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# Behavioral Health Workforce Employer Survey

## Initial Analyses & Key Findings


Fitzhugh Mullan Institute for Health Workforce Equity
THE GEORGE WASHINGTON UNIVERSITY

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The Substance Abuse and Mental Health Services Administration is a branch of the U.S. Department of Health and Human Services.

## Prepared By

The George Washington University
Fitzhugh Mullan Institute for Health Workforce Equity

Authors:
Leah Masselink, PhD
Clese Erikson, MPAff

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## Questions

For questions regarding this report, please contact Clese Erikson at cerikson@gwu.edu.

202-994-3423
gwmi@gwu.edu
www.gwhwi.org

2175 K Street, NW
Suite 250
Washington, DC 20036

Fitzhugh Mullan Institute for Health Workforce Equity
THE GEORGE WASHINGTON UNIVERSITY

# Table of Contents

# Table of Figures & Tables

# Behavioral Health Workforce Employer Survey

## Initial Analyses & Key Findings

The urgent need to prevent and treat substance use disorder and mental illness in the United States demands an increased focus on the distribution and adequacy of the workforce offering behavioral health (BH) services. The George Washington University Fitzhugh Mullan Institute for Health Workforce Equity was awarded a 3-year grant from the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) to build a national database on the mental health (MH) and substance use disorder (SUD) workforce and provide analysis on the extent to which efforts are needed to expand the MH/SUD workforce.

As part of this project, the Mullan Institute research team conducted surveys of behavioral health workers and employers in late 2021. The Clinical Behavioral Health Workforce Survey included licensed behavioral health providers (counselors, marriage & family therapists, psychologists, and social workers), and the Behavioral Health Workforce Employer Survey included representatives of behavioral health provider organizations identified through a membership list from the National Council for Mental Wellbeing. This report describes the findings of the Behavioral Health Workforce Employer Survey, also presented at the 2023 AcademyHealth Annual Research Meeting.[1]

## Executive Summary

The Behavioral Health Workforce Employer Survey was fielded in the fall of 2021 to National Council of Mental Wellbeing members. The survey received a 21.5% response rate and included respondents from all states except Hawaii and Wyoming. More than half of respondents said their organizations provided mental health outpatient services (78.2%), care coordination/case management (76.8%), substance use outpatient services (64.7%), support and recovery services (including peer support—58.3%), and discharge planning services (53.0%).

Findings from this survey point to significant staffing challenges among employers of behavioral health providers in 2021. The vast majority of employers (85.6%) indicated their organizations were severely or somewhat understaffed to provide serious mental illness services (35.4% severe and 51.2% somewhat) and bilingual services (52.6% severe and 34.0% somewhat). However, these staffing challenges do not seem to be leading to widespread delays in access across organizations. Nearly all respondents (93.5%) indicated that crisis services were available on the same day in their organizations. Most indicated relatively quick access for non-urgent new patient appointments, with 31.6% able to provide same-day and 37.1% within one week. However, 1 in 5 respondents indicated four weeks or longer wait times for new patient appointments with a psychiatrist or other prescriber. Not surprisingly, nearly all respondents (92.4%) indicated that their organizations provided services via telehealth as of late 2021 – up from 47.6% in 2019 (the year before the pandemic).

[1] Erikson CE, Masselink LE. Employer Perspectives on Behavioral Health Recruitment & Retention Challenges: A Mixed Methods Study. AcademyHealth Annual Research Meeting. Seattle, WA, June 2023.

Almost all respondents reported employing counselors and therapists, care coordinators/case managers, and peer support recovery specialists, and they also reported that these roles were the most difficult to recruit. About half of respondents reported employing psychiatrists, and slightly less than one-third said they employed psychologists and primary care providers. Respondents were most likely to cite general shortages, non-competitive wages, and challenging patient/client populations as reasons for their organizations' recruitment and retention challenges. When asked an open-ended question about policy recommendations for addressing staffing shortages, respondents focused on better reimbursement for clinical and support staff positions, particularly by Medicaid, and strategies for building the pipeline for Black, Indigenous, and people of color (BIPOC) populations.

