REPORT 1

Understanding and Mitigating Behavioral Health Workforce Shortages

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Executive Summary

The United States is experiencing a severe mental health crisis, with one in three adults reporting mental illness or substance use issues in 2023. Despite effective treatments being available, significant barriers prevent many—especially those in underserved communities—from accessing care, leading to high rates of unmet need. This report, supported by the National Institute for Health Care Reform, explores strategies to enhance the supply and distribution of behavioral health (BH) providers. We conducted interviews across three study states—Michigan, New Mexico, and Virginia—to examine efforts to mitigate BH workforce shortages.

Expanding education and training opportunities is crucial for mitigating BH workforce shortages. States are employing strategies such as **pipeline programs** that encourage youth from underserved communities to pursue careers in health care, with the hope that they will return to serve their communities. Efforts also include **increasing psychiatry residency spots** and **enhancing the availability of supervisors and preceptors**. Despite challenges, some study states have made notable progress. Michigan, for example, has recently supported the development of two new psychiatric residency programs in rural areas. Virginia has launched a Nursing Preceptor Incentive Program, which has significantly increased compensation for nurse preceptors and boosted preceptor recruitment.

Making education and training affordable is essential for expanding and sustaining the BH workforce. Many **BH providers face significant financial barriers to completing training and licensure**, such as unpaid clinical rotations and costly supervision hours, and begin practicing with overwhelming debt. To tackle these challenges, **states are implementing strategies like loan repayment programs, scholarships, and supervision cost relief**. Michigan and Virginia have created BH-specific loan repayment programs that require service in underserved areas. Both Virginia and New Mexico have programs to alleviate supervision costs. **States are also employing targeted strategies to expand the rural BH workforce**, including rural residency programs, distance

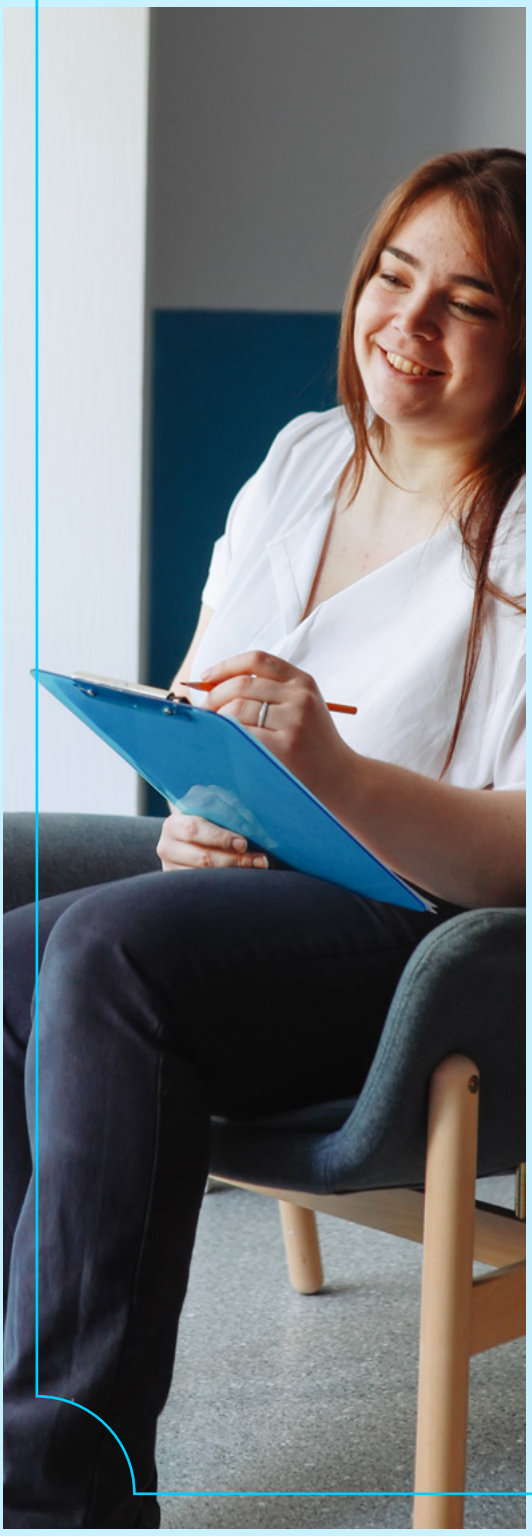
learning, and tele-supervision, which can help retain providers in rural communities post-training.

Removing regulatory barriers to licensure is crucial for expanding the BH workforce. **BH providers often face complex credentialing and licensure requirements**, especially at the master's level, which can delay their entry into the workforce. These hurdles are exacerbated by inconsistent regulations across different state agencies and burdensome scope of practice laws that limit independent practice, particularly affecting providers in rural and underserved areas.

States are implementing strategies to ease these barriers. Virginia, for example, **eased the scope of practice restrictions for psychiatric nurse practitioners** and created a new provider category called "behavioral health technicians" that allows providers with associate's level degrees to join BH care teams. **Efforts to promote interstate licensure and reciprocity are also underway** to mitigate regional shortages by allowing providers to serve across state lines. These initiatives aim to balance the need for high-quality care with the urgency of mitigating workforce shortages.

Valuing BH providers is essential for retaining the existing workforce, which faces low insurance reimbursement rates, overwhelming practice burdens, and limited opportunities for advancement. **Low reimbursement rates make it financially unsustainable for providers to serve underserved populations**. While all three study states have attempted to increase reimbursement rates, these efforts alone have not resolved the complex challenges providers face, such as burdensome administrative rules and high patient acuity. **Excessive workloads, lack of support staff, and minimal opportunities for career advancement also contribute to high burnout rates** and drive providers out of the field. **Initiatives that offer upskilling and career advancement opportunities are crucial for recruiting and retaining skilled professionals**.

Workforce planning is essential to comprehensively tackle BH workforce shortages, but challenges like inadequate data, lack of comprehensive planning, and limited collaboration can hinder progress. **States struggle to accurately assess the supply and demand of BH providers** due to unreliable and conflicting data sources, making it difficult to plan for the future. To drive comprehensive planning, **collaboration among diverse stakeholders is crucial**. All three study states are taking steps to enhance cross-sector collaboration.



KEY RECOMMENDATIONS FOR STATE POLICYMAKERS

- **Expand Education and Training:** Increase funding for BH education programs, support pipeline initiatives to recruit from underserved communities, and incentivize experienced professionals to train new providers.
- **Make Education Affordable:** Implement loan repayment and scholarship programs targeting BH providers who serve in high-need areas, and alleviate financial barriers associated with licensure and supervision requirements.
- **Remove Regulatory Barriers:** Simplify licensure processes, expand scopes of practice for advanced practitioners, and promote interstate licensure reciprocity to increase provider availability.
- **Value BH Providers:** Improve reimbursement rates to reflect the value of BH services, reduce administrative burdens, and offer career advancement opportunities to retain and support providers.
- **Enhance Workforce Planning:** Improve data collection to accurately assess workforce needs, foster collaboration among stakeholders for coordinated planning, and ensure sustainable funding for long-term workforce development.

