REPORT

Behavioral Health Workforce Shortages and State Resource Systems

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- Promote policy innovation and communication among state legislatures.
- Ensure state legislatures a strong, cohesive voice in the federal system.

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Overview

As the prevalence of mental and behavioral health conditions and substance use disorders increases, so does the need for mental and behavioral health care professionals. But large caseloads, burnout and confusing or costly credentialling processes all contribute to a critical shortage of providers.

This policy brief underscores the urgent need to address the provider shortage for behavioral health services in America. It reflects intensive deliberation and research conducted by the Mental Health Matters National Task Force, a bipartisan group of policymakers and experts convened by the State Exchange on Employment and Disability (SEED) in collaboration with the National Conference of State Legislatures and The Council of State Governments. The task force explored policy options to address major workforce challenges and barriers to employment for people with mental health conditions. Its preliminary findings outlined policy principles and factors policymakers may want to consider when drafting and evaluating related policies.

About SEED

The State Exchange on Employment and Disability is a unique state-federal collaboration that supports state and local governments in adopting inclusive policies and practices that lead to increased employment opportunities for disabled people, and a stronger, more inclusive American workforce and economy. SEED is funded by the U.S. Department of Labor's Office of Disability Employment Policy.

IN THIS REPORT

The policy options presented in this brief, which were informed by the findings of the task force's Behavioral Health Workforce Shortages and State Resource Systems subcommittee, broadly fall into five categories:

Understanding the Challenge

The United States is facing an acute behavioral health provider shortage. Mental Health America's "The State of Mental Health in America 2023" report notes that, as of June 2022, only one mental health care provider is available for every 350 people in the country. This shortage is particularly evident when examining regional and state differences, leaving more than 152 million people in a "mental health workforce shortage area."

Addressing this workforce shortage takes on an even greater urgency when viewed in the context of the current American mental health landscape. According to the Substance Abuse and Mental Health Services Administration, 58 million adults experienced a mental health condition in 2021, but an undersized mental health workforce and lack of available treatment options in workforce shortage areas resulted in only 28% of mental health needs being met. Geographic and income disparities also significantly impacted availability of care, with nearly two thirds of shortage areas located in rural or partially rural areas.

Perhaps most concerning is the fact that the shortage of mental health care workers has negatively impacted the workers themselves. A U.S. Surgeon General report identified excessive workloads, administrative burdens, limited say in scheduling and lack of organizational support as key contributing factors to rising burnout rates among the mental health care workforce. Wheel, a virtual care platform, published a 2021 article outlining some of the challenges facing behavioral health workers. Specifically, three-quarters of surveyed psychiatrists reported burnout, and 1 in 6 screened for depression. More than 90% of college counseling center practitioners reported burnout as well.

Gather Data and Promote Employment Opportunities

Data collection and analysis are strategies some states have used to gain greater insight into the mental health and behavioral health workforce gaps. Proper data can inform decision-making and lead to improved outcomes. Data collection and analysis, coupled with identifying and disseminating effective strategies for recruiting, training and retaining additional mental health professionals, can be an important first step in reducing workforce shortages.

States may want to consider the following policy options to gather data and promote employment opportunities:

- Complete studies on the behavioral health care workforce, including challenges and solutions related to the recruitment and retention of mental health professionals.
- Publish reports that highlight effective strategies for recruiting, training, and retaining of additional mental health professionals with diverse backgrounds and identities that reflect the populations they serve.
- Require the applicable state agency to issue a statewide substance use disorder workforce needs assessment.
- Develop a comprehensive workforce plan to increase licensed and/or certified behavioral health professionals, which may include recommendations on topics such as the following: promoting related careers, providing more resources for training and degrees in-state; expanding tuition reimbursement for those studying to work in the behavioral health field; and expanding virtual behavioral health care.
- Explore the use of apprenticeship programs for substance use counselors to remove barriers to entry into the workforce.
- Require certain state-funded medical institutions to develop and implement mandatory training on health equity.

