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Grow Your Own: Educating Social Workers in Rural and Frontier Areas to Address the Behavioral Health Workforce Crisis

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Abstract. Workforce shortages in behavioral health are a longstanding reality in most rural areas. Given the increasing impact of mental health and substance abuse in rural communities, it is critical to seek solutions to address the inadequate number of behavioral health professions in these areas. This paper focuses on a university's efforts to prepare and support master's level social workers for practice in their rural and frontier communities to address behavioral health workforce shortages.

Keywords: rural social work, behavioral health, rural workforce development

The distribution of the behavioral health service provider workforce is a critical factor in ensuring access to essential mental health and substance abuse treatment (Health Resources and Services Administration [HRSA], 2016). Workforce shortages are a commonly noted barrier to health care services in rural areas. Prevention and intervention services are especially needed at this time due to increasing rates of suicide and drug overdose deaths in rural communities (Hedegaard & Spencer, 2021; Pettrone & Curtin, 2020). University social work programs have the opportunity to play a critical role in preparing social workers for practice in rural communities with the ultimate aim of eliminating rural health disparities.

Behavioral Health Disparities in Rural America

Rural populations experience higher rates of chronic disease and premature death than urban communities (Matthews et al., 2017). While the overall prevalence of mental health disorders generally does not vary greatly between urban and rural adults, rural children are more likely than their urban counterparts to have a mental, behavioral or development disorder (Breslau et al., 2014; Kelleher & Gardner, 2017). In addition, there are rural/urban differences seen in some specific behavioral health conditions and risk factors (Carpenter-Song & Snell-Rood, 2017). Differences are reflected in higher rates of suicide which has been increasing at faster rates in recent years among rural residents (Ivey-Stephenson et al., 2017; Pettrone & Curtin, 2020). Substance misuse is another concern plaguing rural areas of our country. Alcohol and drug problems are severe in rural areas with higher rates of overdose than in urban areas for particular substances like methamphetamines (Centers for Disease Control and Prevention, 2017; Hedegaard & Spencer, 2021). Rural providers believe that delays in treatment contribute to problem severity and undermine successful outcomes for rural residents (Pullen & Oser, 2014). Recent research suggests that rural residents with mental health needs have fewer visits and may go untreated for behavioral health conditions even when controlling for insurance status (Kirby et al., 2019).

Disparities in rural health are attributable to demographics, social determinants, and health behaviors as well as accessibility and availability of care. Rural residents are older than

their urban peers and these rural older adults experience higher rates of depression, suicide, and alcohol misuse (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013). Rural residents are more likely than urban residents to be in poverty, smoke cigarettes, and be physically inactive while less likely to be insured (Matthews et al., 2017). Access, availability, and acceptability issues include greater distances to services, lack of specialty care, provider shortages, and a lack of culturally competent service provision (Carpenter-Song & Snell-Rood, 2017; SAMHSA, 2016).

Disparities in Rural Kansas

Western Kansas is a rural region that reflects many of these disparities. Kansas, in its entirety, is made up of 105 counties with 85% considered to be densely settled rural (20 to 39.9 persons per square mile), rural (six to 19.9 persons per square mile) or frontier (less than six people per square mile) per Kansas Department of Health and Environment classifications (Institute for Policy & Social Research, 2020). Drawing an imaginary line down the middle of the state, creates *western Kansas* a region made up of 46 counties that contrast with the more densely populated eastern portion of the state. Western Kansas includes five counties designated as densely settled rural, 11 designated as rural, and 30 frontier counties. While some communities in this region are losing population, others have grown in number and diversity due to their economic base. From 2000 to 2016 in rural counties throughout Kansas, populations of color grew by 63.3% in frontier counties, 63.8% in rural counties, and 36.2% in densely settled rural counties (Kansas Health Institute, 2017). In southwestern Kansas, meatpacking plants have attracted new residents over the last four decades resulting in minority majority communities. In the hub of this region, Garden City, just over half the population identifies as Hispanic or Latino and another 10% is made up of immigrants from countries such as Guatemala, Vietnam, and Somalia. In 10 counties in the area, the percentage of the total population living in households that speak Spanish at home ranges between 19 to 47% (Bruckner et al., 2018).