Introduction

The United States is in the midst of a mental health crisis.[1] In 2023, one in three U.S. adults—84.5 million people—reported experiencing a mental illness and/or a substance use issue within the previous year.[2] Though clinically proven and effective treatments are available, many people, especially those from underserved communities, face numerous barriers to accessing these services. About half of the adults with a mental illness and three-fourths of people aged 12 and older with a substance use disorder did not receive treatment in 2023.[3] The U.S. health care system is currently ill-equipped to meet the high and growing need for mental health and substance use disorder (together referred to in this report as "behavioral health") services in an equitable manner.[4]

With support from the National Institute for Health Care Reform, we explore the effectiveness of policies and efforts to improve access to behavioral health (BH) treatment services in the United States, especially for underserved, working-age adult populations through a series of five reports. This first report explores efforts to improve the supply and distribution of BH providers. We will explore other domains of BH access issues in upcoming reports, including assessing system capacity; exploring innovative delivery approaches; removing financial barriers; and overcoming stigma, cultural and awareness-related barriers.

DEFINING THE BEHAVIORAL HEALTH WORKFORCE

The behavioral health (BH) workforce encompasses a wide range of clinicians and paraprofessionals who specialize in delivering or supporting mental health and substance use disorder treatment.[5] Different provider types are subject to various education, training, licensing, and/or certification standards that often vary by state.[6] Multiple provider types can have overlapping competencies, such as the ability to diagnose conditions and/or provide psychotherapy. A central challenge in describing and evaluating the BH workforce is a lack of consensus on the exact provider types and their roles within the BH workforce.[7] Examples of BH providers considered in this report include:[8]

- **Prescribers:** Physicians (psychiatrists, addiction medicine physicians) play a unique role as prescribers of medications to treat BH conditions. Depending on the state, advanced practice professionals (psychiatric nurse practitioners, physician assistants), might be able to prescribe

medication either individually or under a physician's supervision. Prescribers can also provide other BH services, such as diagnosis and psychotherapy.

- **Other licensed clinicians:** Psychologists, licensed professional counselors, clinical social workers, and marriage and family therapists are licensed clinicians that have at least bachelor's-level education and training to diagnose BH conditions. They can provide psychotherapy and can practice and bill independently or as part of a team.
- **Clinical supporters or paraprofessionals:** Peer support workers and community health workers leverage their lived experience or community connections to support BH treatment and recovery in clinical or community settings.[9]

EXTENT OF BH WORKFORCE SHORTAGES

As of August 20, 2024, 122 million Americans, more than a third of the population, live in a federally designated mental health professional shortage area (MHPSA).[10] MHPSAs are geographic areas or population groups that lack access to an adequate supply of BH providers relative to the population size and need.[11] Current shortages for many provider types are projected to increase over time as the need for BH services increases (see Exhibit 1).[12]

Exhibit 1. Projected Shortages and Adequacy of Selected BH Providers in 2036

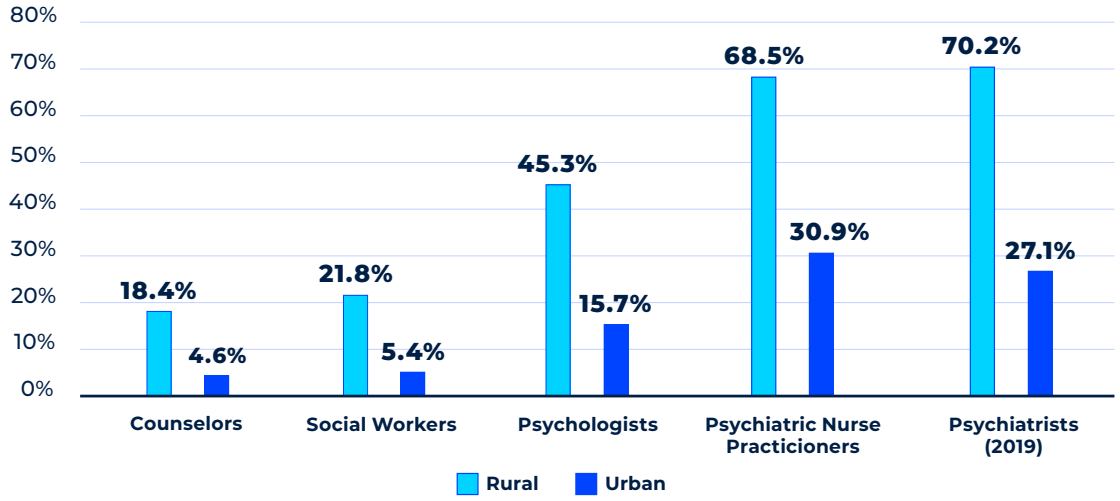
Profession	STATUS QUO SCENARIO		UNMET NEED SCENARIO	
	Shortage	Adequacy (%)	Shortage	Adequacy (%)
Addiction Counselors	-87,630	53%	-125,010	45%
Adult Psychiatry	-37,980	45%	-51,680	38%
Mental Health Counselors	-69,610	62%	-105,950	52%
BH Social Workers	-8,250	93%	-32,350	78%
Psychologists	-62,490	63%	-95,970	52%

Notes: Shortage data are full-time equivalents, and negative amounts indicate a projected shortage in 2036. Adequacy percentage is calculated by dividing projected 2036 supply by projected 2036 demand. While the status quo scenario estimates shortages based on current usage of BH services, these usage numbers underestimate the demand for BH services in the entire population given that many individuals who need BH services are currently not using them because of access barriers. The unmet need scenario corrects for this underestimation. Information on modeling and scenarios is available at Health Resources and Services Administration. *Health Workforce Projections Dashboard*, HRSA. Retrieved August 22, 2024.

Source: National Center for Health Workforce Analysis. (2023, December). *Behavioral Health Workforce 2023*. Health Resources and Services Administration. Retrieved August 22, 2024.

While BH workforce shortages are widespread, they disproportionately impact rural and marginalized communities, exacerbating the considerable barriers to BH care in these communities (see Exhibit 2).[13] Significantly fewer licensed BH clinicians practice in socially and economically disadvantaged communities, and counties with lower per-capita income are associated with larger BH provider shortages.[14]

Exhibit 2. Percentage of U.S. Counties without BH Providers by Type, 2021



Notes: Provider type data from 2021, other than psychiatrist data from 2019. See source for information on which provider types or job titles constitute each category.