STATE EXAMPLES

California AB 666 (2022) required a comprehensive assessment on the state of the substance use disorder workforce as well as barriers to entry into the substance use disorder workforce. The bill also authorized increased workforce development programing for substance use disorder professionals.

Pennsylvania HR 193 (2019) requested a study on the mental health care workforce, including substantial challenges and possible solutions. The published report, developed by the Pennsylvania Joint State Government Commission, provides recommendations, such as utilizing integrated care models and developing additional psychiatric residency positions in the state.

Tennessee SB 0298 (2021) required state medical colleges and institutions to administer residency programs for psychiatrists in rural and other underserved areas.

Minnesota created a Rural Health Advisory Committee to assess mental health care in rural areas. After its research, the committee recommended expanding recruitment efforts, decreasing barriers to training, greater mental health collaboration in primary care and extending the careers of retiring workers.

Idaho created a Behavioral Health Council that developed a comprehensive workforce plan to increase licensed and/or certified behavioral health professionals. The plan includes recommendations for promoting careers in behavioral health and providing more resources for training and in-state degrees. It also recommends expanding tuition reimbursement opportunities for those studying to work in the behavioral health field and expanding behavioral health care options.

Washington established a behavioral health training facility and scholarship program for students who commit to going into a behavioral health profession.

Embrace New Tools

States are using available resources, such as the National Suicide Hotline or 988 Lifeline, to increase access to emergency mental health care. The launch of the 988 Lifeline came with more than $432 million in federal funding, including $105 million from the American Rescue Plan Act. These funds provided states flexibility to invest in state level programs to support their 988 call centers and other mental health professionals. To buttress and sustain these programs, some states also include telecommunications fees that support their 988 programs.

States may want to consider the following policy options as strategies for supporting and/or embracing new tools:

- Adopt legislation establishing a statewide behavioral health crisis response system offering individuals mental health, substance use or emotional crisis help, and information and referrals;
- Create a line tax to fund 988 implementation and plans for call center hubs; the technology platforms to operate and support them; and the behavioral health crisis response services system for callers;
- Establish a task force, committee and/or crisis hotline center to improve equity in behavioral health treatment and ensure culturally, linguistically and developmentally appropriate responses to individuals experiencing behavioral health crises; and/or
- Provide extensive technical assistance guidance, including links to national resources, on the implementation of the National Suicide Hotline Designation Act of 2020.

STATE EXAMPLES

Virginia SB 1302 (2021) established a crisis call center to provide crisis intervention services and crisis care coordination to individuals accessing the National Suicide Prevention Lifeline 24/7.

Colorado SB 154 (2021), along with the launch of the 988 Suicide Prevention Lifeline, established telecommunication fees that support the call centers and mental health professionals.

Minnesota SF 2995 (2023) established a 988 Lifeline center to answer calls from individuals accessing the Suicide and Crisis Lifeline from any jurisdiction within the state 24/7. The crisis center is directed to actively collaborate and coordinate service linkages with mental health and substance use disorder treatment providers, local community mental health centers (including certified community behavioral health clinics and community behavioral health centers), mobile crisis teams, and community based and hospital emergency departments. The bill also established a 988 special revenue account to fund and maintain the statewide crisis hotline.

Delaware HB 160 (2023) created the framework to maximize the benefits of 988 and provide crucial support to Delawareans in need through the implementation of a practical, modern, comprehensive and integrated crisis care system. Under this act, the proposed integrated crisis care system consists of a statewide 24/7 behavioral health crisis communications center capable of telephonic, text, and chat to receive communications made to 988. This act also establishes a Behavioral Health Crisis Services Board to provide additional oversight and input on the development of the system.

For more information on state legislation that leverages available resources to support 988 crisis response, see the 988 Crisis Response Legislation Map.