As a state, Kansas has experienced the greatest decline in health rankings among U.S. states in the last 30 years (Norman, 2020). Norman (2020) notes that Kansans faces obstacles to care for mental health and substance abuse disorders and exhibit high rates of unhealthy behaviors with poverty as a main driver of poorer health. From 2017 to 2018, 7.2% of Kansas adults reported an unmet need for mental health treatment compared to 5.6% of U.S. residents overall (Kaiser Family Foundation, 2018). In a 2016 study looking at suicide by geography, Kansas frontier counties had the highest suicide rates of 25.9 per 100,000 population compared to fewer than 18 suicides per 100,000 statewide (Kansas Health Institute, 2018). Suicide rates are particularly increasing in the northwestern region of the state. Lack of insurance is a significant barrier in western Kansas exacerbated by the state's failure to pass Medicaid expansion. In a study that included 28 counties in southwest Kansas, researchers found that 16% of residents were uninsured, which was almost twice the national average at the time (Bruckner et al., 2018). Across all Kansas counties, the rates of uninsured children in 2017 ranged from 3.6% to 17.5%. The 21 counties with the highest rates of uninsured children (10.1% to 17.5%) were all located in the western half of the state (Kansas Health Institute, 2019).

Rural Kansas Behavioral Health Workforce

Mental Health Professional Shortage Area (MHPSA) is a designation used by HRSA to identify a shortage of providers for a geographic area, population, or facility (HRSA, 2020). MHPSAs represent areas that lack enough mental health providers of any kind (e.g., psychologists, psychiatric nurse, social workers). Eighty-five percent of MHPSAs are in rural locations (Hoge et al., 2013). In Kansas, 101 of 105 counties were considered MHPSAs in 2019 including all counties in the western Kansas region. In 2013 (prior to the workforce development efforts described hereafter), data from the State of Kansas Behavioral Sciences Regulatory Board (BSRB) indicates that there was a total of 184 licensed master's level educated social workers, Licensed Master's Social Worker (LMSW), or Licensed Specialist Clinical Social Worker (LSCSW), in western Kansas. This equated to 0.60 social workers per 1,000 residents. By comparison, in the same year in the eastern region of Kansas there were 4094 master's social workers equaling 1.6 social workers per 1,000 residents. In 2013, there were nine counties in Kansas with no licensed master's level social worker, all in western Kansas.

Another workforce challenge is the availability of behavioral health services that are culturally appropriate and acceptable for diverse populations in need. Research indicates that utilizing clinicians who can speak the native language of participants in a psychotherapy process produces better outcomes for the participant (Guilman, 2015). The number of social workers who speak a language other than English is difficult to pinpoint. Anecdotally, individuals of color, particularly Latino or Hispanic persons, are underrepresented as social workers across Kansas and bilingual social workers are in high demand particularly in the southwest area of the state. Having few clinicians able to offer same language, culturally competent services to diverse individuals is a barrier to access in western Kansas.

The availability of clinical supervision for social workers is another factor affecting the workforce in Kansas. The LSCSW level of licensure is needed for independent clinical practice and to bill for many behavioral health services as outlined by Centers for Medicare and Medicaid Services (CMS) guidelines. To become a LSCSW in Kansas requires a master's degree in social work, passing of a clinical competency exam, 3000 hours of post-graduate supervised clinical work experience, and at least 100 hours of clinical supervision with no less than 50 of those hours in-person individual supervision. In 2013, there were 69 LSCSWs in all of western Kansas with 21 counties in the regions having no clinical social worker licensed at this level.

Taken together these factors have contributed to a behavioral health workforce shortage that has reached a crisis level in many rural communities in western Kansas. The need for innovative strategies has become a priority for the region and was the catalyst for developing social work education partnership sites to assist in meeting these needs.

