Lisa Dixon (00:08):

Welcome to our podcast, Psychiatric Services From Pages to Practice. In this podcast, we highlight new research or columns published this month in the Journal of Psychiatric Services. I'm Lisa Dixon, editor of Psychiatric Services, and I'm here with podcast editor and my co-host Josh Berezin.

(00:26):

Hi Josh.

Josh Berezin (00:27):

Hi Lisa.

Lisa Dixon (00:28):

Today we're going to be talking about a problem I am sure everyone has experience and can relate to; the workforce shortage in mental health.

Josh Berezin (00:36):

We're very excited to have Eliza Hallett here to talk with us about her and her co-author's paper, Factors Influencing Turnover and Attrition in the Public Behavioral Health System Workforce: Qualitative Study. Eliza is a policy analyst at the Center for Health Systems Effectiveness at Oregon Health and Science University.

(00:55):

Eliza, thanks so much for coming on to talk with us.

Eliza Hallett (00:58):

Thank you for having me.

Josh Berezin (00:59):

I can't believe we haven't done a workforce episode. This is very long overdue for us, I think, because everybody is talking about this all the time. I was really eager to read the paper, and I thought it was really thought-provoking. It kind of confirmed some of my preconceived notions and it gave me a lot of other things to think about.

(01:25):

Just to get started, how bad is it out there in terms of the workforce crisis? How grim are we talking here?

Eliza Hallett (01:33):

I think, unfortunately, the audience probably understands that the United States is really undeniably facing this critical shortage of behavioral health workers across a range of providers that really predates the pandemic. The pandemic has exacerbated things. But in Oregon, which I'm more familiar with, the context there, where we conducted this study, the needs are really acute where Oregon ranks 49 out of 50 states in DC in terms of unmet needs for behavioral health for adults. Those issues are just compounded even more in the public behavioral health system, which is generally financed through a combination of Medicaid payments and grant funds. We're seeing in Oregon as well as in many other parts of the country, this high level of unmet need crashing up against the workforce shortage.

(02:21):

The purpose of our study was to assess factors contributing to workforce turnover and attrition in the public behavioral health system in Oregon. The body of literature has really looked at this question more in other settings, like in primary care, but we were able, through our work, to focus on expanding the qualitative data for this provider group and really hear firsthand experiences from them. And through this work, we learned that the turnover and attrition in Oregon's public behavioral health system is really worsened by chronic trauma and stressors that providers are experiencing in their day-to-day work environment.

(02:57):

Another point I'll make here is that the policy conversation thus far has really focused on reimbursement rates and on low wages. Those are certainly things that we need to be thinking about and addressed, but I think that the main value add with our paper is that we find that there are additional factors in the clinical work environment that really are often overlooked in policy discussions that-

Lisa Dixon (03:18):

Eliza, can I interrupt you just for a second?

Eliza Hallett (03:20):

Yup.

Lisa Dixon (03:21):

I think that if you have any thoughts about the ways in which Oregon may be similar to other states or different, because obviously, the study was conducted in Oregon, but we have listeners nationally and internationally. This may not be your area of study, but I'm curious to know how you think how representative Oregon is of the rest of the country.

Eliza Hallett (03:45):

Yeah. I would say that each state obviously has its own public system that looks slightly different state to state, but I think that these issues really have similar contours across all states. And so I would say that these issues are generalizable to the extent that each state can think about their own situations, but the core issues here I would think would be generalizable to public systems across the country.

Josh Berezin (04:11):

They certainly rung as familiar for me over here in New York, for sure. It does seem like, if not universal, would be something that would be similar across a lot of settings, just on the face of it. One of the other unique things about the study was how it was conceived of and initially funded. That does seem very specific and involves [inaudible 00:04:39]. Tell us a little bit about that.

Eliza Hallett (04:40):

Yeah, it was an interesting process. There was a house bill 2086 that was passed by the Oregon Legislature in 2021, and that was a huge bill that had a lot of different components to it. One of the stipulations was conducting a study that is looking to provide recommendations for achieving a living wage for behavioral health workers in Oregon.

