

Chapter 14: Workforce Development and Training

The purpose of this chapter is to describe workforce development and training, including existing resources, strengths of current programs, and needs. The chapter includes narrative information gathered through focus groups and personal interviews, as well as existing data from ODMHSAS and other sources.

A. Strengths/ Existing Resources

In order to improve the quality of behavioral health treatment in Oklahoma, the state legislature has enacted licensure credentials for seven types of behavioral health professionals, as listed in Exhibit 14.1. Most behavioral health professionals must achieve at least a Master's degree in their field, complete one to three years of supervised professional experience, and pass a state examination prior to becoming licensed.

<u>Exhibit 14.1. Licensure and Certification requirements for Select Behavioral Health Professionals</u>		
	Minimum requirements for State Licensure	Minimum requirements for State Certification
Social Worker	Bachelor's degree in Social Work plus two years post graduate experience and pass state examination, or a Master's degree in Social Work and pass state examination	N/A
Psychologist	Doctoral degree in Psychology plus two years supervised professional experience and pass state examination	Health Service Psychologist: licensed psychologist who also provides health services and has two years of supervised health service experience
Psychiatrist	Medical license.	Psychiatry is not separately licensed or certified by the State. However, most programs expect completion of a psychiatric residency and certification by the American Board of Psychiatry and Neurology.
Alcohol and Drug Counselors	Master's degree in behavioral science plus one year supervised work experience and pass state examination	Bachelor's degree in behavioral science plus two years supervised experience and pass state examination
Professional Counselors	Master's degree in a counseling field plus three years supervised professional experience and pass state examination	N/A
Marital and Family Therapist	Master's degree in marital and family therapy plus two years supervised professional experience and pass state examination	N/A
Behavioral Practitioner	Master's degree from a program in psychology plus three years supervised professional experience and pass state examination	N/A

As shown in Exhibit 14.2., the number of new behavioral health professionals licensed each year varies by type of licensure. Since FY 2001, the number of new Licensed Professional Counselors (LPC) has decreased by 65 percent, while the number of Licensed Social Workers has increased by 72 percent. Very few behavioral health professionals seek licensure as Marital/Family Therapists or as Behavioral Practitioners. The data for licensed Psychologists and Alcohol and Drug Counselors were not readily available. It should be noted that over the past six fiscal years, Oklahoma has a net loss of four psychiatrists with the non-renewal of licenses due to death, retirement, disciplinary action or moving out of state.

Exhibit 14.2. Number of New Behavior Health Licenses Awarded						
Year	Type of Licensure					
	Licensed Professional Counselor (LPC)	Licensed Marital/Family Therapist (LMFT)	Licensed Behavioral Practitioner (LBP)	Licensed Social Worker: All	Licensed/Certified Alcohol and Drug Counselor	Certified Psychiatrist
FY 2001	411	11	310	92	not available	22
FY 2002	309	15	8	89	not available	19
FY 2003	220	22	3	118	not available	24
FY 2004	158	18	2	112	not available	24
FY 2005	142	17	6	159	not available	22
Total Current Licenses	2,681	502	243	1,384	874	454
Sources: All information provided by means of personal correspondence. LPC, LMFT, and LBP information provided by Nena West with the State Department of Health. Licensed Social Worker information provided by Kandi Hoehner with the Oklahoma State Board of Medical Licensure and Supervision. Licensed/Certified Alcohol and Drug Counselor information provided by Stori Johnson with the Oklahoma Board of Licensed Alcohol and Drug Counselors. Psychiatrist information provided by Chris Maloney with the Oklahoma State Board of Medical Licensure and Supervision.						

Exhibit 14.3 shows information on the number of new social work licenses awarded between FYs 2001 and 2005. Social Work Licenses require a Master's degree, except in the case of Licensed Social Work Associate, which requires only a Bachelor's degree.

Exhibit 14.3. Number of New Social Work Licenses Awarded					
Year	Type of Licensure				
	Licensed Clinical Social Worker (LCSW)	Licensed Social Worker (LSW)	Licensed Master's Social Worker (LMSW)	Licensed Social Worker-Administration (LSW-ADM)	Licensed Social Work Associate (LSWA)
FY 2001	64	4	2	0	10
FY 2002	62	4	6	1	9
FY 2003	69	10	11	1	12
FY 2004	106	2	39	1	0
FY 2005	130	2	32	0	0

Source: Personal correspondence with Kandi Hoehner with the Oklahoma State Board of Medical Licensure and Supervision.

As ODMHSAS-funded outpatient agencies hire new staff, educational and licensure information is collected. According to this information, there is currently 2,183 staff whose primary type of service provided is psychological or counseling services. Of these, only 39 percent have a behavioral health license. The educational level of these staff, however, demonstrates that 62 percent have achieved a Master's degree, as noted in Exhibit 14.4. This exhibit also shows that 67 percent of all staff have achieved a Bachelor's degree or higher. Staff in the medical services tend to have the highest level of education, with 33 percent achieving a Doctorial degree, and staff comprising the "other services" category have the least education, with 56 percent having less than an Associate's degree.