Social Work Education in Western Kansas

The University of Kansas School of Social Welfare (KUSSW) provides the only comprehensive social work education program in Kansas, including professional degrees at bachelors, masters, and doctoral level. Since 2013, the KUSSW has offered their MSW degree in two partnership sites located in the western region. These sites were developed to directly

address the disparity of behavioral health providers in the rural and frontier regions. At this time, all accredited MSW programs in Kansas were offered in the more urban areas of central and eastern Kansas. The intent of the partnership site program was to offer a more accessible opportunity for individuals who live in the western area to get a graduate degree in social work. The hope is that by offering the program in the region, increasing the likelihood that these individuals would stay and practice in their home communities. This prospect is supported by a study that found recruitment and retention of health professionals is affected by their rural background and preference of smaller sized community (Daniels et al., 2007).

Partnership sites are between 230 to 350 miles away from the main campus and draw students from a large geographic area including the entire central and western half of the state. The KUSSW partnership sites offer a blended format with students attending in-person classes taught by local adjunct instructors every other Saturday with online asynchronous work and assignments through Black Board. Students are required to complete a 720-hour field placement that is supervised by a social worker which students typically do at an agency within or near their home communities.

Within a year of the launch of the partnership sites, the KUSSW was awarded a Behavioral Health Workforce Education and Training (BHWET) cooperative agreement through the HRSA. The BHWET program aims to expand the behavioral health workforce in integrated healthcare with a focus on underserved and rural populations. In 2014, BHWET awards targeted serving children, adolescents, and transition-age youth at risk for developing, or who had developed, a behavioral health disorder while a subsequent award in 2017 also received by KUSSW, broadened the scope to serving populations across the lifespan.

The KUSSW's BHWET award established its Behavioral Health Scholars Program, later renamed the Integrated Health Scholars Program (Scholars Program) with the goal of expanding the number of master's level social workers who are serving persons in rural and other medically underserved communities in Kansas. To meet this goal, the Scholars Program had to increase field placement opportunities in integrated behavioral health that include interprofessional training for students, faculty/staff, and field instructors. A key focus of this work is with KUSSW partnership sites that are located in and serve rural students and communities.

Students in the Scholars Program complete a field practicum in a site that provided interprofessional practice opportunities such as federally qualified health centers (FQHC), community mental health centers (CMHC), and school-based mental health programs. Specialized training to develop knowledge and skills needed for clinical practice and leadership in integrated health care is required along with a capstone project and presentation related to the field experience. Scholars receive a \$10,000 stipend and commit to seeking employment in the field of behavioral health after graduation.

Students from rural partnership sites are given preference in the selection process for the Scholars Program. To date, 136 KUSSW students have participated in the Scholars Program including 52 from rural areas throughout the state with 44 specifically attending the western Kansas partnership sites. This includes one year when there were no eligible (e.g., clinical level) students at partnership sites due to how the sites were structured at the time.

Fitting Education to Needs

Graduate social work students at partnership sites complete the same course of study as students on the main campuses. In addition to courses in policy, practice, and research, all social work students have a field practicum that provides the opportunity to put knowledge and skills into practice. Practicum agencies are located in a student's home community or within a 60-mile radius. Many students in this region choose to complete an employment-based practicum which allows them to remain employed (with benefits) at a workplace that provides flexibility to complete practicum hours in a different part of the agency.

Partnership sites do not have enough students to support multiple electives so all students at these sites take the same coursework throughout their education. When the partnership sites began, the elective courses for these students were all related to serving children and families. While learning to work with children and families is certainly an important aspect of social work, rural students need to be prepared with a wide range of intervention skills to take on a breadth of roles and responsibilities that includes serving all ages and populations (Daley, 2010). These authors and a colleague created an informal survey to collect perspectives of behavioral health providers and employers regarding needed competencies (Holmes et al., 2017). These providers' perspectives supported advocacy efforts of the authors to change electives offered in partnership sites to better align education with community needs. For example, instead of multiple electives in family services and therapy, the sites shifted to offering courses in crisis intervention, substance use, and grief and loss with child and family content covered in required practice classes.

It is important as well that students understand rural social problems and models of care that show promise in rural areas such as integrated care, telehealth, and innovative partnerships with schools, churches, and community organizations. Students must be prepared for the unique aspects of rural social work practice such as ethical issues that can arise from managing multi-layered relationships with clients common in rural communities (Blue et al., 2014; Humble et al., 2013). They also need knowledge and skills in how to manage personal and professional isolation, getting supervision and mentorship, and other aspects of navigating working as professionals within rural community culture. This preparation is offered by field instructors as well as adjunct classroom instructors with extensive background in working in rural communities.