Source: Adapted from Rosencrans, J. (2023, August). *Rural Behavioral Health Workforce*. Rural Health Research Gateway. Retrieved August 26, 2024.

DIVERSITY IN THE BH WORKFORCE

Studies suggest that when BH providers and patients have a shared racial or ethnic identity, it can have a beneficial impact on their therapeutic relationship.[15] However, the current BH workforce in the country does not reflect the diversity of the population it serves.[16] The more highly trained and paid provider types in the BH workforce remain disproportionately White compared to the U.S. population. In 2016, only 10 percent of practicing psychiatrists were Black/African American, Hispanic, or American Indian, Alaska Native, Native Hawaiian, and Pacific Islander.[17] In 2021, only 16 percent of psychologists were Hispanic, Black/African American, Asian, American Indian/Alaska Native, or Native Hawaiian/Pacific Islander.[18] Research shows that most people of color in health care jobs are in entry-level or lower-paying jobs.[19]

Methodology

To better understand the prevalence and types of BH conditions, available treatments, and the providers and facilities that deliver BH treatment and services, we first conducted a review of the existing literature. We then selected three states to serve as illustrative examples throughout our five reports: Michigan, New Mexico, and Virginia. We selected these states based on: (1) the availability of high-quality Medicaid data to support the quantitative analysis (described below); (2) recent, notable state efforts to improve access to BH care; and (3) geographic, demographic, and political diversity.

Between April 23, 2024, and June 18, 2024, we conducted 10 interviews with state agency officials, provider association representatives, and academics with broad expertise in each state's BH landscape. Between June 10, 2024, and July 1, 2024, we conducted 15 additional interviews with those who have specific expertise in BH workforce issues in our study states. These interviewees including agency officials, directors of higher education or training programs, researchers and academics, and state philanthropies that invest in BH workforce development.

As part of this project, we collaborate with the Urban Institute for quantitative analyses of access to BH services. The Urban Institute's findings can be found on their website and will be featured in our website and upcoming reports.

NOTE ON SCOPE

This report focuses on access to diagnosis and treatment services for working-age adults, with a particular emphasis on underserved communities.[20] Due to the unique delivery models within the criminal justice and Veteran's Administration systems, we exclude justice-involved and veteran populations from this scope. Additionally, this report is limited to barriers related specifically to diagnosis and treatment services. While recognizing the critical role of nonclinical services in supporting recovery—such as recovery housing and supportive employment—these services are beyond the scope of this study. Harm reduction and crisis response services are also excluded. Finally, while behavioral health encompasses a wide range of conditions, this study centers on access to services for major mood disorders and substance use disorders.

Understanding Shortages in the Study States

Like most states in the country, our three study states—Michigan, New Mexico, and Virginia—are currently experiencing significant BH workforce shortages. The entire state of Virginia is a federally designated mental health professional shortage area (MHPSA), while most of Michigan and New Mexico are designated either as partial or full MHPSAs (see Exhibit 3).[21]

Stakeholder interviews from all three states found that rural and urban areas tend to have the most severe BH provider shortages, while suburban areas generally fare better. For example, Michigan's and New Mexico's largest cities—Detroit and Albuquerque—are designated MHPSAs, while the wealthier, suburban areas surrounding these cities generally avoid the designation.

Exhibit 3. Population and Selected BH Workforce Adequacy Statistics; Michigan, New Mexico, Virginia, and the United States

	Michigan	New Mexico	Virginia	United States
Total population (2023)*	10.0 million	2.1 million	8.7 million	334.9 million
Ratio of residents to mental health providers (state rank)†	320:1 (22nd)	230:1 (11th)	450:1 (38th)	340:1
Percentage of countries fully or partially designated as a Mental Health Professional Shortage Areas‡	89%	97%	100%	91%

Notes: †Mental health providers include psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health.

Sources: *U.S. Census Bureau. *Annual Estimates of the Resident Population for the United States, Regions, States, District of Columbia, and Puerto Rico: April 1, 2020, to July 1, 2023. December 2023*. Retrieved August 23, 2024.

† Reinert, M., Fritze, D., & Nguyen, T. (2024, July). *The State of Mental Health in America, 2024 Edition*. Mental Health America. Retrieved August 23, 2024.

‡ Author's analysis of data at Rural Health Information Hub. (2024, July). *Health Professional Shortage Areas: Mental Health, by County, July 2024*. Retrieved August 22, 2024.

PRESCRIBER SHORTAGES

Interviewees in all three study states identified particular shortages of BH professionals who can prescribe medication—i.e., physicians and advanced practice professionals, like nurse practitioners. Stakeholders expressed concerns not just about the numbers of these professionals currently in practice, but the likelihood of a worsening shortage, as the current workforce is generally older and likely to retire without enough younger professionals to take their place. A psychiatric nurse practitioner (NP) training program administrator in Virginia even described current shortages in psychiatric NP workforce as a "vicious cycle" that not only limits access to care today, but also contributes to a shortage of preceptors who are critical to growing the workforce of the future.

SHORTAGES OF OTHER BH PROFESSIONALS

Beyond prescribers, stakeholders across the study states raised alarm about shortages "across the board" of BH providers. One New Mexico policy expert informed us that job opportunities in BH care tend to be open for a year or more before they are filled. Some stakeholders drew special attention to shortages in the peer support workforce and in the graduate-level therapist workforce, including master's-level licensed clinical social workers, who can diagnose and treat BH conditions. A 2022 analysis of Virginia's BH workforce found that the state's graduate-level programs have been unable to graduate enough students annually to "maintain even the current inadequate supply, let alone address the tremendous growth in demand."[22]

LACK OF DIVERSITY IN THE BH WORKFORCE

Stakeholders in all three states observed that the BH workforce often fails to reflect the racial and ethnic diversity of the state population it serves. Stakeholders in New Mexico, a state with a higher proportion of Indigenous populations and Hispanic immigrants, specifically pointed to the need for more BH providers who can speak tribal languages and Spanish.[23]

Expanding Education and Training Opportunities

Expanding education and training opportunities is crucial for building up the BH workforce. States are exploring a variety of approaches to reduce workforce shortages, from early-stage pipeline programs to increasing the number of psychiatry residency spots and improving the availability of supervisors and preceptors. While these initiatives show promise, they face challenges, including piecemeal funding, accreditation barriers, and a shortage of experienced professionals willing to train the next generation.

PIPELINE PROGRAMS HAVE THE POTENTIAL TO BUILD TOMORROW'S WORKFORCE, BUT DOUBTS ABOUT THEIR EFFICACY PERSIST

All three study states have a patchwork of pipeline programs that attempt to get school-aged children or young adults interested in careers in health care, including behavioral health care. According to one academic BH workforce researcher, the goal is to recruit students from underserved communities, support them through their education, and encourage them to return to practice in their home communities. For example, a physician and an educator in New Mexico highlighted the University of New Mexico's BA/MD program,[24] which recruits heavily from high schools in rural areas and reserves the vast majority of its 30 slots for students from these areas. The goal of this program is for these physicians to then return to serve their rural communities once they complete their training.