Findings from this study indicate that CCBHCs have fewer workforce staffing shortages than other behavioral health organizations. Still, nonetheless, one out of three CCBHCs reported severe workforce shortages for addressing serious mental illness.

# Methods

The Behavioral Health Workforce Employer Survey was conducted by the Mullan Institute research team from September to November 2021. We invited points of contact for all provider members of the National Council for Mental Wellbeing (n = 2,307) via email to participate in the electronic survey, which we administered via Qualtrics. The survey was administered using the Dillman approach of an initial survey mailing, followed by up to three reminders with links to the survey. Survey domains included organizational treatment focus and activities, current staff configuration, recruitment and retention experiences, and staffing needs. The survey received 496 responses (21.5% response rate). The survey was cleared through the Office of Management and Budget (OMB) and approved by the GW Office of Human Research.

We conducted descriptive data analysis, including overall descriptive statistics and comparisons between certified community behavioral health clinics (CCBHCs) vs. other practice settings. The results of these analyses are reported below. We focused on CCBHCs to understand how organizations that have pursued SAMHSA's CCBHC designation (which requires them to meet specified standards for staffing, accessibility, care coordination, and range of services provided with support from Medicaid, SAMHSA and/or state grants)[2] differ from others in the field.

We also presented initial survey findings to National Council member employers (n = 24) through a series of 4 focus groups. Key discussion points from the focus groups are included below to add context and detail to the survey findings.

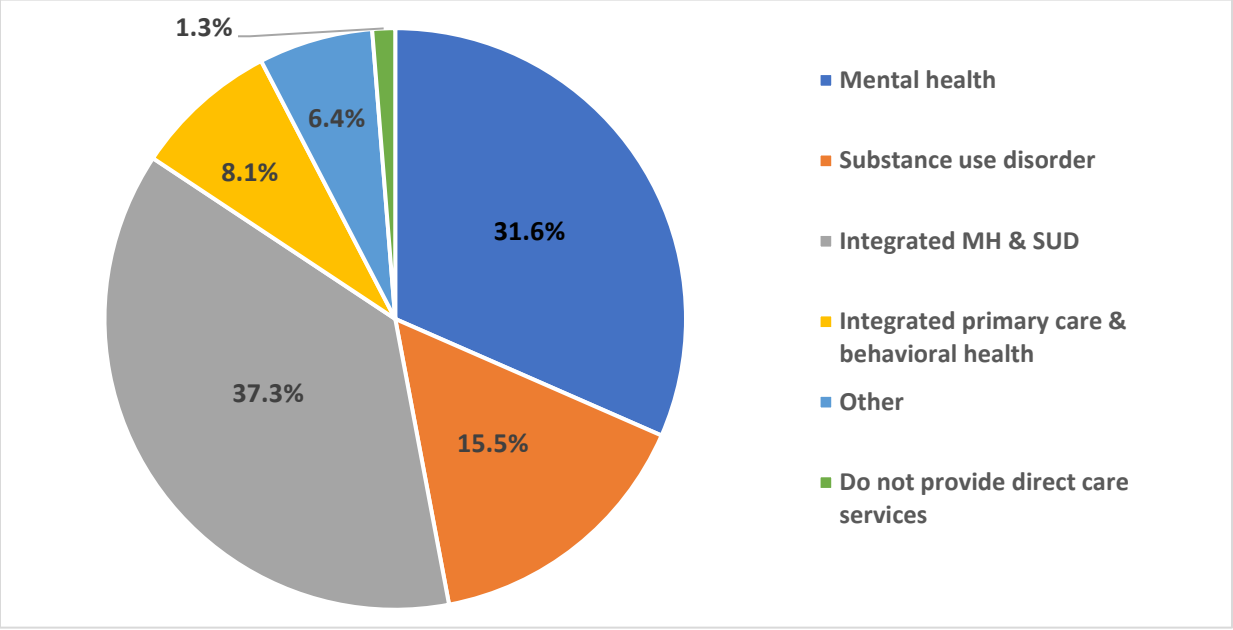
[2] Certified Community Behavioral Health Clinics. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/certified-community-behavioral-health-clinics

# Results

## Treatment Focus

When asked to indicate the treatment focus of their organizations, the largest number of respondents (37.3%) indicated that their organizations provided integrated mental health and substance use disorder treatment, followed by mental health only (31.6%), substance use disorder only (15.5%) and integrated primary care and behavioral health treatment (8.1%). The full distribution is shown in Figure 1.

