

Behavioral Health Workforce is a National Crisis: Immediate Policy Actions for States

Introduction

Nationally, there is more demand for behavioral health (mental health and substance use) treatment than workforce capacity to deliver services. Payment, clinical and regulatory models underlie what has become a national behavioral health workforce crisis. Health Management Associates (HMA) and the National Council for Mental Wellbeing prepared a series of three issue briefs that offer states immediate policy actions to expand current capacity and build a more stable future workforce:

- + **Policy, Financial Strategies and Regulatory Waivers** (October 2021)
- + **Clinical Care Delivery Models and Digital Solutions with an Emphasis on Leveraging the Certified Community Behavioral Health Clinic Model** (October 2021)
- + **Strategies to Address Diversity, Equity and Inclusion** (November 2021)

These issue briefs provide solutions that can be immediately implemented, reduce administrative burden and maximize existing provider resources. The goal is to rapidly improve access to treatment services at a time of rising demand by expanding current workforce capacity and promoting strategies that will have long-term, enduring impact. All recommendations have been developed by subject matter experts from HMA and the National Council with input from state leaders, a survey of state associations of the National Council and additional networks.

Demand for Behavioral Health Continues to Grow

The COVID-19 pandemic significantly exacerbated pre-existing behavioral health conditions and has resulted in even higher levels of demand for behavioral health services. The Centers for Disease Control and Prevention (CDC) reported that the percentage of U.S. adults with recent symptoms of anxiety or a depressive disorder increased from 36.4% to 41.5% and the percentage reporting an unmet mental health need increased from 9.2% to 11.7%, with the largest increase seen among young adults (18-29) during August 2020 to February 2021 (Vahratian A. et al, 2021).

Similarly, the rising risk for substance use as a result of the COVID-19 pandemic is well documented (Alexander, C.G, et al. 2020) and early signs indicate that both alcohol use and opioid overdose are already on the rise (AMA, 2020). In the early months of the pandemic, the nation saw an 18% increase in overdoses compared with the same months in 2019. The trend has continued throughout 2020. The American Medical Association recently reported that **every state** had seen increases in opioid-related mortality (Pettersson, S. et al 2020).

Behavioral Health Workforce Has Reached a Tipping Point

Access to behavioral health services is a complex topic impacted by systemic factors such as federal and state policy, payment, provider capacity, social determinants of health, historical disparities and an individual's capacity to engage in services. Limited funding streams for behavioral health contribute to non-competitive salaries for the nation's behavioral health workforce. This forms the foundation of the workforce shortages that have developed over time and are now at a crisis point. The reality is that individuals with mental health and substance use needs are facing challenges accessing adequate, timely and affordable care **in every state in the country**—and this can lead to dire consequences such as worsening symptoms, the need for acute care services, subsequent engagement in the criminal justice system and, in some cases, suicide or overdose. Furthermore, the current crisis is contributing to long documented health disparities, including significant (and avoidable) early mortality for those with behavioral health conditions (de Mooij et al, 2019). The workforce can no longer be a separate focus area but must move squarely into the center of behavioral health policy and funding priorities for all policymakers.

According to a recent online poll conducted with 260 members of the National Council for Mental Wellbeing between September 8-23, 2021:

Demand for behavioral health organizations' services has continued to increase.

Three-quarters of members (78%) say demand for their organization's services have increased over the past three months. Since August 2020, this percentage has increased 26%. Demand has specifically increased over the past three months for organizations offering mental health treatment, crisis services, social support services and youth services.

Increased demand is causing patient waitlist to grow.

Three in five (62%) member organizations say their patient waitlist has grown over the past three months, a 17% increase since February 2021.

Organizations are having trouble recruiting and retaining employees.

Nearly all member organizations surveyed (97%) say it has been difficult to recruit employees, including 78% who say it has been *very difficult*. In an open-ended question, organizations say the main obstacles they're facing in recruiting employees include a lack of applicants overall, specifically a lack of qualified applicants; not being able to offer a competitive salary; and burnout from COVID-19.

When asked about short-term policy solutions to meet increased demand, member organizations reference **additional funding** to hire qualified staff, continuing to offer **telehealth services**, updating **reimbursement rates** and **reducing the amount of paperwork/regulation** that causes a burden to staff.

