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

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,

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

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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.
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+ **Review policies to support expanded access points for**

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:

+ **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

Appendix

- 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).

References

Annuals of Internal Medicine, M20.

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