**Figure 1. Treatment Focus of Survey Respondent Organizations**




## Practice Setting

When asked to indicate the practice setting(s) of their organizations, survey respondents most frequently said their organizations included outpatient settings (86.2%), followed by inpatient settings (45.8%) and other settings (34.9%). (NOTE: Respondents could select multiple responses to this question.)

The most frequently identified **outpatient** settings were:

- Community mental health centers or clinics (52.6%)
- Substance use disorder outpatient centers (31.4%)
- Certified community behavioral health clinics (CCBHCs—24.8%)

The most frequently identified **inpatient** settings were:

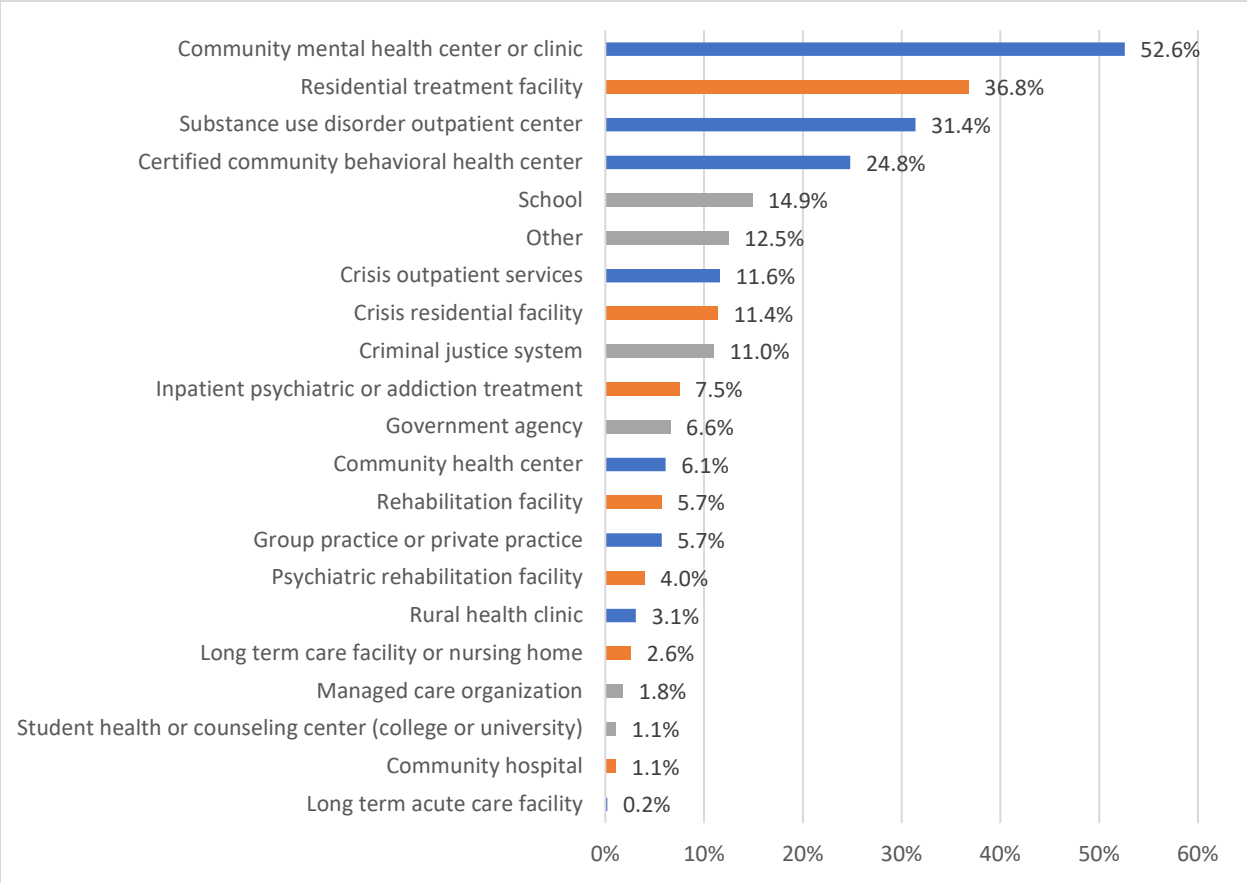
- Residential treatment facilities (36.8%)
- Crisis residential facilities (11.4%)
- Inpatient psychiatric or addiction treatment hospitals (7.5%)