Immediate Policy Recommendations

The following recommendations are intended to be short-term policy levers to quickly impact workforce availability and retention. States can collect data to measure the impact of these interventions on the behavioral health workforce and improved access to care to inform permanent changes to regulations and payment.

RECOMMENDATION

Leverage strategies that states have used for emergency preparedness and response.

Problem with Current Status: Immediate COVID-related demands require outreach and targeted attention to those with the greatest need. Emergency preparedness and response can be an ongoing avenue for funding expansion of the workforce and meeting heightened demand following COVID-19.

Potential Solution and Outcome:

- + States, tribal or territorial governments can seek a **presidential major disaster declaration for individual assistance to obtain Federal Emergency Management Agency (FEMA) funding to implement the FEMA Crisis Counseling Assistance and Training Program (CCP)** (FEMA, 2021; FEMA, 2020). CCP includes free, strengths-based, anonymous, outreach-oriented, brief supportive counseling, public education and referrals to other services. CCP services can be delivered in-person or remotely, to individuals or groups, by clinical or non-clinical crisis counselors recruited from targeted communities. The approach addresses immediate needs and strengthens existing community support systems, arguably expanding the available mental health “safety net.” Services can be delivered via phone, internet and the media to protect health and safety. FEMA has also approved requests for model adaptations to address more intensive needs over an expanded number of sessions.
 - A lesson learned from states is that it is important to ensure that CCP programming is explicitly designed to integrate responses with existing crisis systems to reduce silos and fragmentation and improve the efficiency and effectiveness of multiple and separately funded crisis programs.
 - Additional examples from states are highlighted in Appendix A.

RECOMMENDATION

Increase funding and financial incentives to attract and retain the workforce.

Problem with Current Status: Behavioral health providers must be compensated at a level reflecting their demand within the health care system. The pandemic exacerbated the need for behavioral health providers across all disciplines (i.e., all mental health and substance use providers) including peer recovery specialists and other paraprofessionals (National Council for Mental Wellbeing, 2018). However, Medicaid and non-Medicaid funded program reimbursement rates have not kept pace, creating a financing shortfall and making it impossible for employers to invest in the wage and benefit increases necessary to retain their existing workforce or hire as necessary to meet expanded needs.

Potential Solution and Outcome:

- + **Leverage one-time stimulus funds to:**
 - Support initial signing and retention bonuses as well as training and certification costs.
 - Invest in standardized high-quality training programs.
 - Support the use of technology to expand training opportunities and distance learning.
 - Provide incentives or reimbursement to cover the cost of clinical supervision for individuals seeking higher level credentials.
 - Offer subsidies to workers to support needs such as childcare, relocation costs and transportation.
 - Provide financial resources and/or technical assistance opportunities to behavioral health providers to develop and implement local workforce development strategies and/or succession planning.
- + **Leverage stimulus funds** to create infrastructure and training to shift to value-based payment and alternative payment models that lead to long-term sustainability for providers (shifting away from fee-for-service models that were a challenge during the COVID-19 pandemic).
- + **Explore [legislation](#) to expand eligibility for the Rural Health Practitioner Tax Credit** to include behavioral health providers. The tax credit is an effective measure to attract and retain practitioners in rural communities.
- + **Identify opportunities to leverage innovative financing models** for the workforce such as career impact bonds (CIBs). CIBs offer a holistic financing model that pays for the cost of a training program and wraparound services on behalf of the student. In the case of the behavioral health workforce for example, an initial investment by public and private sector partners such as universities, philanthropy, associations, would support a CIB for Licensed Clinical Social Workers (LCSWs). LCSWs would have access to a customized solution to help support tuition and training as well as comprehensive social determinants of health benefits to support housing, transportation and childcare needs. Students pay back the costs over time as a percentage of their wages if they are able to keep jobs above a certain salary threshold. The initial investors of the CIB are reimbursed based on the successful outcomes of the [student](#).

- + **Promote existing programs and partnerships.**
 - **Promote loan repayment and the substance use disorder workforce loan repayment** available through the National Health Service Corps. Consider emergency reform of loan repayment program requirements to make more accessible. For example, consider reforming the requirement of site location hours to also include time in the community.
 - **Expand existing loan repayment and/or tuition reimbursement programs** that traditionally focus on physical health to include behavioral health practitioners.
 - Promote Health Resources Services Administration's (HRSA) willingness to **waive residency requirements** for J-1 visa holders who agree to provide services in health care professional shortage areas for three years.
 - **Consider partnerships with other state agencies** such as the Departments of Labor and Employment that may have additional federal dollars to support workforce activities.