However, the academic researcher noted that demonstrating the effectiveness of these programs is challenging, because it requires tracking participants over many years. As a result, investment in these programs is often insufficient and intermittent, limiting their potential impact.

DESPITE NEW FUNDING, ACCREDITATION BARRIERS LIMIT PSYCHIATRY RESIDENCY EXPANSION IN SOME STATES

After completing medical school, physicians must complete residency training, also known as graduate

medical education, to be licensed for practice. Residency spots are limited because they are primarily funded by the federal Medicare program, which restricts the number of available positions. To mitigate physician workforce shortages, all three study states have allocated their own funding to expand residency spots, especially for high-need specialty areas, such as primary care and psychiatry. An interviewee who has worked for many years in the BH policy space in Michigan informed us that the state has recently supported the development of two new and "really robust" psychiatric residency programs in rural Michigan.[25]

However, state officials in Virginia report that despite recent increases in funding for psychiatry residency spots, they have struggled to encourage health care institutions to establish these programs. Health care institutions note that psychiatry residency programs are particularly difficult to set up due to higher accreditation-related burdens. To overcome this, the state plans to offer increased technical assistance to health care institutions next year to help them achieve accreditation and host psychiatry residents.

STATES COUNTER THE LACK OF BH SUPERVISORS, PRECEPTORS, AND FACULTY

Interviewees in all three study states uniformly raised concerns about how the current BH workforce shortage is contributing to a dearth of supervisors, preceptors, and faculty who are crucial for developing the BH workforce for tomorrow. Aspiring BH providers need supervisors, preceptors, and faculty to successfully complete their education and licensure requirements. However, several interviewees who interact regularly with students trying to become BH providers find that experienced providers are often "too busy with their own patients," especially since they can earn significantly more by seeing patients than by training aspiring BH providers. One interviewee from New Mexico worried that even when supervisors agree to oversee a trainee, they often lack proper training on how to effectively monitor and develop professional skills.

To ensure higher quality supervision, an interviewee said that the state of New Mexico makes a supervision guide available as a free resource.[26] Interviewees in Virginia expressed hope for their new Nursing Preceptor Incentive Program, which allocated $3.5 million in 2024 to raise compensation for nurse preceptors and increase their availability in the state.[27] According to a director of a psychiatric NP training program, this raises preceptor pay from about $1,000 per student up to $5,000,[28] which they noted has "helped tremendously" in attracting preceptors. A state official involved with the program said that they are at "about 900 applications now," and have been "very busy" operationalizing this program.

Making Education and Training Affordable

Expanding and sustaining the BH workforce, especially in underserved and rural areas, requires tackling significant financial barriers to education, training, and licensure. States are implementing a variety of strategies, including loan repayment programs, scholarships, and supervision cost relief to alleviate these burdens.

BH PROVIDERS FACE SIGNIFICANT FINANCIAL BARRIERS TO TRAINING AND LICENSURE

Interviewees in all three study states raised concerns about the significant financial barriers that BH providers face when trying to complete clinical practice requirements for their licensure. The financial burden of pre-licensure clinical practice is particularly severe for graduate-level BH providers, such as clinical social workers and professional counselors who are often required to complete a set number of "supervision hours," during which their work and professional development is overseen by a licensed provider. Aspiring providers often have to pay the supervisors for their time out of pocket. For example, interviewees informed us that in Virginia, social workers pay an average of $100 per hour of supervision, which totals $10,000 for the required 100 hours.[29] Counselors in Virginia require 200 hours of supervision that can often cost them upwards of $20,000.[30]

An interviewee who regularly works with aspiring BH providers told us that many recently licensed graduates enter the workforce with debt ranging from $65,000 to $75,000, while earning less than $50,000 annually in their early careers. One interviewee from Virginia emphasized that while there is a strong pipeline of eager and qualified candidates, these financial barriers act as a "wall" that prevents them from progressing in their careers.

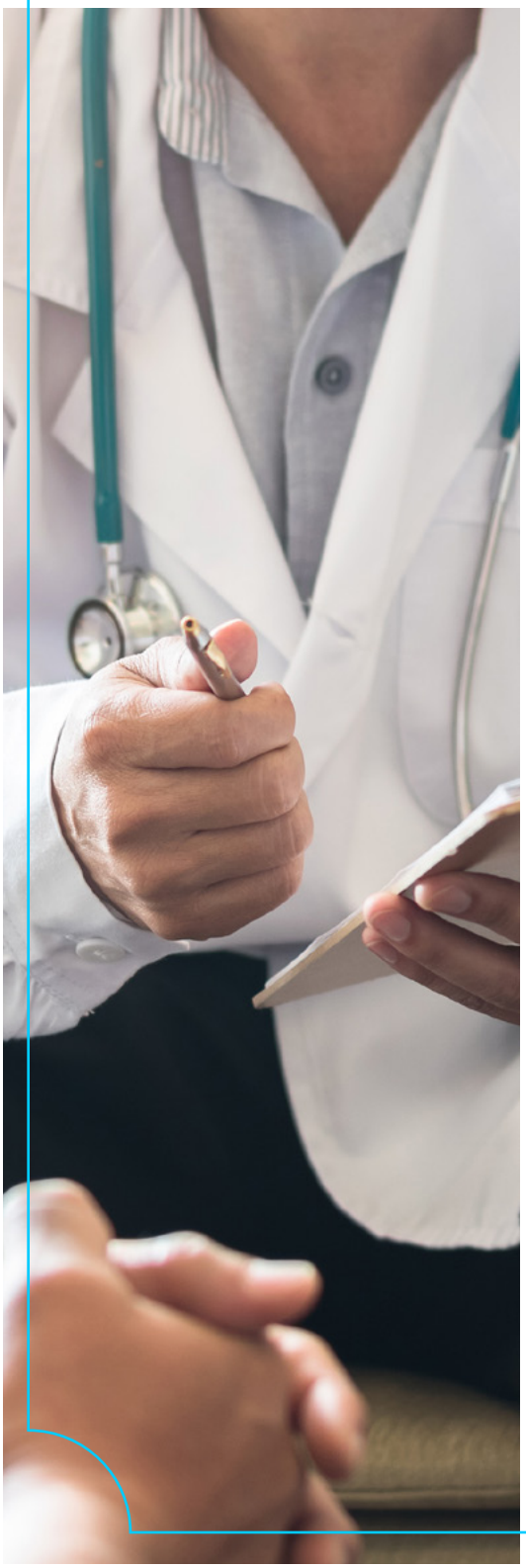
These concerns were reiterated by an interviewee familiar with this workforce in New Mexico, who finds that many master's-level recent graduates end up finding jobs outside of clinical care to

avoid supervision-related hurdles. The interviewee described the lack of a coordinated strategy around training for master's-level BH providers as a "huge gap that leads to a dearth of BH professionals across the country."