(05:00):

The interviews for this study were actually conducted as part of that house bill directed study, where the interview guide was focusing on low wages and the reimbursement piece, but the semi-structured nature of those interviews left room for the providers that we were speaking with to talk about other things that were impacting their work and their work environment. The interviews were broad enough to be reanalyzed for this study focusing on low wages and reimbursement, but also other factors in the clinical work environment that were really impacting provider's experience.

Josh Berezin (05:32):

So you got into a little bit about the design of the study, but tell us a little bit more about who were you talking to? What were some of the questions that you were asking people?

Eliza Hallett (05:42):

Because the study was directed as part of that wage study, some of the questions in the interview guide were definitely around wages, reimbursement, billing practices. But again, the semi-structured nature of it left it open for us to hear about more general experiences in the work environment. We tried to achieve a geographic representation across the state in terms of work area, work setting, job description, job title.

(06:06):

In total we spoke to 24 folks around the state who were behavioral health providers, policy experts, state agency administrators or state association administrators. 80% of those folks that we spoke to were either in direct behavioral health clinical care or had done that work in the past and had since transitioned to a more administrative role, but still within the behavioral health system.

Josh Berezin (06:30):

There's nothing like a good figure to explain results, and you've got a great one. It's obviously not going to be great radio to talk about each aspect of the figure, but it gives a really good broad conceptualization of what you heard from people and then how you organized it. So maybe you could do a figure in podcast form for us.

Eliza Hallett (06:52):

Yeah, definitely. This figure that we have in the paper was really helpful to me honestly as we were writing to just organize my thoughts around all of these interconnected factors that were being brought up in the interviews. We identified these factors that affected provider's workplace experience, and what we did for the figure was designate those factors across three levels. We have system level, organization level, and individual-level factors.

(07:16):

The system level factors were really overarching government policies or societal views on behavioral health, whereas the organization level factors were more focused on infrastructure, administration, and support within a workplace. And the individual factors were the day-to-day experiences that affected someone's financial, emotional, or physical wellbeing.

(07:38):

Organizing those in those three levels was helpful for us to then think about these coalescing into the three direct drivers of turnover and attrition, which we identified as chronic trauma and stress in the workplace, feeling undervalued and unsupported and a lack of fulfillment or sense of purpose. And the five major themes, which I know we'll talk about more, came from an analysis of those various factors.

Josh Berezin (08:01):

Before we get to that, that multi-level model, was that your theoretical framework going into the paper or was that generated from the responses or did those just kind of dovetail with each other?

Eliza Hallett (08:12):

Yeah, they were generated from the responses. I think again, just going in with that, being able to re-look at the interview transcripts and reanalyze them with an emphasis on these workplace clinical factors, we weren't exactly sure what those were going to be. And so those factors that we put as part of the figure were really taken directly from the transcripts.

Josh Berezin (08:32):

Yeah, it's just interesting to think about that you're generating a model that people might not have individually. Somebody might talk about the organizational level, and another person might talk about the funding and [inaudible 00:08:48] policy level, and then bring everybody together and come up with this model that no one individual person might be able to articulate on their own saying, "Well, actually there's three levels that I think about when I'm thinking about this workforce crisis-"

Eliza Hallett (09:00):

Right. Exactly. Folks have their own perspectives and own experiences. And this is not to say that this figure encompasses everyone's thoughts, but it is interesting to think about how the different factors interact. It's not necessarily a trickle down where the societal factors lead directly into the organizational ones or vice versa, but I think it's helpful to have the basic understanding that these societal factors are playing into organizational level things and day-to-day work experiences of employees, and it's all interconnected.

Lisa Dixon (09:30):

I think one of the things that your method demonstrates is the power of using qualitative methods. Maybe if you could say a word about that, that would be great.

Eliza Hallett (09:42):

Yeah, I'm glad you asked that, Lisa. I think that one of the things that I love about qualitative research is being able to lend context to statistics and quantitative data that we hear about. I know that the industry turnover rate in behavioral health has been quoted around 30%, which is really high. And so, thinking about what's going on here? How can we dig into this statistic a little bit?

