Mental and Behavioral Health Needs Assessment

ADMINISTRATORS AND PRACTITIONERS SURVEY

Prepared for:
The Lincy Institute
University of Nevada Las Vegas

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Executive Summary

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Overview and Background of the Study

To assist The Lincy Institute in understanding mental and behavioral health workforce needs in Southern Nevada, the Cannon Survey Center (CSC) conducted a bi-modal (Internet and mail) survey of mental and behavioral health agency administrators and practitioners in Southern Nevada. CSC collected a total of 301 completed surveys from 53 administrators and 248 practitioners between June 19, 2013 and November 27, 2013.

Data Collection Methods

Sample Construction

The population sample of mental and behavioral health agency administrators was compiled from several publicly available community resource and referral lists of agencies that provide mental and behavioral health and substance abuse counseling services, including a list compiled by the Nevada Department of Health and Human Services and a list of Medicaid-approved service providers. A total of 334 agencies that serve Southern Nevada were targeted for the survey of agency administrators. The population sample of practitioners consisted primarily of mental health clinicians currently licensed (as of 2012) from their respective boards.

Survey Instrument Construction

To design the survey instruments for data collection, several existing workforce surveys were consulted. The end result was a pair of nearly-identical questionnaires with 31 questions for administrators and 23 questions for practitioners.

Data Collection

Data collection occurred in two phases: a preliminary online-only phase with a subset of the population, and a mail phase with a supplemental online option. The overall response rate for administrators and practitioners combined after adjusting for undeliverable cases was 21.2%. 
Results

Respondent Profile

The vast majority of respondents (89.1%) indicated that they are currently practicing in the field of mental health. Length of time respondents reported having worked in the field in Southern Nevada ranged from six months to 45 years. Nearly one in four (23.4%) reported five years or less, followed by 22.6% at six to ten years, and 20.1% with 21 years or more. A smaller percentage reported 11 to 15 years (19.3%); 14.6% reported in the 16 to 20 year range. Of those who provided an estimated time remaining in the field and area, 28.8% anticipated that this will be for five years or less, followed by 27.5% who estimated six to ten years of continued service to the area. Those who anticipated staying longer included 12.4% for an additional 11 to 15 years, 19.3% for 16-20 years, and 12.0% for more than 20 years.

A clear majority of respondents (75.3%) reported their gender as female. A small minority of respondents reported their age as less than 35 years (9.8% each). Roughly one in four (25.6%) were between 35 and 44, followed by 23.5% who were 55 to 64, 22.1% who were 45 to 54, and 18.9% who were 65 or older. The majority (78.9%) identified as Caucasian/White, followed by 12.6% who identified as African American.

A slight majority of respondents (58.8%) reported their highest academic degree as a master’s degree, followed by 19.6% with a bachelor’s degree, 15.7% with a doctoral degree, and the remaining 6% giving some other response. A small minority (7.8%) indicated being fluent in a language other than English, with Spanish being the most common secondary language. The most common licensures among respondents were Licensed Clinical Social Worker (30.4%), Licensed Marriage and Family Therapist (25.2%) and Licensed Psychologist (16.7%).

Respondent Position, Work Setting, and Populations Served

The most common positions among practitioners that responded were Licensed Clinical Social Worker (27%), Marriage and Family Therapist (23.8%), and Clinical Psychologist (17.7%). The remaining 31.5% serve in a wide variety of other positions. The most common types of settings or facilities within which respondents work were outpatient community mental health programs (46.2%), private practices (27.6%), and co-occurring substance abuse and mental health facilities (22.9%).

Clinical practitioners were far more likely than non-clinical respondents to indicate their workplace setting as a private practice (42.2% vs. 6.6%). Non-clinical respondents were more likely than clinical practitioners to indicate their workplace settings as being psychosocial rehabilitation facilities, residential programs, school programs, shelters, and therapeutic community programs. Clinical practitioners were more likely than non-clinical respondents to indicate that they provide services to individuals with mental health disorders. Non-clinical
respondents were more likely than clinical practitioners to indicate that they do not provide services to individuals with mental health or substance abuse disorders. A clear majority of respondents provide services to individuals with mental health disorders (83.1%) and/or to individuals with co-occurring substance abuse and mental health disorders (70.5%). A large minority of respondents indicated that they provide services to individuals with substance abuse disorders (42.4%).

Clinical practitioners were more likely than non-clinical respondents to indicate that they provide services to individuals with mental health disorders. Non-clinical respondents were more likely than clinical practitioners to indicate that they do not provide services to individuals with mental health or substance abuse disorders.

The vast majority of respondents indicated that they work with adults between the ages of 18 and 64 (86% or higher for each age group in this range). A smaller majority indicated that they work with adults age 65 and older (71.7%) or youth age 12 to 17 (67.6%). About half (50.5%) work with youth ages 6 to 11. About one in four (24.6%) work with very young children age 5 and under.