Embrace Peer Support Specialists

States are also addressing the mental health crisis by increasing the role and prevalence of peer support specialists. While care provided by a peer support specialist does not replace treatment from a health care provider, it can provide an added layer of support. As nonclinical health professionals, peer support specialists bring their lived experience with mental health conditions or substance use disorder into a formal setting to support and advocate for those experiencing or in recovery from mental health conditions. Growth of the profession has been partially propelled by Medicaid reimbursement; at least 39 states currently allow Medicaid reimbursement for peer support specialists. However, certification and training requirements vary by state, and according to the American Psychiatric Association "there is limited agreement regarding supervisory structures, certification standards, and the ways in which peer support specialists should collaborate with other professionals in the field."

States may want to consider the following policy options as strategies for embracing peer support specialists:

- Define the term "peer support specialist" in statutes, clearly identifying their roles and responsibilities, including how they complement other mental health professionals.
- Establish training and certification requirements for state-run programs or third-party organizations, including terms of curriculum, requirements, and continuing education standards to become eligible peer support specialists.
- Allow certified peer support specialists to qualify as medical assistants under the state's Medicaid program, and thus qualify for reimbursement.
- Include peer support specialists in behavioral health criminal justice programming.

STATE EXAMPLES

Florida Statute 29 § 397.417 (2023) requires certified recovery peer specialists to complete 3,000 hours of supervised work or volunteer experience and 40 hours of training or obtain a certificate of completion from a program approved by Mental Health America.

Montana HB 137 (2023) required certified peer specialists to have a behavioral health disorder diagnosis from a mental health professional; have received treatment for the diagnosed behavioral health disorder; be in recovery, as defined by board rule, from the behavioral health disorder; and have successfully completed an approved program in behavioral peer support, including ethics requirements. In addition, the applicant for certification must have completed 1,000 hours of supervised training and work experience as a peer support specialist.

Oregon Statute 34 §414.665 (2021) requires peer wellness specialists to complete 80 hours of training and peer support specialists to complete 40 hours of training.

Utah HB 468 (2023) defined a peer support specialist as an individual who has a disability or a family member with a disability or is in recovery from a mental [health condition] or SUD and uses personal experience to provide support, guidance or services to promote resiliency and recovery. The bill also required a comprehensive review of an applicant's background if the applicant is applying to work in a program as a peer support provider.

Virginia HB 1525 (2023) permits the Department of Behavioral Health and Developmental Services to hire peer support specialists to support adult substance abuse treatment programs. These individuals include those who may have previously been convicted of a specified offense substantially related to their own substance abuse or mental illness and have been successfully rehabilitated.

Break Down Barriers to Behavioral Health Care Professions

Growing the behavioral health workforce requires taking steps to remove barriers to pursuing and entering various related professions. Educational and financial burdens, limited career pathways, reciprocity and licensure restrictions, and provider burnout are some of the factors impeding this sector's growth and fueling workforce shortages.

States may want to consider the following policy options to break down barriers to behavioral health care professions:

- Promote reciprocity and expedited licensing for those with behavioral health licenses from other states, including for active military, military spouses, and veterans.
- Participate in interstate compacts around behavioral and mental health occupations.
- Evaluate licensure requirements for behavioral health professionals and considering ways to increase the number of providers, such as allowing foreign education equivalents, actively recruiting individuals with lived experience, or updating the type of degrees needed to obtain licensure.
- Promote alternative pathways to licensure, such as apprenticeship and credential programs.
- Prioritize scholarship and loan repayment programs to individuals pursuing behavioral health careers.

STATE EXAMPLES

Arkansas Act 260 (2023) created the Counseling Compact in Arkansas. The purpose of this compact is to facilitate interstate practice of licensed professional counselors with the goal of improving public access to professional counseling services. It allows licensed professional counselors in Arkansas to treat clients in person or via telehealth in other compact member states.

