regions are more likely to have chronic health problems and poorer health status compared to their urban counterparts^{5,28,57}.

These factors suggest that the practice of rural behavioral health is fundamentally different from behavioral health practice in urban or metropolitan settings, and a disparity exists in the number of behavioral health professionals practicing in urban and rural areas. An increased emphasis on rural practice during professional training could contribute to overcoming barriers to providing quality mental health care in rural settings^{6,23,24}, including the number of behavioral health professionals choosing to practice in rural communities. In addition, those providers such as primary care physicians, nurses and Emergency Medical Technicians, who practice in rural areas, should also receive continuing education in how to address mental health and substance abuse issues, as they are often the only source of help available.

At a March 2008, National Organization of State Offices of Rural Health conference on “Rural Health Workforce Trends,” the following challenges/questions regarding rural behavioral health care were identified as being the only tip of the iceberg when focusing on the delivery of adequate behavioral health care to U.S. rural and frontier residents⁵⁸.

- How do we determine who is able to practice or provide mental health care? Rules and legislation vary from state to state and licensure lists do not actually reflect who is able to practice.
- Although there is a great need for behavioral health providers of all types in rural areas, where are the employment opportunities? We do not know enough about the demand, especially by occupation/type of provider.
- How will behavioral health providers of all types be reimbursed? Which type of providers can direct bill and which cannot?
- In small rural and frontier areas where there is a great deal of stigma attached to behavioral health problems, how do we provide services for both those who are chronically mentally ill and those who need acute services only, especially given the growth of adolescent behavioral health issues?
- Should we be encouraging greater utilization of telepsychiatry, based on measures of its effectiveness, and what are the reimbursement issues?
- What is the impact of the current large number of returning veterans to rural areas on the supply of behavioral health providers employed by the Veterans Administration?

III. Rural Behavioral Health Workforce Recruitment and Retention Issues

A. Interrelated issues hindering workforce recruitment

The Omnibus Budget Reconciliation Act of 1981 (PL 97-35) shifted funding responsibilities from the federal government to the state mental health agencies^{59,60}. This shift resulted in significant strains on state resources to provide mental health services in both metropolitan and rural areas. Compounded by court-ordered deinstitutionalization of state mental hospitals resources dwindled, resulting in a serious and persistent problem in local communities attempting to deal with severe, chronically mentally ill patients, and taxing a local, community-based system that was being eroded by state funding cuts⁶¹. The community-based mental health system began imploding. As a result, incentives under the community-based system evaporated and workforce shifts occurred towards the more populated, better paying environments of middle to upper-middle class America. Without adequate funding for rural communities, behavioral health services declined dramatically. Psychiatrist, Clinical Psychologists, Clinical Social Workers, Psychiatric Nurse Practitioners and Behavioral Health Counselors had little or no incentive to remain in rural environments. As a result, “Many rural and low-income urban areas have experienced persistent shortages of these resources, creating barriers to access that lead to poor health and mental health outcomes”⁶². In 1992, Congress abolished the Alcohol, Drug Abuse and Mental Health Administration and created the Substance Abuse and Mental Health Services Administration. The goal was to improve quality and access to mental health and substance abuse treatment services, as well as to develop and promote models and strategies for training and education. “In spite of this, the agency appears to have only limited resources available for direct support of clinical training or for workforce planning and development activities”⁶³.

Over the years, the federal government has instituted several programs in an attempt to address rural health workforce shortages. These programs include the National Health Service Corps, shortage area designations such as the Health Professional Shortage Area (HPSA) and the Mental Health Professional Shortage Area (MHPSA), the Graduate Medical Education National Advisory Committee, and the J-1 Visa Waiver Program. While all of these program have had measured success, significant gaps remain concerning access to rural behavioral health care.