- + **Provide financial resources and/or technical assistance opportunities** to behavioral health providers to develop and implement local workforce development strategies and/or succession planning.

RECOMMENDATION

Optimize access to the available behavioral health workforce.

Problem with Current Status: Increased demands for behavioral health services continues to escalate, exacerbating pre-existing shortages in the workforce and widening the gap in access to comprehensive health care. Policy and regulatory variances across the nation preclude opportunities to optimize the behavioral health workforce and expand access to care. There are immediate policy adaptations and supports that would aid in advancing evidence based and industry leading approaches to care, which ultimately could result in ability to reach more individuals in need.

Potential Solutions:

- + **Through payment, regulatory adaptation and training, provide support for physical health providers** to conduct routine behavioral health screening and treat behavioral health conditions through effective integrated care models and enhanced referral relationships. Access available and free technical assistance through the Substance Abuse and Mental Health Services Administration (SAMHSA) and HRSA-funded centers to integrate evidence-based models and explore sustainable adoption of integrated care models.

- + **Reduce regulatory and administrative rule paperwork requirements for behavioral health providers working in primary care** to be more aligned with primary care routine documentation standards (e.g., a tailored assessment, SOAP or subjective, objective, assessment and plan note). This will increase behavioral health provider time delivering services. (See the next recommendation on waiving administration burden).

- + **Support a psychiatric consultation model** for expanding access to psychiatry through health care providers. Although a long-term policy lever, for many states this can be improved in the short-term by sharing resources and education with providers and eventually expanding payment (such as opening collaborative care codes for Medicaid (Raney, 2020)).

- + **Review policies to support expanded access points for behavioral health in community settings.**
- + **Make regulatory/policy adjustments and/or leverage one-time stimulus funds to supplement and streamline crisis response and mobile crisis services,** for example:
 - Make mobile crisis and crisis transport an essential benefit, as ambulance transport is covered.
 - Add a central access resource line to provide pre-screening to keep people from waiting in the wrong line and speed access for all (e.g., state-level 988, LifeNet in New York City).
 - Add ride-along or telehealth consult assistance for fire departments, police departments and emergency medical transportation by supporting use of tablets and mental health tele-consultation.
- + **Update policy to allow reimbursement for clinicians eligible and working toward licensure** (completing supervised hours) at commensurate rates, provided they receive supervision.
- + **Elevate mid-level staffs' ability to approve treatment plans, approve/certify diagnosis, commitment criteria, etc.** in states where this currently remains limited to PhD and MD/prescriber staff (e.g., LCSW, Licensed Mental Health Counselor [LMHC], Licensed Clinical Addiction Counselor [LCAC], Licensed Marriage and Family Therapist [LMFT]).
 - This is both a federal and state policy measure. The limited provider capacity for Medicare treatment plans has long been a documented challenge (Pan Foundation, 2021; McGinty, 2020).
- + **Extend/adopt telehealth policies and regulatory reforms** implemented during COVID-19 to promote and support continued telehealth expansion with accountability protections. New York and Arizona offer examples (see New York State Public Health Law Article 29-G and Arizona House Bill 2454).
- + **Leverage non-traditional (paraprofessional), non-specialist providers and peer support specialists in behavioral health.**
 - **Support integration and expansion of peer workforce** with guidance from peer led organizations such as the Family Run Executive Director Leadership Association (FREDLA) and the New York Association of Psychiatric Rehabilitation Services (NYAPRS).
 - **Review criteria** for peer and recovery support workforce to ensure that it is not overly restrictive.
 - **Supplement costs for training** peer specialists and make training readily available and continually accessible.
 - Supplement funding, or **permit billing**, for peer support staff who are in training.
 - **Provide funding for peer support mentors** to promote retention.
- + **Explore innovative approaches to expanding the workforce.** Include the use of pharmacists to augment behavioral health care (e.g., provide education, conduct screenings). Increase access to behavioral health using non-specialists to deliver collaborative care (Meadows Mental Health Policy Institute (MMHPI), n.d.). Review other national and international approaches underway to train and utilize a nontraditional workforce (<https://empower.care/>).