**Perceptions of Service Availability and Barriers to Care**

The majority of respondents indicated that all but one on a list of services are limited in Southern Nevada. The services most commonly identified as limited were community re-entry programs (82.7%), integrated services for people with mental illness and substance abuse/addiction problems (82.5%), and crises intervention services (81.0%).

The services most commonly identified as being not available were alternatives to hospitalization (13.0%), jail diversion programs (11.1%), prevention and screening services (9.0%), and community re-entry programs (8.9%). Psychotherapy was more likely than other services to be rated as adequate (46.3%) or outstanding (5.8%).

Responses among the majority of respondents indicate that the most frequently occurring barriers are lack of insurance (73.9%), long waiting lists (60.5%), and no outreach to people who are homeless (55.4%). These were followed by people needing services cannot afford the co-pay (49.6%), and lack of appropriately trained staff, including cross training in substance abuse/addiction issues (47.4%).

Administrators who indicated that they will be hiring two or more mental and behavioral health workers in the next 12 months were more likely than other administrators to indicate that their workplace setting is a psychosocial rehabilitation facility (77.8% vs. 16%) or therapeutic community program (37% vs. 4%). Clinical practitioners were more likely than non-clinical respondents to indicate that long waiting lists are often a barrier and less likely to indicate that this is not a barrier. Administrators who anticipate hiring two or more workers were more likely than those not hiring to indicate that no outreach to homeless is often a barrier.
**Workforce Training Needs**

The clear majority of administrators (77.4%) indicated that the workers they supervise have been trained on Cognitive-Behavioral Therapy, followed by 69.8% who have been trained on behavior modification. Roughly two thirds of respondents also indicated that employees have received Solution Focused Therapy (66%) and Strengths Based Therapy (66%).

The most common forms of training administrators desired for employees included Dialectical Behavior Therapy (58.5%), Exposure Response Therapy (56.6%), and Electronic Therapy (56.6%). These were followed by integrated substance abuse and mental health, pharmacotherapy, Reality Therapy, and the Minnesota Model (54.7% each).

The vast majority of practitioners (89.8%) indicated having been trained on Cognitive-Behavioral Therapy, followed by 81.2% who have been trained on behavior modification. Roughly three quarters of respondents also received training on family therapy (75.5%), Solution Focused Therapy (74.3%), Solution Focused Brief Therapy (73.1%), and psychotherapy or psychodynamic therapy (73.1%). About half of respondents (50.6%) indicated that they would like to receive training on electronic therapy, followed by 47.3% who indicated as such for community reinforcement, 46.1% for culturally-specific interventions, 46.1% for pharmacotherapy, and 45.7% for Dialectical Behavior Therapy.

**Workforce Demand**

The majority of respondents (65.5%) indicated that they feel there is a gap between the projected supply of mental health and substance abuse workforce employees and the demand. Elaborations indicate that this opinion is based on the current gap between supply and demand. When asked to ask what types of mental health workforce employees are needed in Southern Nevada, the majority of respondents indicated that psychiatrists (73%), licensed clinical social workers (61.2%), and substance abuse counselors (52.9%) are needed.

Clinical practitioners were more likely than non-clinical respondents to indicate that more physicians, physician’s assistants, and psychiatrists are needed in the mental and behavioral health workforce. They were less likely to indicate that clinical professional counselors, licensed social workers, and social workers are needed.

**Other Resources Needed**

When asked to elaborate on other resources that are important to help improve the mental health and substance abuse workforce in Southern Nevada, respondents gave a wide range of responses.
Recurring themes included: residential care, care for minors, and issues related to licensing and documentation for providers.

**Direct Workforce Measures**

Administrators were asked a series of questions regarding issues surrounding the current workforce in their respective agencies, particularly hiring and turnover. Only 5.7% of respondents indicated having no employees that could be classified as a mental health worker. Over one in five (22.6%) indicated having one or two such employees, over half (54.8%) reported having between three and 20 mental health workers as employees, and 17% reported having a larger group of between 21 and 150 employees.

About one in five respondents (20.8%) indicated that they have not hired mental health workers in the past 12 months. One in four (24.5%) have hired one such worker, while 39.6% have hired two to ten, and 15.1% have hired 11-36 mental health workers. Over one third (34%) indicate that they do not plan to hire mental health workers in the next 12 months. A small minority (13.2%) plan to hire one such worker, while 41.5% plan to hire two to ten, and 11.3% plan to hire 11-30 mental health workers in the next 12 months. Similarly, just over half (53.8%) of respondents indicated that their agencies will likely be growing in the next 12 months. Half (50.7%) reported that their agencies had difficulty filling vacancies. Reasons for difficulty were largely due to poor quality of applications (76.9%).

Over one third of respondents (36.5%) indicated that turnover among mental health workers has been a problem for their agencies. Leading reasons cited by respondents were that employees left to work for local competitors (57.9%), employees had complaints about salary or benefits (52.6%), and personal reasons (47.4%).