Exhibit 14.4. Level of Education for ODMHSAS-funded Outpatient Service Staff

Level of Education	Primary Type of Service (PTS)											
	Psychological or Counseling Services		Other Services		Medical Services		Case Management Services		Administrative		Other Therapeutic Services	
	%	#	%	#	%	#	%	#	%	#	%	#
Less than High school	0.1%	2	3.9%	73	0.7%	5	0.0%	0	1.0%	5	1.7%	2
High school diploma/GED	1.3%	29	30.4%	569	12.3%	88	3.3%	22	19.3%	100	16.2%	19
College credits, no degree	2.5%	55	22.4%	420	11.7%	84	2.7%	18	23.4%	121	10.3%	12
Associate's Degree	1.6%	35	5.5%	103	20.9%	150	2.5%	17	7.3%	38	11.1%	13
Bachelor's Degree	29.0%	634	24.0%	449	13.2%	95	69.0%	463	21.4%	111	43.6%	51
Master's Degree	62.4%	1,362	12.5%	235	8.2%	59	21.6%	145	24.9%	129	15.4%	18
Doctorate	3.0%	66	1.3%	24	33.0%	237	0.9%	6	2.7%	14	1.7%	2
Total Staff in PTS	35.9%	2,183	30.8%	1,873	11.8%	718	11.0%	671	8.5%	518	1.9%	117

In order to provide continuing educational opportunities for behavioral health professionals, ODMHSAS sponsors an ever-increasing number of conferences and training sessions each year. As shown in Exhibit 14.5., the number of conferences and trainings sponsored by ODMHSAS has increased 169 percent beginning in FY2002. In FY 2006, the conferences with the highest attendance included: the 2006 Children's

Conference, the 2006 Substance Abuse Conference, the 2005 Consumer Conference, and the 2005 Best Practices Conference. The OHCA, ODMHSAS, and OFMQ provider training had one of the highest attendances for a training seminar in FY 2006.

Exhibit 14.5. ODMHSAS Sponsored Conferences and Trainings			
Fiscal Year	Total conferences & trainings	Total hours	Total participants
FY02	85	514	7962
FY03	119	758	9392
FY04	119	903	9386
FY05	182	1413	10547
FY06	229	1629	11403

B. Needs and Existing Barriers

The comments of focus group participants and personal interviews focused on five major areas of concern: barriers to recruitment and retention of highly qualified staff; the need for in-service training and continuing education that prepares staff to work in a person-centered, recovery-oriented service system; the need to bring a focus on recovery and person-centered services to graduate programs in the mental health and substance abuse fields; licensing and certification issues; and training on substance abuse and mental health issues for staff of other systems and agencies that interact with ODMHSAS clients.

Recruiting, Hiring and Keeping Staff

Providers across the state reported that they face a number of obstacles in recruiting, hiring and keeping good staff. Among the barriers identified are low salaries, the enormous paperwork burden which forces many staff to put in too much unpaid overtime, and, in the substance abuse area, a requirement for enhanced credentials without corresponding pay increases. “We have high counselor vacancy rates due to low salary rates,” one substance abuse program manager said. “We are not competitive with the private sector.” A supervisor in a System of Care agency said, “It is hard to find staff and it takes six months before they are good at it. Then they leave. They love the work but hate all the stuff the state makes them do.” A manager in a mental health program noted that he and his staff were so over-worked due to staffing shortages that they can’t find time to train and orient new staff once they get them.

Salaries for behavioral health professionals in Oklahoma are generally lower than those in surrounding states and compared to the nation as a whole, as demonstrated in Exhibit 14.6. In four of six professional specialties, Oklahoma ranks either at the bottom or close to the bottom within the region. One exception to this trend is the salaries for Licensed Marital/Family Therapists in Oklahoma, which rank higher than the nation and the surrounding states. However, this group has the smallest number of persons. Another

exception to this trend is the salaries of psychiatrists, who are also in short supply in Oklahoma.