The most frequently identified other settings were:

- Schools (14.9%)
- Criminal justice system (11.0%)
- Government agencies (6.6%)

The full range of responses is shown in Figure 2.

**Figure 2. Practice Setting of Survey Respondent Organizations**



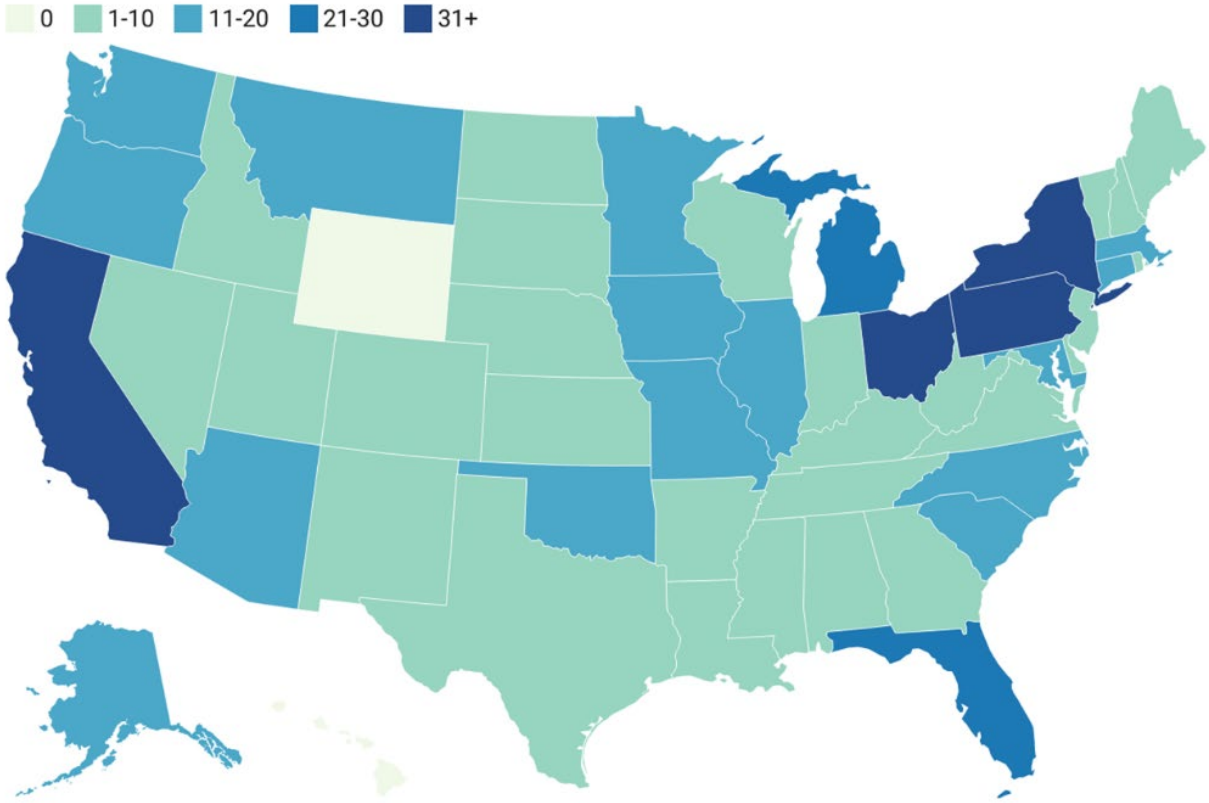

## Location

When asked to report the state(s) where their organizations were located, respondents indicated locations in all states except Hawaii and Wyoming. (NOTE: Respondents could select more than one state if relevant.) The largest numbers were in the following states:

- Ohio (9.9% of respondents)
- New York (8.3%)
- Pennsylvania (7.2%)
- California (6.8%)
- Florida (4.8%)

The distribution of respondent organizations (respondents per state) is shown in Figure 3.