STATES HAVE DEVELOPED VARIOUS PROGRAMS TO DRIVE DOWN EDUCATIONAL COSTS FOR BH PROVIDERS

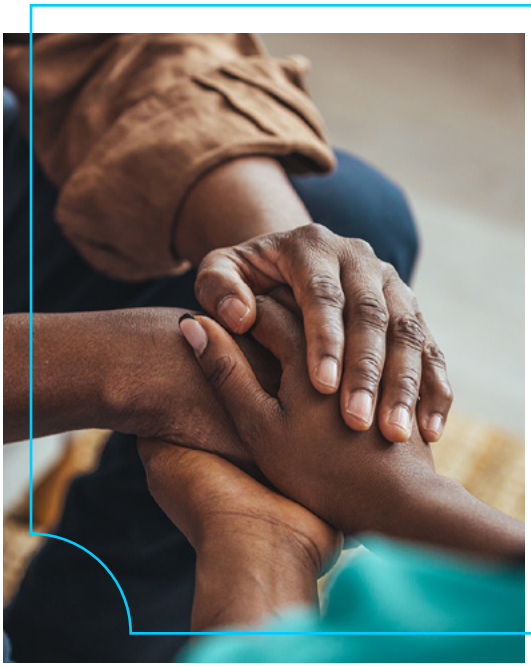
Michigan and Virginia have created BH provider-specific loan repayment programs that offer to pay back student loans in return for providers agreeing to practice in an underserved setting for a certain amount of time. Interviewees in Virginia familiar with the program said that funding for the program increased from $1.6 million in 2021 to $7.35 million in 2024.[31] An interviewee familiar with the program noted that the program prioritizes BH providers who are multilingual or professionals of color.

Michigan recently established a pilot "Michigan Opioid Treatment Access" loan repayment program that targets providers who treat opioid use disorders.[32] However, interviewees familiar with this new program find that the program has far more interested applicants than available funding to support them. State officials are leveraging opioid settlement funds (see discussion below) to help maintain this pilot program. In addition to loan repayment initiatives, Michigan launched a scholarship program



to encourage providers graduating with a bachelor's degree in social work (BSW) to immediately pursue a master's degree in social work (MSW).[33] This program aims to increase the number of providers who can offer clinical care, as MSWs can provide clinical services, but BSWs cannot. The program is projected to add about 167 MSWs to the state.[34]

Both Virginia and New Mexico have also introduced programs to alleviate the costs of supervision for aspiring graduate-level BH providers, such as clinical social workers and professional counselors. Interviewees from Virginia expressed enthusiasm about the Boost 200 program, which pays for the supervision hours for over 300 graduate-level BH providers in return for an obligation to practice in the state for two years.[35] Program officials reported that 74% of awardees are people of color,[36] and 43% are first-generation graduates. An interviewee in New Mexico familiar with the graduate-level BH workforce informed us that a similar program in the state offers free supervision to certain provider types but faces capacity limitations due to underfunding, leaving applicants on a six-month waitlist.



However, several interviewees suggested caution when relying on programs that provide financial support in exchange for certain years of service in an underserved location as the primary or only BH workforce development initiative. Some interviewees noted that providers often view these service obligations as a means to get loan repayment rather than as a long-term commitment to underserved areas. An academic researcher said that many awardees leave underserved locations as soon as their service obligations are fulfilled. Even if these programs successfully manage to retain providers, one state official managing these programs notes that their scale is insufficient to fully eliminate shortages because "[BH workforce] shortage numbers dwarf program numbers."

STATES EMPLOY TARGETED STRATEGIES TO OVERCOME CHALLENGES IN EXPANDING THE RURAL BH WORKFORCE

Expanding the BH workforce in rural areas remains a particular challenge. Several interviewees find that providing more opportunities for providers to train while embedded in rural communities can help them gain critical skills serving the unique needs of rural populations. A rural track psychiatric residency program in New Mexico[37] helps psychiatry residents gain an immersive experience within the community by providing them with housing and transportation support and has successfully retained providers in these areas post-training. Michigan State University also offers a similar rural track psychiatry residency program, which brings residents to the state's rural Upper Peninsula region.[38]

Interviewees who administer psychiatric NP training programs in Virginia and Michigan said that in their experience, psychiatric NP candidates were more likely to come from underserved areas and continue serving these areas once licensed. The administrator of the Virginia program, which specifically focuses on the needs of the rural patient population, said that "[rural health care] is a theme that runs through our seminars as well as our practicums."

In Michigan, distance learning programs have allowed psychiatric NPs to gain the necessary education while remaining in their rural communities, increasing the likelihood that they will continue to practice there after completing their degrees. An interviewee who works with the master's-level BH workforce in New Mexico mentioned that they have similarly been able to provide supervision via telehealth to aspiring BH providers living in rural communities, enabling them to continue living and practicing there after attaining full, independent licensure.

Removing Regulatory Barriers to Practice

BH providers face professional credentialing requirements and must navigate various regulatory hurdles before providing—and being reimbursed for—their services. While credentialing and other regulatory requirements are important in ensuring that patients are receiving high quality care, sometimes these requirements can be burdensome and limit entry into the workforce. Policymakers are responsible for balancing concerns related to quality of care and workforce shortages.

LICENSURE REQUIREMENTS FOR GRADUATE-LEVEL BH PROVIDERS, ESPECIALLY THOSE RELATED TO PRE-LICENSURE SUPERVISION, CAN BE COMPLEX AND BURDENSOME, OFTEN CREATING BARRIERS OF ENTRY INTO THE WORKFORCE

Interviewees familiar with the licensure process for various graduate-level BH providers, such as licensed clinical social workers (LCSWs), raised concerns about the complex patchwork of requirements imposed by multiple state agencies. A former state health official in Virginia noted that the regulatory framework of the state's Board of Counseling and Medicaid payment policies both have requirements for certain types of licensed counselors that do not align, and "[it is] nobody's day job to pull these together and make sense of them."

State regulatory hurdles directly contribute to the ongoing workforce shortages by delaying the time it takes for new professionals to enter the field. For example, an LCSW supervisor in New Mexico shared that "two-thirds of [LCSW supervision] hours have to come from a LCSW, so even if you are in a setting where you're supervised by a counselor or a psychologist, that's not going to be sufficient for being able to advance with your license."[39] Interviewees find that these types of regulatory hurdles can be especially burdensome for rural and/or less resourced graduates, who may have to travel far to find a supervisor that can dedicate the necessary amount of time and who meets the required criteria.