Connecticut HB 5001 (2023) established a Human Services Career Pipeline program, intended to facilitate collaboration between workforce boards and educational institutions as they develop career pathways. The program is intended to ensure enough trained providers are available to serve the needs of persons in the state with developmental disabilities, physical disabilities, cognitive impairment or mental [health conditions], as well as elderly persons. The bill also mandated that the chief workforce officer consult with Mental Health and Addiction Services and other disability agencies to identify: (1) the greatest needs for human services providers and (2) barriers to hiring and retaining qualified providers.

Maine HB 631 (2021) allowed Maine psychologists to provide services to clients while they are out-of-state through the Psychology Interjurisdictional Compact (PSYPACT). PSYPACT was created to facilitate telehealth and temporary in-person, face-to-face practice of psychology across jurisdictional boundaries. Maine psychologists must possess an active "E.Passport" issued by the Association of State and Provincial Psychology Boards to provide telehealth services or possess an active Interjurisdictional Practice Certificate from the association to provide in-person services under the compact. As of 2023, 26 states had passed laws allowing such interstate practice.

Nevada SB 44 (2021) required agencies to examine and update their licensing and certification requirements to lower barriers to entry. Notably, this bill allowed people who had received their behavioral health education from a foreign institution to apply for licensure if they meet the other requirements. Another change allowed for expedited licensure for military spouses, military personnel and veterans.

Oklahoma SB 773 (2019) established the "Oklahoma Mental Health Loan Repayment Act," requiring the Oklahoma Department of Mental Health and Substance Abuse Services to administer the Oklahoma Mental Health Loan Repayment Program. The program is intended to provide educational loan repayment assistance for mental health or substance abuse treatment providers who provide services in Health Professional Shortage Areas (for mental health).

Minnesota Statute §144.1501 (2022) created a Rural Physician Loan Forgiveness Program for family practice, obstetrics, gynecology, pediatrics, internal medicine, and psychiatry physicians.

Iowa's Health Careers pilot supports registered apprenticeship programs that help students pursue nursing pathways. The 2023 program expands opportunities for health care apprenticeships to include emergency medical technicians, registered nurses, direct support professionals, behavioral health and substance abuse specialists, and other critical occupations. At least four 2023 awardees have a training focus on behavioral health care apprenticeships.

Washington State has a multi-partner program with apprenticeship opportunities in behavioral health professions. In 2022, it launched apprenticeship programs for behavioral health technicians, peer counselors, and substance use disorder professionals.

Address Burnout

Mental health professionals report higher burnout and stress compared to other workforce segments. According to a 2023 survey from the National Council for Mental Wellbeing, 93% of behavioral health workers said they have experienced burnout, and 62% report suffering from moderate or severe levels of burnout.

States may want to consider the following policy options to address burnout:

- Establish mental health hotlines for specific groups, including behavioral health care workers and frontline workers.
- Develop new or expanded supports to meet the needs of client populations that have historically required high levels of support (e.g., establishing outreach and substance use disorder recovery programs for homeless veterans).
- Create a work group and corresponding report related to frontline worker trauma-informed care.
- Require the state insurance agency, or similar agency, to issue an emergency rule waiving certain mental health service costs for frontline health care workers for a specified time, with retroactive applicability.

STATE EXAMPLES

Arkansas Act 537 (2023) ensured insurance coverage for traumatic event counseling for public safety employees and required a study of availability for peer support access for volunteer firefighters. Eligible employees include firefighters, police officers, marshals, and other public safety workers.

New York SB 1301 (2021) directed the Commission of Mental Health to create a work group and corresponding report regarding frontline worker trauma. The report was also required to identify training opportunities for employers with frontline workers to support their mental health and wellness.

Vermont SB 42 (2021) created the Emergency Service Provider Wellness Commission. The purpose of the commission is to holistically examine the state's support for emergency service providers and identify gaps and opportunities to better serve them.

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