(10:05):

Through this qualitative process, I was able to just hear story after story that was being really eloquently and poignantly told to me from these behavioral health providers with on the ground experience. And so the qualitative piece, that's really the only way you can get those experiences and uncover these things that are really affecting workforce stability, honestly. I think it was a great method for the paper and I think it will hopefully lend some context to policy discussions as well.

Josh Berezin (10:33):

You identified that multi-level framework, and then within that you said you identified five themes that came up in the interview. Walk us through some of those themes. And maybe for a couple of them you could give us a little bit of a flavor of what sorts of things people are actually saying to you.

Eliza Hallett (10:49):

Yeah. The five factors that we identified that were affecting workforce turnover and attrition are low wages, documentation burdens, poor administrative and physical infrastructure, lack of career development opportunities, and a chronically traumatic work environment. I'll just go through those and we can expand on them more if we want.

(11:09):

For the low wages piece, this was a natural thing to come out of this study that was originally focused on low wages, but I think that the depth of responses here really shocked me. We were hearing from our interviewees that entry level behavioral health jobs around the state were paid on par with or lower than rates for fast-food restaurants around the area. So that's pretty stark. A community mental health program director put it really bluntly and just said, "There's no attraction to working here where you can go elsewhere, probably have a job with a bit less stress and make more than we have the ability to offer." So that painted it very starkly for me.

(11:48):

The documentation burden piece is again something that we probably expected to come out of this conversation, but again, the poignancy of these stories really has stuck with me. I think hearing a county behavioral health director saying that the amount of reporting burden that they have exceeds what can feasibly be completed in a regular work week. The work itself is very stressful and very difficult and then having this burden on top of that was really wearing folks down and contributing to turnover and attrition.

(12:16):

A potential strategy for the documentation burden piece, we were thinking about just revisiting and streamlining and simplifying the state and federal reporting requirements that are experienced by providers. That again, seems like low hanging fruit that we should be thinking about this and addressing this.

(12:34):

I think the last three themes were really what were interesting to us that came out that we might not have expected to.

(12:41):

The poor administrative and physical infrastructure theme is interesting. You think, what is infrastructure? What are we needing here? On the administrative side, we were hearing that organizations had insufficient funds to hire human resources, administrative and supervisory staff, which have a whole host of trickle-down effects for the organizational operations.

(13:01):

On the physical infrastructure side, we were hearing of course that there's just a general lack of facilities around the state to treat a spectrum of behavioral health needs, particularly in rural areas and particularly for child and adolescent behavioral health. So that was very clear.

(13:16):

On the physical side, we also heard that organizations were often using state or community grants to provide basic services or to hire staff. Using that money to basically backfill basic services was really limiting investment in physical infrastructure, where folks were saying that they were working in really outdated buildings. One person said it was crumbling down around them. These are really important

things to think about these providers coming to work every day in an environment that they don't feel good about working in necessarily.

(13:48):

So the strategy here; I'm thinking about even just raising the reimbursement rates might give organizations a larger, stable source of funding to then be able to use these onetime appropriations from the legislature to actually go towards those physical improvement projects.

Josh Berezin (14:05):

Well, before we get onto the last two, this was really interesting to me as well, because thinking about it's not just about increasing wages. The underfunding is not just about saying we need to have higher wages for people. It's really about a broader funding thing that's going to affect people beyond what the money that they're taking home in their pockets. That was one of the things that really stood out about the whole paper and then this particular aspect of it as well.

Eliza Hallett (14:37):

Right. Definitely.

Lisa Dixon (14:40):

I'm thinking about my own work and clinical work, and one of the things that I always struggle with, frankly, is electronic health records. I know that I need somebody who can be called to help me when I can't figure out what to do. I have no idea whether that's an issue. But I think that the whole shift to electronic health records is now you need infrastructure for that, and you need to pay people to support that kind of infrastructure.

Eliza Hallett (15:16):

Right, absolutely. And just going back to if you don't have administrative staff dedicated to that, then defacto, the other staff who have clinical responsibilities are having to do that work as well on top of their reporting burdens, on top of seeing clients, and so it's just adding on to something that's already stressful and already probably too much.