Exhibit 14.6. Median Wage for Select Behavioral Health Professionals, Oklahoma Comparison with Surrounding States and Nation, 2005		
Location	Median Wage, May 2005	
	Hourly	Annual
Psychiatrists**		
Colorado	89.93	187,060
Kansas	83.66	174,010
OKLAHOMA	81.53	169,580
New Mexico	77.49	161,180
Missouri	73.28	152,420
NATION	70.26	146,150
Arkansas	68.64	142,780
Texas	63.06	131,170
Psychologist		
Texas	39.20	81,530
Kansas	38.43	79,940
Arkansas	37.78	78,580
NATION	35.70	74,260
Colorado	35.62	74,100
Missouri	33.94	70,590
OKLAHOMA	30.30	63,020
New Mexico	26.16	54,420
LMFT		
OKLAHOMA	28.73	59,760
NATION	20.34	42,300
Texas	19.71	41,010
Colorado	19.40	40,350
Kansas	18.14*	37,731*
Arkansas	17.83	37,090
New Mexico	17.31	36,010
Missouri	16.41*	34,132*
Mental Health Counselors		
Missouri	19.54	40,650
Arkansas	19.35	40,240
New Mexico	19.25	40,040
Texas	17.90	37,230
Kansas	16.57	34,460
NATION	16.35	34,010
Colorado	15.42	32,070
OKLAHOMA	15.11	31,430
Substance Abuse and Behavioral Disorder Counselors		
New Mexico	16.83	35,010
NATION	15.66	32,580

Missouri	15.49	32,210
Kansas	14.42	30,000
Texas	13.67	28,440
Colorado	13.56	28,200
OKLAHOMA	13.08	27,220
Arkansas	11.60	24,130
Mental Health and Substance Abuse Social Workers		
NATION	16.54	34,410
Kansas	16.25	33,790
Arkansas	15.44	32,110
Texas	15.40	32,020
New Mexico	15.34	31,910
Colorado	15.31	31,840
Missouri	14.06	29,250
OKLAHOMA	13.13	27,310
*Data based on November 2004. **Data based on Mean Wages. Source: U.S. Department of Labor, Bureau of Labor Statistics, Occupational Employment Statistics, May 2005. http://www.bls.gov/data/		

Staffing problems are particularly acute in rural areas, where it is hard to attract professionals. One CMHC reported difficulties in getting an approved PACT Team off the ground because they were unable to attract any applications for the psychiatrist and nurses' positions.

Prevention providers said that low salaries, a requirement for enhanced credentials, and a lack of training opportunities combined to make it difficult to keep good staff. "The Department wants people to have greater credentials, but it hasn't raised the salary caps," one provider said. "The department doesn't offer enough opportunities for training, so we have to pay out of pocket to get trained elsewhere," a provider said. "We have to use program funds for training, and staff have to pay some training costs out of pocket. It takes a lot to train people, and then they leave because the pay is so low."

A significant shortage of mental health and substance abuse professionals from minority cultural groups was identified as a key barrier to the delivery of culturally competent services. Focus group members called for ODMHSAS to develop a targeted outreach and recruitment program aimed at people of color. A Latina professional said that large segments of the Hispanic population are not receiving services, primarily because there is not enough trained Hispanic or bilingual staff. She also noted that there is still little ethnic diversity among students in professional training programs, partly because successful students from cultural minority groups chose to go into higher-paying professions than human services. She suggested that scholarship programs to support master's level study for students from ethnic and cultural minority groups would be one way to increase the diversity of the system's staff.

For state-run programs, staff and managers indicate that ODMHSAS' hiring freeze and associated procedures to fill vacant positions can result in delays and missed opportunities in hiring qualified staff.

One potential reason for staff shortages is the declining number of degrees awarded each year in fields such as psychology and social work. According to the

Oklahoma State Regents of Higher Education, there has been a 20 percent reduction in the number of licensure level degrees awarded from 1999/2000 (727 degrees awarded) to 2003/2004 (576 degrees awarded; OSRHE, 2005). In order to increase the number of health service professionals nationwide, the National Health Service Corps Loan Repayment Program offers trained health care professionals, including behavioral health professionals, the chance to compete for repayment of their educational loans if they choose to serve in a community of need. The initial contract period must last two years, and the loan repayment is \$25,000 each year. The contract may be extended until qualifying loans are repaid. Years of service after the initial two years provide \$35,000 repayment per year. In addition to the loan repayment, health care professionals also receive a competitive salary and some tax benefits (HHS, 2004).

There are very serious shortages of psychiatrists in Oklahoma. In most communities we visited, respondents repeatedly noted that it is difficult to get appointments for medication assessment or for ongoing medication monitoring. Focus group participants also said that programs often rely on non-psychiatrist physicians for prescribing. Child psychiatrists particularly are in very short supply. Because of the immediate demands on their time, one respondent reported that “child psychiatrists are on the edge of burnout as soon as they enter the system. They are too busy and stretched too far.” The state’s Physician Manpower Training Commission has programs to enhance medical care in rural and underserved areas of the state by administering residency, internship and scholarship incentive programs that encourage medical and nursing personnel to practice in rural and underserved areas. However, these programs do not extend to addressing the state’s deficits in medical specialty areas such as psychiatry.