STATES EASE SCOPE OF PRACTICE RESTRICTIONS IN THE HOPES OF EXPANDING ACCESS TO PROVIDERS IN UNDERSERVED RURAL AREAS

Beyond supervision and licensure, scope of practice (SOP) laws present another set of barriers for certain BH providers looking

to provide independent care, especially in rural areas. SOP laws define what services a particular type of health care professional can provide independently. They vary by profession, with physicians having the broadest scope, and other advanced practice professionals (APPs), such as NPs, PAs, and pharmacists generally having a more limited scope. Given physician workforce shortages, APPs can potentially help fill gaps, but SOP laws that limit independent practice by APPs can serve as barriers.

In response, states have been trying to enact legislation to expand the SOP for APPs, but interviewees in Michigan and Virginia shared that these bills have been contentious, often resulting in a "tug of war" between physicians and APPs. Despite the pushback, a director of a psychiatric NP program in Virginia noted that the state recently reduced the required collaboration period with a physician from five to three years before psychiatric NPs can practice independently.[40] They found that state policymakers were swayed by the expectation that independently practicing NPs would provide services in underserved rural areas that have been unable to attract physicians.

Spotlight

Virginia creates new pathways to BH practice

Interviewees from Virginia were particularly enthusiastic about two new laws aimed at expanding the BH workforce by creating new pathways to practice.

First, the state recently established a new provider category called "behavioral health technicians."[41] These professionals can now join care teams, deliver BH services to patients, and receive compensation with only an associate's degree. Previously, a minimum of a bachelor's degree was required to qualify as a BH professional and gain employment.

Second, the state passed legislation allowing master's-level psychologists to practice independently after completing one year (2,000 hours) of supervised practice under a doctoral-level psychologist.[42] According to interviewees familiar with these policy changes, the state aims to expand the pool of independently practicing BH providers, with master's-level psychologists as the first step toward achieving this goal.

ASPIRING PEER SUPPORT WORKERS FACE REGULATORY BARRIERS THAT STATES ARE WORKING TO REDUCE

Stakeholders familiar with peer support workforce issues highlighted certain state laws that can prevent aspiring peer support workers from seeking certification or finding employment. First, interviewees shared that in certain states, peer support workers seeking certification or employment must clear background checks that demonstrate that they have had no prior criminal convictions. Given that the intention of the peer support workforce is to have people with lived experience of mental health and substance use disorders provide support to those seeking treatment, banning those with prior convictions from qualifying as peer support workers can eliminate far too many qualified candidates.[43] Virginia recently enacted legislation to remove barriers related to hiring peer support workers with certain prior criminal convictions.[44]

Second, state requirements that peer support workers have personal experience with BH treatment can sometimes be overly narrow. For example, Michigan had a requirement that peer support specialists had to have received treatment through the public mental health system. This significantly limited the pool of people who could qualify.[45] The state has subsequently expanded eligibility allowing those who have received public or private mental health services to qualify as a peer support specialist.[46]

INTER-STATE LICENSURE AND STATE LICENSURE RECIPROCITY CAN POTENTIALLY MITIGATE REGIONAL SHORTAGES

Interviewees familiar with BH workforce issues in all three study states praised inter-state licensure and state reciprocity as a way to increase access to BH providers by allowing them to serve populations in multiple states. Additionally, they find that allowing this kind of flexibility can help attract and retain talent by broadening job opportunities and reducing bureaucratic hurdles. However, some states have struggled to join these inter-state compacts. For example, a stakeholder in New Mexico who works with several graduate-level BH provider groups said that the state has experienced "major barriers" to joining interstate compacts because of the perception that out-of-state providers might not be able to provide culturally competent care. However, the stakeholder noted that this concern is rarely an issue in practice, as BH providers in interstate compacts often work in communities near the state border with similar cultures.

Valuing BH Providers

Across all three study states, interviewees expressed concerns about the undervaluing of BH providers within the health care system. They pointed specifically to low reimbursement rates, overwhelming practice burdens, and minimal opportunities for advancement. These issues create barriers to recruitment and retention, contributing to the ongoing workforce shortages in the BH field.

LOW REIMBURSEMENT RATES FOR BH SERVICES LIMIT ACCESS FOR UNDERSERVED POPULATIONS BUT INCREASING RATES ALONE CANNOT SOLVE THE COMPLEX CHALLENGES PROVIDERS FACE

Interviewees in Michigan and Virginia said that reimbursement rates for BH services, under Medicaid and private insurance, tend to be too low and that these low rates significantly limit access to care for underserved populations. For example, one provider in Virginia described how low reimbursement rates for BH services have led to providers shifting to "cash-only practices," eschewing both public and private insurance. A provider from Michigan, whose practice focuses on serving low-income populations with SUDs, reported that low Medicaid reimbursement rates have made the practice financially unsustainable. The practice has had to rely on philanthropic donations and grant funding to provide even the most "basic standard of care."

In addition to limiting access to care, inadequate reimbursement directly impacts the recruitment and retention of BH providers. As one expert on Virginia's BH workforce policy noted, providers have to consider their return on investment given the cost of their education and licensure. Another policy expert noted that the high level of stress in providing BH services, combined with low reimbursement, discourages new providers from entering the field and drives experienced providers away. One provider in Michigan highlighted significant pay discrepancies between physicians who deliver non-BH medical services, such as surgeons, and those who practice in the BH space, and claimed that this discrepancy was rooted in a lack of respect for the BH workforce and the people they serve.

Both Michigan and Virginia have attempted to remedy this issue by increasing their reimbursement rates. In Michigan, an interviewee who works closely with the BH provider community found that the increases had been insufficient, and that it would require "doubling the [current] rates" to move the

needle, but worried that this would be "politically infeasible." Virginia Medicaid, on the other hand, increased its reimbursement rates significantly but only for SUD treatment services. In 2017, the state established the Addiction and Recovery Treatment Services program, which among other policy changes, increased reimbursement for SUD treatment services for the first time since 2007.[47] An early evaluation of the program found that it had increased the number of SUD providers participating in Medicaid by 173% (from about 1,000 to almost 3,000).[48] A former state official said that the higher reimbursement rate has "created a financial model that allows businesses to operate and stay in practice," and not have to rely on nonprofit funding to keep their doors open.

However, according to what we heard from interviewees from New Mexico, increasing reimbursement rates alone is unlikely to be a silver bullet in increasing access for low-income people seeking BH services. Interviewees familiar with the BH landscape in New Mexico informed us that the state has some of the highest Medicaid rates in the country,[49] but despite this, many providers still do not accept Medicaid beneficiaries for a few different reasons. First, they find that higher rates do not always translate into higher salaries and wages for BH providers. Second, the high acuity of the Medicaid patient population and the intensity of the work can serve as a deterrent. Third, interviewees find that New Mexico's Medicaid rules can be burdensome, and many times, providers do not get paid the entire amount for submitted claims.