Josh Berezin (15:36):

What were the last two themes that you had mentioned?

Eliza Hallett (15:39):

Yeah. The fourth theme was around lack of career development opportunities. This was a really interesting one for me, hearing that a lot of participants felt like these career advancement opportunities were either unclear or non-existent in their field. These participants felt like these public behavioral health jobs didn't have defined career paths with established supervisory or leadership positions. One former peer provider told me that they had never felt like they had a track where they could grow incrementally in terms of job responsibility and then also be incentivized by a higher pay structure.

(16:13):

Just again, these simple strategies coming out of this; creating supervisory roles that are compensated for experience and effort would be a great start to having that aspiration to grow and move into.

(16:25):

On the training side, folks are really tied up in making sure they're seeing enough patients to generate revenue for their organizations. That type of environment doesn't allow, or at least doesn't encourage, folks to take time to be engaged in professional development and training opportunities. And so providing paid time off specifically for employees to do that would also be a good strategy to have that balance a bit in client care and then also professional development.

(16:53):

I think with this theme, really there was just this sense of disillusionment around public behavioral health jobs with a few participants viewing these jobs in this field as an unsustainable career choice in the medium or long term, which does not bode well for long-term workforce stability. So this is a really important piece that might get overlooked because it's a little bit of a longer term thing. It's not filling immediate positions now, but critically important as well.

(17:20):

The last theme is chronically traumatic work environment. Again, this was one of the most poignant things to emerge out of the interviews for me. Just hearing time and time again from these providers that they have consistently large caseloads, really high acuity patients, and there is this general feeling of insufficient organizational support, which all created a really high stress daily work environment for a lot of participants.

(17:45):

One person compared it to a boulder gaining steam, where you have this metaphor of folks leaving and then the remaining staff just having additional burden, additional burden to take on those caseloads, take on those administrative responsibilities, and it's a downward spiral at that point.

(18:03):

One of the most impactful quotes that I still think about a lot from a community mental health program director. They told me that, "In this county behavioral health setting, they tend to see people who are very ill for very long periods of time, and there's not the satisfaction of seeing those people improve over time." They said that, "10 years ago, the folks who are being seen in the community now might've been seen in a hospital setting, but now they're being seen in the community and it's putting out fires almost every single day, and you can only do that for so long before you're going to be burned out."

(18:34):

The inevitability piece to that was really impactful and just thinking about, that's almost like putting a timeline on it. You can only do this for so long and then you will burn out of this job.

(18:44):

Again, simple strategies here; encouraging organizational leaders to consistently recognize both the work that providers perform and the chronic trauma that they're experiencing as part of their daily work, but also concretely providing adequate PTO, having scheduling flexibility, having frequent rotations off of crisis calls. Things like that just again, to balance the scales as much as possible in this work that is already really demanding and challenging.

Josh Berezin (19:11):

When I was reading a lot of these responses, it seemed really in line with a lot of the more popular press accounts of issues across the medical field in general or things that are coming out of different fields in various ways. I was interested in the paper points out, or maybe the respondents point out, that there's things that are unique to behavioral health or they felt the issues were worse in behavioral health than

they were in other areas. I'm just wondering if that's something that you noticed as well, or if you had any thoughts on that.

Eliza Hallett (19:49):

Yeah, it's a super interesting question, and I've read some of those articles that have come out recently about the term moral injury as when healthcare providers have these external demands of leadership, or insurers, that stray from providing the best client care. I think that that idea that the pandemic merely worsened the strain on a healthcare system that was already failing in some ways because it prioritizes profits over patient care, definitely resonates in behavioral health and physical health for sure. I think that in behavioral health, there is this added burden of the behavioral health system, specifically public behavioral health, being underfunded for decades, and so those issues are all just compounded.

(20:33):

One behavioral health leader said, "We're just always behind the eight ball." That metaphor of never quite feeling like there is enough funding to do what is best for clients anyway, I think that is more acute in behavioral health.