Training and Continuing Education Opportunities

Focus group participants voiced the need for additional training on recovery-oriented services to increase their skills. There was also a call for staff to receive training that would allow them to help clients find housing, employment, government benefits, and other community-based services. Most staff and managers indicated an interest in learning more about recovery and the new skills and attitudes required to transform the system. Participants noted a pressing need for cultural competency training at all levels. There was a consensus that cultural competence training should be required for all staff. It was also suggested that one-time training on cultural competence issues was not sufficient to change agency cultures, and that leadership from the top and supervision are vital for the kind of environmental change needed within the system.

Managers also pointed out that some vital trainings, like orientation for PACT staff, are offered only twice a year, and that this makes it difficult for new staff to perform their jobs. One manager pointed out that nurses on her staff were required to attend a training that was only offered once, and that it was impossible to pull all nurses off their shifts to send them to training. Prevention staff noted that entry-level positions require certification as a prevention specialist, which requires 150 hours of CEUs and 120 hours of supervised work within 18 months of hire. “This is difficult because the department doesn’t offer enough opportunities for training, so we have to pay out of pocket to get trained elsewhere,” a provider said. “We have to use program funds for training, and staff have to pay some training costs out of pocket. It takes a lot to train people, and then they leave because the pay is so low.”

There was broad agreement that requiring staff to travel to Oklahoma City for a 2-hour training was not a good use of time. Many called for the use of new technologies like computer-based distance learning and teleconferences to allow for more people to be trained at less cost. Consumers, family members and advocates also noted that being required to pay to attend trainings is a major disincentive to their involvement.

Professional Training Programs

Many respondents said that professional training programs in the state, including social work, nursing, psychiatry, and Licensed Professional Counselor (LPC) programs, have not incorporated educational material and skills training that is needed to work successfully in a consumer-driven mental health and substance abuse services system. Advocates, consumers, managers and staff expressed concerns that these graduate programs are “still training in antique models,” as one participant put it. Providers and consumers alike expressed an interest in working with local colleges and universities to develop recovery –oriented curricula for the future mental health workforce. “We need to be speaking to graduate classes and to medical students and interns on a regular basis,” a consumer advocate said. “That’s the only way recovery will be made real for them.”

Licensing Requirement for Substance Abuse Staff

There were mixed feelings among staff about ODMHSAS’ new licensing requirements. By 2010, substance abuse services staff will have to become Licensed Alcohol and Drug Counselors (LADCs), which requires a master’s degree. Some see this as a positive development: “Substance abuse professionals should get the same recognition as other professionals,” one staff member said. “The stigma is that they are just a bunch of old drunks. More people should embrace credentialing.” Others said that the new requirements have already caused some staff to lose their jobs. “People who were on track to get a degree have had the rug pulled out from under them,” a staff person said. “I’m glad they are increasing required credentials of staff, but they should have done this more gradually so people had time to meet requirements,” another said.

Others viewed the licensing requirements as an unwelcome change in the philosophy of substance abuse treatment. “The department is professionalizing treatment to a dangerous degree. Counselors who are people with lived experiences are being phased out, and non-recovering professionals who don’t know how to deal with addicts are being promoted,” an advocate said. It was also noted that it is ironic that while the mental health system is promoting the inclusion of staff with lived experience through its development of Recovery Support Specialist and Family Support Specialists, the substance abuse side is working to eliminate peers from the workforce.

Training for Staff in Other Systems

Focus group participants and personal interviews stressed the need for expanded training on mental health and substance abuse issues for local law enforcement officers and correctional staff who interact with people with mental health and /or substance abuse problems on a daily basis. A lack of needed information on the part of these staff can jeopardize their safety and the safety of people on the street or in custody, and can lead to counter-productive interventions for people with mental health and substance abuse problems. While many local law enforcement agencies have staff trained in Crisis

Intervention Training (CIT) and similar training, others have not, and people with mental health problems in those communities who participated in focus groups indicated that they felt at risk from the police. It was noted that most degree programs in criminal justice either do not address mental health issues at all, or that they erroneously teach that mental illness is a cause of crime. Both staff and inmates on specialty mental health units in prisons said there is a large unmet need among correctional staff for training on mental health issues; this echoed one of the findings of a 2005 Oklahoma Board of Corrections' resolution.

Counselors working for the Department of Rehabilitation Services (DRS) expressed a need for more information on mental health issues. DRS staff noted that one of the barriers they face working with people with psychiatric disabilities is that this issue was not addressed in their rehabilitation master's program. Both mental health staff whose clients are involved with DRS services and DRS staff working with people with psychiatric disabilities expressed a need for cross-training and co-training to better enable the two systems to work effectively on the clients' behalf.

References:

HHS (2004). *National Health Service Corps, Loan Repayment Program*. U.S. Department of Health and Human Services, Health Resources and Services Administration, National Health Service Corps. Retrieved September, 2006 from http://nhsc.bhpr.hrsa.gov/join_us/lrp.cfm

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