**Figure 3. States of Survey Respondent Organizations**



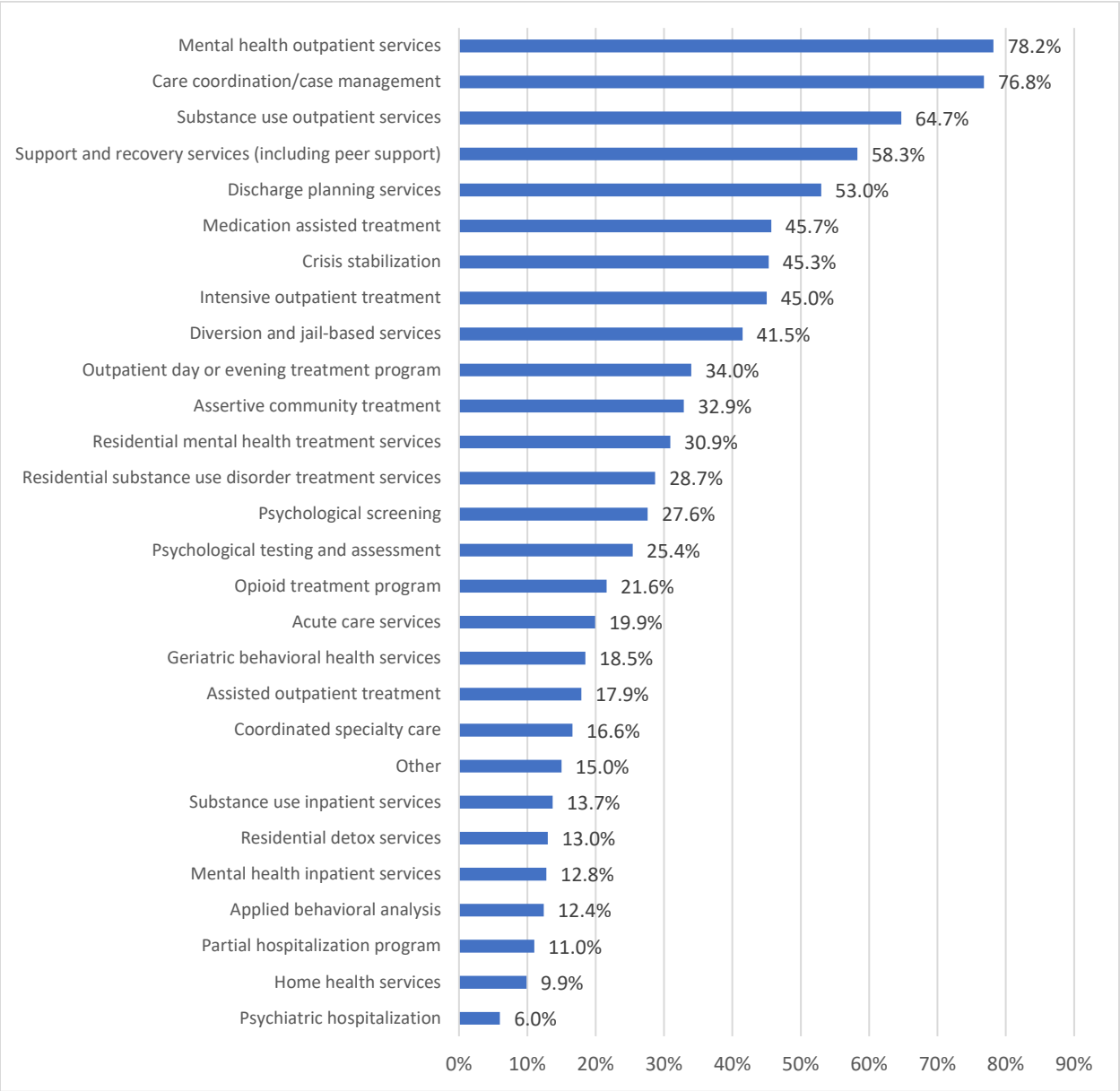

## Services Provided

When asked to indicate which mental health and/or substance use disorder services their organizations provided, more than half of respondents said their organizations offered mental health outpatient services (78.2%), care coordination/case management (76.8%), substance use outpatient services (64.7%), support and recovery services (including peer support—58.3%), and discharge planning services (53.0%).