RECOMMENDATION

Waive burdensome documentation and administrative activities.

Problem with Current Status: Inefficiencies can be reduced at every point on the continuum to maximize the available workforce while improving access to care and patient satisfaction. Traditional practices warrant review to reduce administrative burden and ensure that only necessary and valuable documentation is required. The average number of sessions for an outpatient therapy appointment is one, and this may be a result of a process that is geared towards administrative paperwork and regulation rather than symptom relief and treatment (Simon et al., 2012). The paperwork demands for behavioral health are far more expansive than other health care disciplines and as a result reduce provider time for service delivery and limit innovations in improved and alternative forms of access.

Potential Solutions:

- + **Waive elements of the comprehensive psychosocial assessment or timeline for completion:** Create a core set of necessary psychosocial elements to be completed that are consistent with health care more broadly. Extend the time for clinicians to document the entire psychosocial elements (often close to 20 separate elements) over a series of sessions and as relevant to the individual's care.
- + **Extend deadlines for service or treatment plan:** Most states require that a service plan is in place within three-to seven days of the first appointment. Allow a clinical program to create a service plan within 30 days to support more attention on the individual's needs and clinical relief up front with a plan tailored to patient specific goals.
- + **Consider eliminating requiring that the treatment plan be a separate document:** Update treatment plans as part of the clinical documentation in each session, as is done in primary health care.
 - o Standard medical care integrates the treatment plan into the body of the visit note allowing the plan to be reviewed and updated at each visit.
 - o Long-term, states need to advocate with federal agencies such as the Centers for Medicare and Medicaid Services (CMS) to allow a more streamlined and responsive service planning that is updated at each visit rather than maintaining the requirement that behavioral health treatment plans be developed as a separate document that is updated every 90 – 120 days.

Core Set of Necessary Psychosocial Elements

- + Identification and demographic data.
- + Main concern/chief complaint.
- + Relevant history of main concern.
- + Brief history of previous mental health/substance use treatment.
- + Family history of mental illness and/or substance use (if applicable).
- + Physical and whole person needs.
- + Risk assessment.
- + Mental status.
- + Potential barriers to treatment.
- + Diagnosis and sufficient supporting criteria.

- + **Adapt regulatory rule and payment to allow individuals to receive two brief intervention sessions (30 minutes each) prior to intake completion.**
 - Create immediate access and relief and allow those who need brief intervention to get services and move on more rapidly.
 - As an alternative, allow payment for two sessions with peer support specialists ahead of an intake to support engagement, individual identification of treatment goals and support to inform the next phase of care.

RECOMMENDATION

Maximize use of Medicaid graduate medical education (GME) for training the behavioral health workforce.

Problem with Current Status:

State government support for GME has been vital to supporting medical education, but there has not been parity enforcement in extending this support to behavioral health education.

Potential Solution:

- + **Expand Medicaid GME.** Medicaid GME is not a mandatory Medicaid program, but more than 40 states currently participate in this payment mechanism, which, unlike Medicare GME, is not limited to position training and teaching hospital payments. No CMS guidance has been issued and there is broad flexibility for states to structure it to pursue specific policy goals.
 - Payments can be structured with requirements for specific provider types and locations and a wide variety of different payment methodologies have been approved.
 - Any state or local tax revenue funds currently spent on behavioral health organizations could be used for new Medicaid GME payments.
 - New Medicaid GME programs could be made specific for behavioral health professionals in behavioral health community provider organizations and include requirements for specific types of training or service following receipt of the GME funding.
 - Federal Medical Assistance Percentages (FMAP) could be obtained for states deciding to appropriate new funding for behavioral health training.
 - It would be useful to survey existing Medicaid state GME programs to inventory all currently approved applicable options and recommend the best options going forward for the behavioral health field.

The behavioral health workforce shortage is a national crisis. As the demand for behavioral health treatment continues to grow, immediate action is required to address the workforce crisis. The recommendations outlined in this brief are intended to offer states short-term, immediate solutions to expand workforce capacity to meet the growing demand for services. A number of states have already acted. See Appendix B for specific examples.