(20:46):

There's also this ethos of self-sacrifice that I heard a lot in the interviews where people get into this profession wanting to really help people, and that goes for physical health as well, but really hearing, "This is a labor of love." I heard that time and again. One participant actually said, "This is a labor of love, but it's also a labor of labor, and we need to compensate folks appropriately."

(21:11):

I do think more so in behavioral health, there's this perception of historical bias towards the field which results in this persistent stigma and financial undervaluing of behavioral health services that again, I think is more acute on the behavioral health side.

Josh Berezin (21:25):

Well, you do end with maybe some good news about increased funding in Oregon. I don't know if this is true, but it seems like the alarm has been sounded maybe more than it has in the past that it's impossible to ignore these issues right now if you want an even moderately functioning-

Lisa Dixon (21:51):

And the fact that the legislature even got into this in Oregon is pretty impressive, right?

Josh Berezin (21:58):

Yeah.

Eliza Hallett (21:59):

I was just going to say, yeah, it's very encouraging to see the legislature taking concrete steps towards funding this in the 2021 to 23 biennium, that they appropriated 1.35 billion to support large-scale infrastructure improvements to the system in the state. Things like converting temporary positions at the state psychiatric hospital into permanent positions, grants to provide recruitment and retention efforts at different organizations across the state. Those are all very encouraging.

(22:28):

I think that in the back of my mind though I'm conceptualizing Oregon and likely other states struggles as this two-pronged issue, where you have on the one hand, an acute need to stabilize the system because it is in crisis right now. And so you need to fill empty positions and maintain access to critical care across the state period. And I think that these infrastructure investments will be really helpful towards that.

(22:55):

On the other side though, this is getting back to that training and career development piece. I think there's also a need to create more robust recruitment and training pathways for all behavioral health professionals, including unlicensed professionals, like peer providers. I think that there's a need to increase equitable access across the state and achieve more parity between behavioral health and physical health in general.

(23:16):

And those longer term things are what I hope still continue to be thought about and prioritized. There is such an acute need now. I understand that a lot of resources are going to that. And I think equally important for long-term workforce stability and the future of the field really is those long-term goals as well that I hope that this money will help. We'll see. Time will tell with that.

Josh Berezin (23:39):

I stepped back from the paper and I just thought about going to work and feeling like your work had been invested in, that it was important and it was recognized as important and it was supported appropriately, both monetarily and just also sort of the feel of it. You walk into some fancy hospitals and you're like, "There's a lot of resources going here." And I think that that matters.

(24:15):

Also just, it's like the issues that the respondents are talking about are if they were addressed, would create such a better treatment environment on so many different levels. You just think about physical plant issues and the feeling of it being a welcoming, warm, clean, cared for place. That would matter tremendously for I think the providers, but also the clients who are coming in would probably share that sort of feeling.

(24:47):

I'm wondering, as you are looking back on this research, if you have a positive image in your mind's eye about what it could look like. Because there will still be challenges. Some of the challenges are not going anywhere. But what would it look and feel like if some of these issues were addressed?

Eliza Hallett (25:08):

Yeah, it's a really good question. With the obvious caveat that I'm not a behavioral health provider or a clinician, I think from speaking with these providers, what I would say is when an environment where there feels like, exactly what you just said, there's alignment between what is financially incentivized and what is best for client care.

(25:26):

I think about an environment where in some cases what a client really needs is for a peer provider to just sit with them and be there for them in that moment, and that doesn't fit neatly into a billing code. So thinking about a system where there's more flexibility in what services are billable, but also what providers get to bill for those services, I think is a great first step to kind of creating equity across the field and having providers feel like the work they're doing is valuable and that they're best serving their

clients. I think that that main driver that I was talking about in the figure of the lack of fulfillment or sense of purpose, I think that would go a long way towards addressing that.

(26:05):

I also think that maintaining appropriately sized caseloads just seems to really be important for managing chronic stress in the workplace. So things like streamlining hiring practices. An organization that is appropriately staffed on the human resources side to be able to get folks in the door quickly and move through those hiring processes in a reasonable amount of time would really help alleviate that stress and have clinicians be able to focus on a manageable caseload that they can actually not be too stressed about.