Fewer respondents reported that their organizations provided assertive community treatment (ACT—32.9%) and assisted outpatient treatment (AOT—17.9%), discussed in further detail below.

The full distribution of services provided is shown in Figure 4.

**Figure 4. Services Provided by Survey Respondent Organizations**

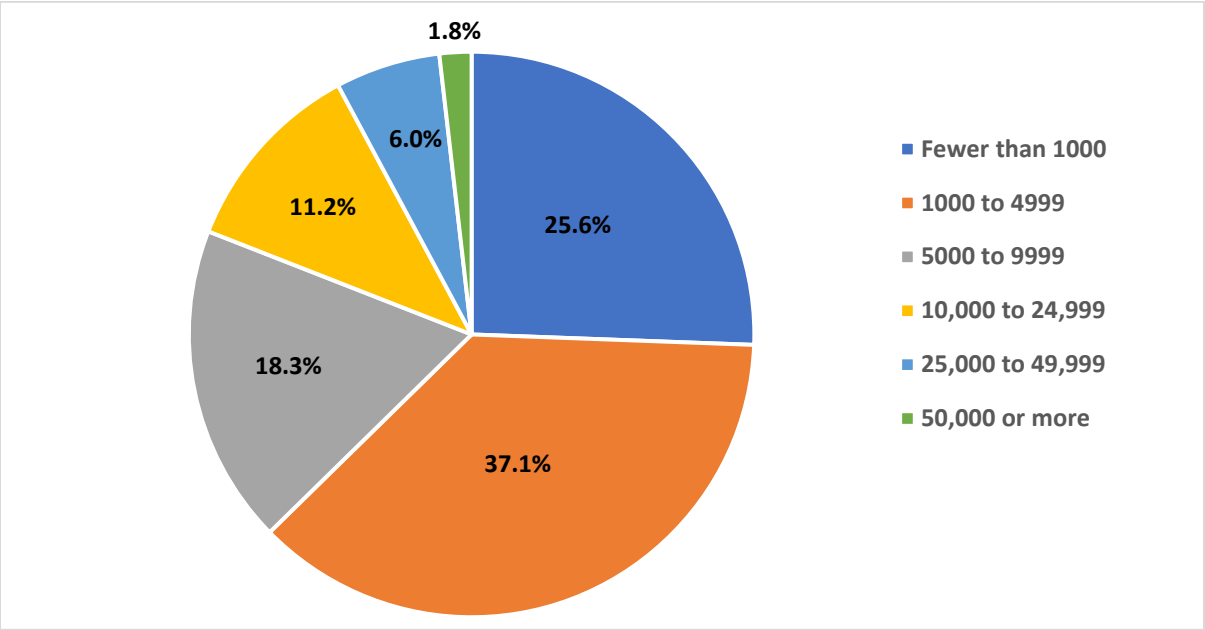



## Clients Served

When asked to indicate the number of unique clients served by their organizations annually, most reported that their organizations were in the two smallest categories: fewer than 1,000 clients (25.6%) and 1,000 to 4,999 clients (37.1%). The remaining respondents indicated that their organizations served many clients annually, including a small number (1.3%) who indicated that their organizations served more than 50,000 clients annually.

The full distribution is shown in Figure 5.