HEIGHTENED PRACTICE BURDENS LEAD TO HIGH RATES OF BURNOUT

In addition to financial stress, excessive workloads and lack of resources contribute to high rates of burnout among BH providers. For example, interviewees in New Mexico noted how bilingual providers are often burdened with more patients due to their unique skill set, but do not receive any additional compensation. Similarly, insufficient support staff and resources force many providers to take on roles beyond their primary duties. Many providers enter this profession motivated by a desire to help people, and without support staff, this has resulted in many going above and beyond the delivery of BH services to try to improve their patients' outcomes. For example, one state official who works on BH workforce issues in New Mexico said that they have even seen physicians "go in and help clean out an apartment" for a patient. These additional responsibilities not only overextend providers but exacerbate burnout.

Furthermore, the practice environment itself can contribute to job dissatisfaction. As one

respondent explained, "those early practice years… [pose] the biggest risk for people leaving the field because they don't feel like they have the support that they need." This lack of support in part stems from a model of care delivery that is isolated and siloed off from medical care, rather than collaborative team-based models.[50] "There's no time to collaborate," as one provider from Michigan explained.

In January 2024, Michigan's Medicaid agency began allowing providers treating substance use disorders to bill for "psychiatric collaborative care management services."[51] However, a provider in Michigan noted that the lack of outreach about this policy change has left many providers unaware, thereby limiting its potential impact.

PROVIDING OPPORTUNITIES FOR ADVANCEMENT AND UPSKILLING CAN HELP RETAIN WORKERS IN THE BH FIELD IN THE LONG-TERM

In addition to burnout, many BH providers face limited opportunities for career advancement, which further drives attrition from the field. Often providers reach the "ceiling of their pay scale," which can then force them to leave the BH workforce entirely. To help these providers advance in their careers and earn more pay, one New Mexico organization offers licensed professionals free access to expensive trainings on skills such as dialectical behavioral therapy and cognitive behavioral therapy.[52] However, access to such free training opportunities is not common.

Similar challenges with career advancement are also faced by the peer support workforce. As an interviewee from Michigan who works closely with this workforce shared, some peer support workers are "ambitious" and seek opportunities to advance, but "there's not a lot of opportunity for other jobs, [and] most places don't have a peer career ladder—you're a peer and that's it." The interviewee shared information about a program out of Wayne State University—Peers to Higher Education—that is helping peers with lived experience transition into bachelor's of social work and master's of social work programs.[53] This program has the dual benefit of (1) bringing those with lived experience into the social worker workforce, and (2) ensuring that peer support workers looking for advancement can do so without exiting the BH workforce. These types of programs create upward mobility in the BH workforce and help retain skilled workers who might otherwise leave the field due to limited opportunities.

Workforce Planning

Workforce planning is crucial for ensuring that the BH workforce can meet growing demand. Effective workforce planning can enable policymakers and health leaders to allocate resources efficiently and prepare the workforce for future challenges. By identifying and overcoming barriers such as inadequate data and limited collaboration, states can build a more resilient BH workforce and improve care delivery for vulnerable populations.

OBTAINING AND USING BH WORKFORCE DATA TO ESTIMATE SUPPLY AND DEMAND IS CRITICAL FOR STRATEGIC WORKFORCE PLANNING

Several interviewees find that BH workforce data issues make it difficult to accurately count current providers or project future shortages.[54] For example, state officials working on workforce issues said that they would gain a more complete picture of workforce needs if they could survey BH providers during their licensing renewal process. However, since this process is often handled by a separate agency, coordinating efforts between the two can be challenging. Improved collaboration between state agencies could help create a more comprehensive understanding of workforce needs. For example, a Michigan state health official said that they would gain a more complete picture of workforce needs if they could survey BH providers during their licensing renewal process. However, since this process is often handled by a separate agency, coordinating efforts between the two can be challenging.

An academic BH workforce researcher in New Mexico reported that the lack of national benchmarks for what constitutes an adequate supply per capita for most BH provider types makes it particularly hard to identify shortages. An academic researcher from Michigan described a project that is under development that will model community needs using local data on BH system capacity and delivery. It could potentially help a community predict outcomes of different interventions, such as adding a provider or treatment team, and could help states and localities make strategic workforce investments.

LACK OF COMPREHENSIVE WORKFORCE PLANNING CAN RESULT IN SILOED REFORMS THAT CREATE UNINTENDED CONSEQUENCES

In all three study states, respondents pointed to programs with financial incentives aimed at filling specific roles that

inadvertently created new gaps in other settings, as the limited pool of providers shifted between positions.

When New Mexico set its Medicaid reimbursement rate for community health workers at $60 an hour,[55] a state public health official reported seeing an influx of nurses and social workers seeking community health worker certification. A former state official from Virginia reported that when the state began offering significant hiring bonuses to fill critically understaffed state hospital positions, community-based clinics in the public BH system became concerned about their ability to compete for providers. Multiple interviewees from Michigan indicated that recent state policy changes designed to bring more BH providers into school settings ultimately shifted existing providers away from the community-based BH system rather than increasing the overall workforce.

COLLABORATION IS KEY TO EFFECTIVE WORKFORCE PLANNING

Interviews revealed that workforce data and the stakeholders responsible for implementing effective interventions are dispersed across multiple entities including state and federal agencies, legislative committees, academic centers, provider associations, higher education institutions, and the BH delivery system. All three of our study states currently have efforts underway to create cross-sectional collaboration.