Over one-third of the partnership students participated in the Integrated Health Scholars Program. Specialized training provided through this program is intended to be *value-added* meaning that it fills gaps or expands upon content currently taught in other MSW courses. All Scholars (whether in rural partnership sites or more urban areas) learn about working in rural communities and serving rural populations through training held at a rural FQHC or CMHC. Scholars' training focuses on practice skills such as a trauma-informed approach and motivational interviewing that can be integrated with other treatment modalities and used in a variety of settings. There is an intentional focus on experiential skill-building particularly through interprofessional education opportunities to prepare for team-based service delivery. One example is training focused on the Screening, Brief Intervention and Referral to Treatment (SBIRT) model used for early intervention and treatment of substance use disorders and those at

risk of developing these disorders. The SBIRT training for Scholars involves didactic learning and an experiential practice opportunity in an interprofessional patient simulation. Scholars training also addresses macro skills such as using and providing supervision, advocacy, and grant-writing so students are prepared for greater autonomy and ready to move more quickly into supervisory or leadership positions.

Scholars' training for partnership site students is offered in a blended format with online modules supplementing traditional in-person training. Scholars are afforded opportunities to participate in a patient simulation, case studies and other interprofessional education with students from other health professions. To increase interprofessional opportunities in rural areas, local practitioners such as nurses or community health workers are occasionally invited to participate in Scholars' training. For the capstone project presentation, Scholars at partnership sites are given the opportunity to present at a local community health coalition to facilitate local knowledge-building and professional networking.

Impact of a Rural-Located Social Work Program

Having a MSW program within driving distance has helped individuals living in rural and frontier regions to get a graduate-level social work degree. In addition, the Scholars program provides additional training and much-needed financial support to a third of these students allowing them to cut back on employment to focus on their education and lessen or avoid student debt. Since the inception of the partnership sites, student enrollment has grown from 15 to 42 students. To date, the partnership site program has graduated 134 students with MSW degrees into the region.

A major benefit of the partnership sites is that they allow individuals with roots in rural and frontier areas to gain a graduate education without having to move to a different town or region of the state. By being educated in or near their home communities, they are more likely to stay and practice there, with 86% of partnership site graduates staying in western or central Kansas after obtaining their MSW degree. Data from the BSRB reflects the growth in social workers in the western region. In 2020, the number of licensed master's level educated social workers (LMSW or LCSW) in western Kansas stands at 246, a 33% increase since 2013. By comparison, the eastern region (which includes all the urban counties in Kansas) increased 20% during this time. Western Kansas now boasts 0.80 licensed master's level educated social workers per 1,000 residents. While the presence of the rural social work education program cannot take full credit for this growth, it is of note that the counties where the partnership sites held classes both experienced a particular increase in social workers during this time period (+17 and +18).

Data from the Scholars program indicates that the partnership sites successfully recruited populations that are reflective of the communities in the region. For example, of the 44 Scholars attending partnership sites, 18 self-reported to be a person of color including: 15 Hispanic, two Native American, and one Asian student(s). In addition, 14 western Kansas Scholars were bilingual, most commonly Spanish/English speakers. With Scholars comprising only a third of the overall partnership site student population, it is highly likely that the true number of bilingual graduates are greater than reflected here. Having clinicians who speak the native languages of

the clients that they are serving and personally understand cultural aspects of mental health and well-being will increase the region's capacity to serve all its residents.

Discussion

Development of the rural behavioral health workforce is essential to ensuring that there is an adequate number of skilled professionals to offer accessible and effective services in rural and frontier communities. The partnership sites offered in a rural area of Kansas attract individuals from local communities with the opportunity to gain a graduate social work education close to home. This "grow your own" approach has increased the number of behavioral health professionals in rural and frontier regions. The corresponding launch of partnership sites with a behavioral health workforce development grant has facilitated coordinated efforts to support experiential training, build practice capacity, enhance interprofessional preparation, develop integrated field placements, and share knowledge about workforce development in behavioral health in frontier and rural areas that has long struggled with recruitment and retention of behavioral health professionals.