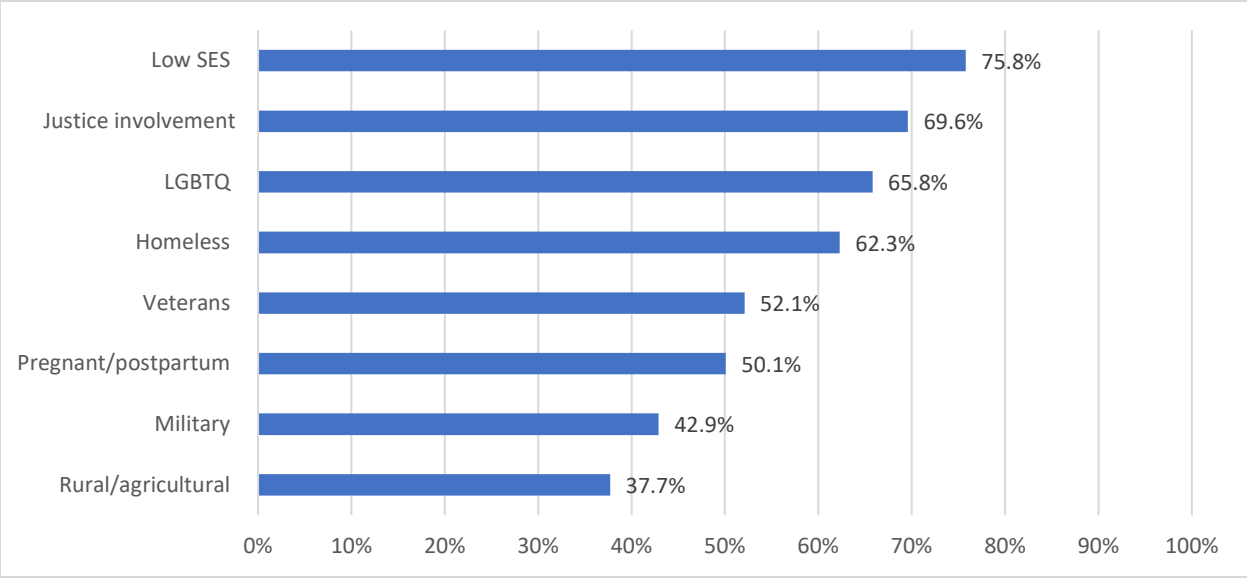
**Figure 5. Unique Clients Served Annually by Survey Respondent Organizations**




## Special Populations

When asked which special populations their organizations served, respondents most frequently cited individuals with low socioeconomic status (SES—75.8%), individuals with justice involvement (69.6%), LGBTQ individuals (65.8%), and individuals facing homelessness (62.3%) as shown in Figure 6. Less than half of respondents indicated they cared for the military (42.9%) or rural/agricultural populations (37.7%).

**Figure 6. Special Populations Served by Survey Respondent Organizations**



## Wait Times for Services

When asked to report when non-urgent new client intake services were available in their organizations, most said either the same day (31.6%) or within one week (37.1%), as shown in Table 1. They were much less likely to report that new client visits with psychiatrists or other prescribers were available on the same day (11.4%) or within one week (26.9%). More than one in five respondents indicated wait times of 4 weeks (12.6%) or five weeks (11.1%) for a new client visit with a prescriber at their organizations. Nearly all respondents (93.5%) indicated that crisis services were available on the same day in their organizations, although a small subset (0.9%) indicated wait times of over one week for crisis services.

**Table 1. Wait Times for Services at Survey Respondents' Organizations**

| | New Client Intake (Non-Urgent) | New Client Visits with Psychiatrist or Other Prescriber | Crisis Services |
|---|---|---|---|
| Same day | 31.6% | 11.4% | 93.5% |
| One week | 37.1% | 26.9% | 5.6% |
| More than one week | 31.3% | 61.7% | 0.9% |

In comparisons of wait times between CCBHCs and other practice settings, we found no significant differences between wait time distributions for CCBHCs vs. different settings for any visit. CCBHCs were slightly more likely to offer same-day appointments for new client intake visits (39.8% vs. 28.6%, p = 0.10) and crisis services (96.9% vs. 91.9%, p = 0.18), but the differences were not statistically significant.

## Care Models: Telehealth and Hub & Spokes

Not surprisingly, nearly all respondents (92.4%) indicated that their organizations provided services via telehealth as of late 2021. On average, they reported that 40.8% of visits were currently conducted via telehealth (median = 40%, range = 0% to 100%) compared with an average of 9.2% (median = 0%, range = 0% to 100%) in 2019 before the COVID-19 pandemic.

