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Preparing Behavioral Health Clinicians for Success and Retention in Rural Safety Net Practices

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Introduction

Many rural communities in the U.S. face a shortage of behavioral health clinicians.[1] One approach commonly employed to address this problem is to create training programs and clinical placements for students in the behavioral health disciplines in rural and underserved communities, and provide curriculum on rural culture, rural mental health care, and skills important for rural practice.[2-5] Rural and underserved community-focused training has been shown to increase learners' interest in and recruitment to work in rural and underserved settings.[4] However, there is a lack of research investigating the effects of this specialized training on the practice successes and job retention of behavioral health graduates who work in underserved rural communities. Among behavioral health clinicians working in rural safety net practices, this study assessed how the amount of exposure to care in rural underserved communities received during training relates to their confidence in skills important to their work settings, successes in their jobs and communities, and their anticipated retention.

Methods

Data used in this study were obtained from surveys administered by the Provider Retention & Information System Management (PRISM) Collaborative, a multistate initiative that annually queries clinicians working in rural mental Health Professional Shortage Areas (HPSA) within a variety of types of safety net practices while they receive education loan repayment support through the National Health Service Corps (NHSC).[6-8] Data are survey responses from an enumeration cohort of Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs) and psychologists whose loan repayment began from March 15, 2015 through April 1, 2022 in PRISM's 21 states during this period. Chi-squared analyses assessed associations between the amount of training exposure clinicians reported they received in care for the underserved in rural areas and indicators of their skills confidence, practice and community successes, and anticipated retention. OLS and logistic regression analyses reassessed these associations while controlling for potential confounders, including clinician discipline, clinician age, rural vs. urban upbringing, and type of practice.

Key Findings

A total of 2,084 of 3,276 (63.6%) behavioral health clinicians of the eligible disciplines in PRISM's 21 states during the 2015-2022 study period responded to surveys, 778 (37.3%) of whom worked in rural zip codes and constituted the study population (n=380 LPCs, n=339 LCSWs and n=59 psychologists). These rural respondents were a median of 39 years of age and were

principally female (83.8%) and non-Hispanic White (86.9%). Approximately 38% worked in mental health facilities, 26% in community health centers, 7% in Rural Health Clinics, and the remaining 29% worked in a variety of other practice settings.

A total of 486 respondents (62.5%) reported having formal training experiences with medically underserved populations during their professional training. These experiences were more common among psychologists (89.8%) than LCSWs (62.2%) and LPCs (58.4%) ($p<.001$). The median reported duration of these experiences was 36 weeks for LCSWs, 48 weeks for LPCs, and 102 weeks for psychologists who have longer training periods ($p<.001$). Among respondents who reported training experiences with medically underserved populations, most (58.8%) quantified the amount of exposure they received in the care of underserved populations within rural areas specifically as extensive, 28.1% reported moderate rural exposure, and 13% reported little or no rural exposure.

Addressing this study's research questions, behavioral health clinicians' relationships with their communities were broadly related to the amount of exposure to care in rural underserved communities they had during training. In controlled analyses clinicians with more rural exposure reported feeling better prepared for what it takes to live happily in their communities ($p=.046$), a greater sense of belonging to the community where they worked ($p=.004$), and that their spouses were happier in the community ($p<.001$), and tended to report greater involvement in community issues important to them at work ($p = .070$). Additionally, in controlled analyses respondents who reported more training exposure to care in rural underserved communities more often anticipated they would remain in their rural safety net practices for at least another five years ($p<.001$) than those who reported less rural-focused training. On the other hand, confidence levels in the six professional skill areas queried, including participating as a member of a health care team, caring for patients of other racial/cultural backgrounds, and practice administration, did not differ statistically with the amount of exposure to care in rural underserved areas clinicians reported. Similarly, none of the queried successes in practice, including feeling a strong personal connection with patients and overall satisfaction with work, were related to the amount of rural underserved care training exposure.

Discussion and Policy Implications

Formal training in providing care for underserved populations is a large part of the education of behavioral health clinicians who later work in rural HPSA safety net practices. Assessed as a group, nearly two-thirds of this study's psychologists, LCSWs and LPCs working in rural safety net practices reported typically lengthy training experiences with medically underserved communities during their behavioral health professional training, and half quantified their exposure to care in underserved communities in rural areas specifically as extensive. Greater rural underserved care training was associated with greater integration and fit in communities for these clinicians working in rural safety net practices, and longer anticipated retention in their practices. These findings support the workforce outcomes of current behavioral health training programs and experiences as a whole that provide training for work in rural

underserved settings. Future studies should assess which combinations of counseling training experiences in rural settings, curricula in rural health care, and health professional skills training are most effective for behavioral health clinicians who will later work in rural underserved areas within safety net practices.

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