B. Factors influencing workforce retention

In a 1995 study Lambert and Agger concluded that “Shortages of mental health professionals appear to be an important factor affecting access to and utilization of mental health services for residents of rural communities”⁶⁴. They identified lack of organizational support, professional isolation, and limited income generation as major detriments to mental health providers remaining in rural settings. Another study identified work-related issues, as opposed to lifestyle and personal issues, as being important for retention of rural mental health workers⁶⁵. The Hogg Foundation for Mental Health completed a study in 2007⁶⁶ which identified the following trends:

- a 7.3% decline in the number of licensed social workers from 2000 to 2007
- a marginal increase of 0.8% in clinical psychologist during the same time period
- an 8.6% drop in psychiatrist. With its focus on the state of Texas, this study also found little cultural and linguistic diversity among providers and a lack of professional and continuing educational opportunities for mental health professionals. Professional staff turnover rates are currently at the 20% level, and workforce shortages in Texas are anticipated to continue into the future. Texas does not appear to be alone in experiencing these trends.

C. Significance of recruitment and retention issues

Behavioral health professional turnover rates in rural community settings have reached alarming rates. The 2007 Hogg study reported the rates of 23% for psychiatrists, 31% for advanced practice nurses, 23% for licensed professional counselors, and 25% for licensed clinical social workers⁶⁶. In addition to turnover, rural areas have serious shortages of doctoral trained mental health professionals⁶⁷. As a result of these shortages, rural residents must seek care from primary care physicians who may be poorly prepared to recognize and treat mental illness and behavioral disorders⁶⁸. In addition, due to the stigma attached to behavioral health problems and the absence of qualified trained behavioral health professionals, rural residents turn to non-traditional and often more poorly trained resources such as ministers, friends, and family⁶⁹. All of these factors culminate in a fragmented system of behavioral health care that lacks integration and consistency.

IV. Recommendations to Foster Rural Behavioral Health Workforce Recruitment and Retention

The section contains a number of concrete recruitment and retention recommendations many of which have demonstrated successful outcomes. While none of these solutions can be considered a panacea, taken together they have been effective in recruiting and retaining a significant number of beginning and experienced health professionals to practice in rural. Given the acute shortage of behavioral health workers in rural America, federal, state, and local government entities, that have a responsibility for ensuring appropriate access to behavioral health care services, would do well to consider funding and fostering as many such programs as possible. In order to deal with the great many diagnosed behavioral health patients that reside in rural areas and the even greater number of undiagnosed rural Americans, the time is now to begin concentrating our efforts on this immensely underserved, but critical part of our rural healthcare infrastructure.

A. Recruitment

Provide behavioral training for a wide scope of rural health professionals. Given the severe lack of rural behavioral health providers, generalists must often increase their scope of practice in order to accommodate the needs that exist in a typical rural population. As a result there is a great need to include behavioral health diagnosis and treatment in the training curricula for not only primary care physicians, but also nurse practitioners and physician assistants as well. These three professionals are the most likely source of regular medical intervention for those diagnosed with both acute and chronic mental illness and behavioral health problems, including drug therapy and ongoing maintenance of patient care. Because the wrap-around services, such as psychotherapy and counseling, are also being provided by licensed therapists and family counselors rather than psychologists, it is important that their training include at least an awareness of the kinds and types of behavioral health issues that are prevalent in rural areas and a thorough understanding of the resources that are available to patients in the local area.

Develop recruitment enhancements such as loan repayments, bonuses and other perks. There are several proven programs that can improve the recruitment and retention of healthcare professionals in rural areas. Scholarships and loan repayment programs have modest success, because they are attractive to both students and early careerists that do not necessarily have a preconceived notion about where they intend to live or work. Salary or payment bonuses for behavioral health professionals, based on a well-defined shortage designation program such as the Mental Health HPSAs, might also attract new providers. In the end, any solution that would enhance these professionals' ability to gain a competitive wage, retire their school-debt, or otherwise ease their transition into a rural practice setting would be a step forward, especially in the area of behavioral health, where reimbursement issues are generally greater than those related to physical health.

Establish relationships between health professional training schools and Critical Access Hospitals to create rural behavioral health practice training sites. Professional schools responsible for training behavioral health students should establish relationships with Critical Access Hospitals to develop mentoring and practice rotation programs that include a rurally-based training component which has proven to be helpful in establishing a comfort level with rural practice among health professionals. By providing training locations for behavioral health students, not only do they become more familiar with the types of diagnoses and treatment options that are specific to rural settings, but they are also given the opportunity to assist with actual rural patients and can better orient themselves to the local environment. Mentoring programs also give students access to seasoned professionals that have practiced in a rural area for an extended period of time. Casual conversations about the field of practice and the value and benefits of rural living are invaluable when it comes to overcoming stereotypes, apprehensions, and unfamiliarity.