(26:34):

I think lastly, just a commitment from organizational leadership to creating more trauma-informed workplaces, both, again, as you were mentioning in the physical buildings that folks are working in, but then also administratively with providing paid time off, those things that we were talking about before. I think the word balance comes to mind. These things need to be balanced out more in the clinical work environment for providers to be able to continue to do this and to continue to show up and have this be a sustainable career for them in the long term.

Lisa Dixon (27:04):

I have one more question. You mentioned that this trend and this problem preceded the pandemic, but I wonder if you could reflect on how the pandemic itself exacerbated or improved the problem.

Eliza Hallett (27:19):

Yeah, unfortunately, I don't think that it improved the problem. I think the two main things I think about with the pandemic are exacerbating the workforce shortage, for sure. We heard time and again that, especially particular job positions, I'm thinking of qualified mental health associates, qualified mental health professionals, certified drug and alcohol counselors, these different positions were frequently cited as we cannot find applicants who have these credentials and qualifications. I think that the pandemic strained those positions that were already harder to fill for and made them just almost permanently unfilled positions.

(28:01):

I also think that it just accelerated burnout. You're seeing it harder to fill positions and more industry turnover during the COVID pandemic, which again creates this downward cycle of agencies being shorter and shorter staffed without the ability to fill those positions. I think we heard about the trifecta of moving out of the public behavioral health system into jobs that had more flexibility to work remotely, had less patient acuity and higher pay.

(28:34):

In the context of the public behavioral health system, again, where these issues are compounded, folks were not necessarily leaving the field altogether, but they were going to work for telehealth companies or larger health systems that could offer them that trifecta that just made their jobs easier, which I understand. That's what I think of with COVID is that it just made those issues, particularly in the public system, worse.

Josh Berezin (28:56):

Well, certainly lots more to talk about and think about, and I think the paper also expands on this and other issues, so we're obviously encouraging folks to check it out.

(29:08):

What's the take home? What would you like people to leave this conversation or the paper with?

Eliza Hallett (29:14):

Yeah. I think that this paper hopefully lends some good context to policy discussions in Oregon and across states who are experiencing similar workforce challenges in behavioral health. We found in the Oregon public behavioral health system that workforce dissatisfaction was associated with low wages, documentation burdens, poor administrative and physical infrastructure, lack of career development opportunities, and a chronically traumatic work environment, some of which have been focused on for policy solutions and some of which have not.

(29:45):

I think, again, the interesting thing about these findings is that the low wages and reimbursement piece is kind of a fixture of policy discussions around the workforce issue, but we found other factors that are often overlooked in the policy realm. Our findings suggest that the organizational efforts to improve the work environment and workforce satisfaction are needed alongside these other systemic investments in the public behavioral health system.

Lisa Dixon (30:12):

Hallelujah.

Josh Berezin (30:15):

Well, I imagine a lot of this is going to resonate with many of our listeners. Thank you so much for writing the paper and also for joining us.

Eliza Hallett (30:22):

I forgot to say one thing. I would encourage anyone to read the Behavioral Health Workforce report that was actually given to the legislature in February of 2022. That was the study conducted for House Bill 2086. If anyone is interested in learning more about a more comprehensive set of policy levers to address these issues, that workforce report has those in there. So I would encourage folks to check it out if you're interested.

Josh Berezin (30:47):

Well, thanks so much.

Eliza Hallett (30:48):

Thank you both so much. This was really fun, and appreciate you reaching out to me. I'm honored and happy to have connections with you both now.

Lisa Dixon (30:55):

That's it for today. Thanks to Aaron Van Dorn for mixing and editing, Demery Jackson for additional production support. We invite you to visit our website, ps.psychiatryonline.org to read the article we

discussed in this episode as well as other great research. We also welcome your feedback. Please email us at psjournal@psych.org.

(31:16):

I'm Lisa Dixon.

Josh Berezin (31:17):

I'm Josh Berezin.

Lisa Dixon (31:18):

See you next time.

Speaker 4 (31:20):

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