Educating students in the skills and knowledge needed for working in rural communities is critical. Without content related to unique nature of rural culture and practice skills, students may lack adequate preparation to successfully practice in rural communities (Barney et al., 2010). It is important for new rural clinicians to understand their communities' demographics, social determinants, health behaviors and barriers, and have the skills to address the many conditions and issues that they will see in rural practice. Quest and Nedegaard (2018) note that rural social workers are required to "be highly prepared to deal with most anything" (p. 1). Through SBIRT training and other preparation in evidence-based practices, newly graduated LMSWs entering the field will be better equipped to address the needs of those that they are serving and do the work they are expected to perform once in the field. More integrated training focused on both mental illness and substance use is needed to address the growing prevalence of co-occurring disorders (SAMHSA, 2018). Continued focus on integration and skills for working inter-professionally is also integral to promoting more positive behavioral health outcomes in the region.

University social work programs located in rural areas must partner with local resources to provide teaching, training, and field education to provide relevant knowledge and skills. A culturally competent diverse workforce will be a continued need in rural America. In western Kansas, for example, the Hispanic population is projected to nearly triple and the Black population is projected to nearly quadruple while the overall population is projected to decrease by 20% between 2016 and 2066 (Hunt & Panas, 2018). Field education provided by agencies in rural and frontier communities supports students to learn unique approaches to serving diverse rural populations while agencies have the opportunity to try out a potential future staff person during a practicum experience.

Developing LSCSWs is an important part of the workforce pipeline. Since 2013, there are an additional 16 LSCSWs in western Kansas. Given that the first partnership class graduated in 2014 and the process of obtaining the supervised hours for an LSCSW typically take two to three years, it is anticipated that the impact will continue to be seen over several years. The

amount of supervision hours required for licensure and the dearth of potential clinical supervisors in rural areas amplifies the challenge of increasing the number of LSCSWs in western Kansas. Recent regulation changes in Kansas now allows for all supervision time to be completed by televideo (KS-BSRB-HB 2208). Allowing more technology-based supervision increases feasibility for new professionals to obtain this level of licensure desired by employers due to their ability to bill for services. Advocating for regulation changes as well as providing training and support for clinical supervisors are ways that university programs could support rural areas in this aspect of behavioral health workforce development.

There is support available to help with behavioral health workforce development that is targeted for rural areas. As the primary federal agency for improving health care to people who are geographically isolated or economically or medically vulnerable, HRSA provides critical support for paraprofessional and professional training programs that address access to behavioral health care for underserved population. Nationally, HRSA programs such as BHWET and the Opioid Workforce Expansion Program are reducing projected national shortages of social workers and building behavioral health workforce capacity in critical areas of need in rural and medically underserved communities (National Center for Health Workforce Analysis, 2019). HRSA workforce funding helps to provide not only direct financial assistance to students to complete their degrees but also important funding to create an infrastructure for workforce development through support for identifying, training, and supporting field agencies and instructors.

Finally, another critical need in this area is for more research around the behavioral health disparities and workforce shortages that have long plagued rural areas of the country. While HRSA provides overall workforce indicators such as MHPSA, more detail is needed at a regional, county, and local level to identify distinct workforce challenges and measure the success of targeted workforce strategies. For example, language and cultural gaps contributing to unmet behavioral health needs. Continued research around the current state of behavioral health care and specific needs and strengths of rural areas will support more appropriate direction of funding and resources.

Conclusion

In many rural areas, suicide and substance misuse continue to rise along with unfilled behavioral health positions. Workforce shortages put a strain on resources for agencies providing the care as well as the clinicians themselves. Social work programs, particularly those within rural communities, have an important role in helping to address workforce challenges and reduce health disparities. The impact of coordinated outreach educational programs such as the KU School of Welfare MSW Program and Integrated Health Scholars Program is evident on the landscape of behavioral health treatment in areas of rural and frontier Kansas. Continued focused efforts like these will be needed in order to make a lasting impact on rural health disparities.

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