Enhance availability of mental health coverage through telehealth. Telemedicine has proven to be an effective method of delivering mental health consults and follow-up treatment. By taking advantage of recent advances in computer technology and high-speed telecommunications, communities have been able to help close the distance that exists between rural areas, and the urban hospitals and large teaching facilities where highly-specialized care is being rendered. These telemedicine sessions allow psychiatrists and psychologists to test and observe behavioral disorders almost as effectively as a face-to-face consultation. Due to their ease of deployment and the time and effort that could potentially be saved by patients and providers, promoting the increased use of telemedicine could help to alleviate the access to care burden that many rural areas are facing. Such promotion must include addressing reimbursement issues around the remote provision of care.

B. Retention

Establish professional support mechanisms. Several key factors that affect the ongoing retention of healthcare professionals have to do with the professional support they can expect to receive once they have elected to begin a rural practice. At that point, connecting with peers and maintaining their educational credentials become an important part of their satisfaction with their career. Building a network of rural behavioral health professionals and ensuring their participation in the overall healthcare provider community will help to prevent them from feeling disengaged. Ensuring that professional societies, Areas Health Education Centers, state behavioral health agencies, and local behavioral health authorities include rural professionals in their program planning and activities will help to create a robust network of support for those currently practicing in smaller, isolated rural communities.

Provide coverage for time-away. As with a great many rural health professionals, the ability to take time away from their practice and their community can help with retention. A behavioral health emergency can strike at any time of the night or day and both local law enforcement and hospital emergency rooms benefit tremendously from having a trained behavioral health expert in their community. However, these communities must provide and encourage time away for behavioral health providers to attend to both their personal well-being and their professional pursuits, such as continuing education and networking. Strengthening behavioral health providers' ability to cope with and more effectively treat patients, with whom they are often already familiar, is another key to retention.

C. Recruitment and Retention

Build capacity within rural communities to recruit and retain behavioral health professionals. A variety of programs have been implemented in rural America to help rural communities enhance their potential to attract and keep health care professional. An example that has had some success is the Recruitable Community Program (RCP), initiated in 1998 by the University of West Virginia Department of Family Medicine to focus on increasing rural communities ability to

recruit medical providers through community development and increased knowledge of recruitment and retention issues. To stabilize West Virginia's rural health care infrastructure and improve access to quality health care services, the RCP developed a collaborative relationship with the Division of Rural Health (DRH) within the Office of Community Health Systems, Bureau for Public Health, Department of Health and Human Resources, and has transferred the program to the DRH. This unique project, with its focus on the role of the "community" in the recruitment and retention of health professionals, helps selected rural communities by:

- Providing the communities with community development and health care expertise through a valuable community assessment and recommendations for enhancing current recruitment techniques.
- Assisting with the organization of a community recruitment effort.
- Strengthening community ties to training programs.
- Enhancing the general appeal of community, thereby facilitating the Retention and Recruitment of Health Care Professionals.

V. Summary

President Bush's 2002 New Freedom Commission on Mental Health was convened to investigate the problems and possible solutions in the current mental and behavioral health system. The Commission reported that the vast majority of Americans living in underserved, rural, and remote areas experience disparities in mental health services compared with their urban counterparts. The Commission concluded that "...rural issues are often misunderstood, minimized, and not considered in forming national mental health policy. Too often, policies and practices developed for metropolitan areas are erroneously assumed to apply to rural areas"⁷⁰.

State and national policy makers cannot continue to operate under a consistent and pervasive misunderstanding of rural realities regarding access to behavioral health care. The themes of rural behavioral health have remained constant over the past 20 years and more. Mounting needs, a lack of available behavioral health providers, and restricted/limited resources strain existing services and limit access to rural residents in need⁷¹. Only policies aimed at resolving the panoply of issues that have resulted in these long-standing themes can make any headway toward resolving them. Leadership is critically needed to develop comprehensive policies which do not perpetuate the tendency to seek a single policy solution to the bewildering array issues that surround the provision of quality behavioral health for America's rural residents.

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