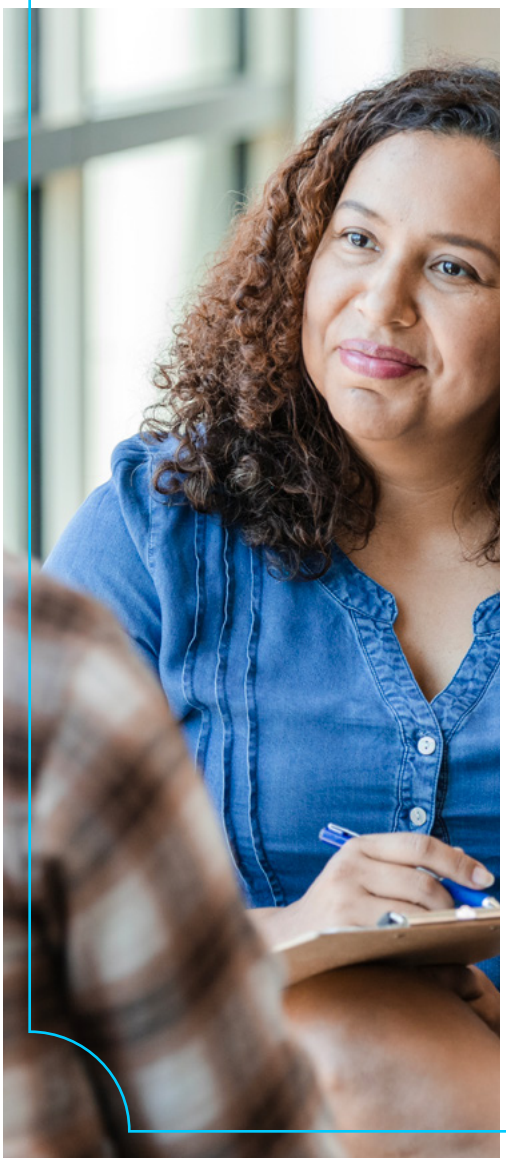
A Michigan state health official said that growing concern over health care workforce shortages has prompted the state's health and human services agency to create a steering committee of departmental leaders and the governor's office. The Michigan legislature also created a separate Opioid Advisory Commission in 2022 to make recommendations on improving the prevention and treatment of substance use disorders, including those related to tackling the state's BH workforce needs.[56] New Mexico has created a legislatively mandated committee that brings together state agencies, professional associations, and academics to annually report on the state's health care workforce and issue policy recommendations.[57] In Virginia, a state health official noted that health care workforce planning has now been centralized under the Virginia Health Workforce Development Authority.

By fostering stronger collaboration across diverse stakeholders, states can ensure a more coordinated and effective approach to tackling workforce shortages, ultimately improving access to BH services for those who need them most.

Recent Increases in Funding Support BH Workforce Development

According to interviewees, all three study states have seen an influx of funding to support BH workforce development because of two recent policy developments.

- **COVID-19 Pandemic-Related Funding:** Stakeholders in all three states reported an increase in attention and funding for BH workforce issues since the outbreak of the COVID-19 pandemic. As one Virginia stakeholder noted, "nobody paid attention to workforce [issues] before, and now everybody is paying attention to it," leading the state's General Assembly to make some much-needed investments in the state's BH workforce. This sentiment was echoed by a Michigan state official, who said that this new funding has allowed them "to implement more creative thinking and roll out additional programs."
- **Opioid Settlement Funds:** Opioid settlement funds are financial settlements between U.S. states, local governments, and pharmaceutical companies,



distributors, and other entities involved in the opioid crisis.[58] These settlements, which total $55.2 billion to date, aim to mitigate the widespread harm caused by the opioid epidemic.[59] While states and localities have invested these settlement funds in different ways, participants from Michigan, Virginia, and New Mexico describe using portions of their settlements to invest in BH workforce initiatives. For example, in Michigan, several interviewees described how these settlement funds let them expand loan repayment programs to support providers who treat opioid use disorders.

However, interviewees cautioned that simply dedicating additional funding to create new employment opportunities for BH providers might not be successful when the state does not have a sufficient pool of providers to operationalize the reforms. For example, interviewees in New Mexico noted that while pandemic-fueled funding had allowed the state to increase peer support worker programming, the state could not fully leverage the opportunity because clinics lacked the workers to implement the new services. Further, interviewees reiterated the importance of consistent and sustainable funding, which raises questions about the ability of these temporary sources of funding to sustain programs in the long term.

Recommendations for State Policymakers

To build a BH workforce that can meet rising demand for services, states have a range of strategies that they can implement to expand education opportunities, reduce financial barriers, and remove regulatory hurdles. Given the pervasiveness of the shortages and the different communities affected by them, there is an opportunity for policymakers with diverse perspectives to build a coalition to drive policy change in this space. The following recommendations outline specific actions that can support the recruitment and retention of a robust BH workforce, particularly in underserved and rural areas.

EXPANDING EDUCATION AND TRAINING OPPORTUNITIES

- Adequately fund program evaluators and researchers to study the impact of pipeline programs on boosting BH workforce numbers.
- Consider developing a pipeline program like the one at the University of New Mexico, which recruits rural students for accelerated BA/MD programs.
- Leverage state funding to expand the number of psychiatry residency spots.
- Offer technical assistance to health care institutions to help them overcome accreditation-related hurdles to establishing psychiatry residency programs.
- Establish programs to adequately reimburse supervisors, preceptors, and faculty for their time and expertise. Ensure that reimbursement amounts are commensurate with the amount of money that licensed providers can earn through clinical work.

MAKING EDUCATION AND TRAINING AFFORDABLE

- Develop a BH-specific loan repayment program.
- To ensure a culturally competent BH workforce, ensure that financial reimbursement programs prioritize multilingual providers and providers of color.
- Leverage opioid settlement funds to create financial support programs specifically for BH providers who treat substance use disorders.
- Develop a coordinated strategy to support the clinical training phase for master's-level BH providers. This strategy could be modeled after the existing framework used to manage and

fund graduate medical education for medical school graduates across the country.

- As a potential component of the above strategy, establish programs that alleviate the financial costs of receiving supervision for graduate-level BH providers, such as clinical social workers and professional counselors.
- Support the development of BH provider training programs set in rural areas to give aspiring providers necessary training and an immersive experience.

REMOVING REGULATORY BARRIERS TO PRACTICE

- Ensure that the regulatory requirements different state entities impose on BH providers are not conflicting.
- Reconsider requirements that prohibit one type of BH provider (such as a clinical social worker) from being supervised by another type of licensed and experienced BH provider (such as a professional counselor or a psychologist).
- Consider easing scope of practice restrictions on advance practice professionals, such as psychiatric NPs.
- Develop BH practice pathways for aspiring providers with associate's degrees and allow them to join BH care teams.
- Expand the pool of independently practicing BH providers, such as master's-level psychologists.
- Remove certification and employment barriers that prevent those with prior convictions from working as peer support workers.
- Consider how joining inter-state licensure compacts and allowing for license reciprocity with other states, especially neighboring ones, could increase the pool of available BH providers in your state.

VALUING BH PROVIDERS

- Evaluate whether current Medicaid reimbursement rates for BH services sufficiently reflect their value.
- Examine Medicaid payment rules to ease administrative burdens and ensure that BH claims are being paid in full when appropriate.
- Ensure that private insurers are complying with mental health parity laws and are not paying less for BH services than they do for comparable physical health services.
- Support collaborative, team-based BH care that can alleviate practice burdens by, for example, reimbursing for care coordination between different levels of BH providers.

- When introducing new billing codes for services, proactively conduct targeted outreach, particularly to independent providers, to ensure timely awareness and adoption of the policy change.

WORKFORCE PLANNING

- Improve data sharing between state agencies to ensure a more accurate understanding of BH workforce numbers and projections.
- Bring together the different state agencies, legislative committees, academic centers, provider associations, and higher education institutions involved in supporting the development of the BH workforce to allow for cross-sectional collaboration and planning.

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