Appendix

A. State Specific COVID-related CCP Programs

- New York, Texas and Louisiana established mental health support lines to expand access to counselors.
- Utah leveraged its SafeUT crisis intervention chat line (<https://safeut.org/>).
- In New York State, Project Hope includes an emotional support helpline staffed by volunteer, intensive crisis counseling services through community-based agencies and free six-week support and resilience virtual group sessions called “Coping Circles.” Specialized interventions have been developed for the health care workforce (<https://nyprojecthope.org/>).
- In Maine, the StrengthenME program includes a Frontline Warmline to support health care workers and first responders, a Teen Text Line for youth via the National Alliance on Mental Illness (NAMI) and additional funding for mobile crisis providers and agencies employing community health outreach workers to provide stress management support to disproportionately impacted communities (<https://strengthenme.com/>).
- In Vermont, VT Care Partners uses CCP funds to support its statewide network of nonprofit community-based agencies to bolster existing mental health services and improve public awareness and education about how to manage stress to prevent more significant mental health distress. Services include weekly virtual wellness sessions (<https://vermontcarepartners.org/>).
- In Arizona, the Resilient Arizona Crisis Counseling Program connects residents to free, short-term counseling statewide via the 211 system (<https://resilientarizona.org>).

B. State Strategies to Addressing the Workforce Crisis

NEW YORK OFFICE OF MENTAL HEALTH

Secured \$21 million through both The Coronavirus Response and Relief Supplemental Appropriations Act (CRRSAA) of 2021 and The American Rescue Plan Act (ARPA) of 2021 in workforce recruitment and retention funds that will help strengthen the state's mental health system and improve access to mental health services in communities across the state. Eligible outpatient and community support providers will receive funding for recruitment and retention benefits, educational expenses, career development and training. [LINK](#)

CALIFORNIA

The FY 2021-22 final state budget proposal includes grants for Medi-Cal behavioral health systems, tribal entities, health care service plans, Medi-Cal managed care plans, community-based organizations, and behavioral health providers to support implementation of evidence-based practices and community-defined programs for children and youth. Requires Department of Health Care Services to establish a Memorandum of Understanding, including \$42.9 million, with the Mental Health Services Oversight and Accountability Commission to partner on this grant program. The final state budget includes \$100 million to support youth behavioral health education and outreach programs through the Department of Public Health. [LINK](#)

VIRGINIA

Budget bill created to allocate federal American Rescue Plan Act (ARPA) that will provide \$45 million in bonuses to state behavioral health facilities and intellectual disability training centers. VA Department of Behavioral Health and Developmental Services (DBHDS) will receive \$10 million for the "continued expansion" of home and community-based services (HCBS) and an additional \$5 million for HCBS related to substance use disorder treatment. Governor Ralph Northam's proposed budget item for FY 2023 that would direct \$76.9 million to raise salaries for behavioral health workers. DBHDS is also working on "crisis system transformation." This initiative aims to make evidence-based approaches to care more easily accessible to people in behavioral health crises. [LINK](#)

COLORADO

Proposed budget through American Rescue Plan Act (ARPA) of \$280 million to strengthen the workforce and enhance rural sustainability focusing on the following: stabilizing the workforce crisis; increasing quality through training; creating career paths and investing in rural providers. [LINK](#)

ILLINOIS

The Illinois Department of Human Services (DHS) and the Illinois Department of Healthcare and Family Services (HFS) announced a \$65.4 million dollar investment in the behavioral health safety net. DMH is working to make approximately \$13M in retention payments to providers and using cannabis tax revenue to: invest \$6 million in establishing a Behavioral Health Workforce Center that will work to engage universities and stakeholders in developing and implementing a plan to strengthen the mental health workforce; invest \$5 million toward implementing a student loan repayment program to support recruitment and retention goals for safety net mental health services; and invest \$8 million to support a grant opportunity for Illinois Higher Education institutions to recruit and train individuals with lived expertise in mental health and substance use recovery to enter the behavioral health workforce. The agencies are exploring how additional funding and/or rate increases could be leveraged for behavioral health providers, whether through ARPA funding or reinvestment of MCO quality withhold dollars. [LINK](#)

HOW STATES ARE SPENDING AMERICAN RESCUE PLAN FUNDING

<https://www.nashp.org/how-states-are-spending-american-rescue-plan-state-fiscal-recovery-funds/>

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