About one in five respondents indicated that their organizations participated in "hub and spokes" models for opioid use disorder treatment, either as *hubs* (specialty opioid treatment program clinics that dispense medication and provide daily dosing and therapeutic services—7.7%) or *spokes* (general medical settings providing office-based opioid treatment in which medications are prescribed and patients are seen weekly or monthly—12.7%).[3]

[3] Hub and Spokes Model. Rural Health Information Hub. https://www.ruralhealthinfo.org/toolkits/moud/2/systems-of-care/hub-and-spoke

## Forms of Payment Accepted

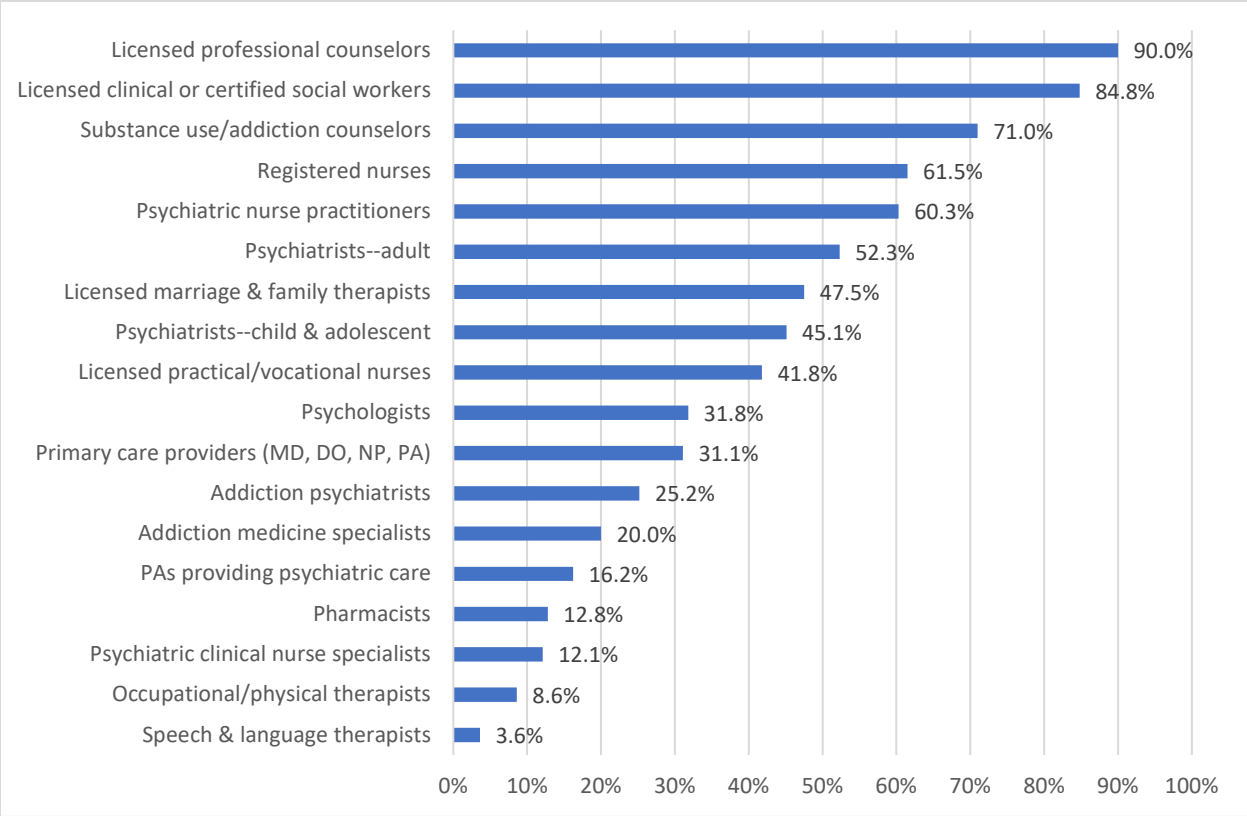
When asked to indicate the forms of payment their organizations accepted, nearly all (92.2%) reported that their organizations accepted Medicaid, followed by commercial insurance (74.7%) and Medicare (61.9%). Most respondents also indicated that their organizations accepted self-pay (81.5%) and sliding scale payments (71.9%) from patients, as well as grants, contracts, and private fundraising (81.2%). Fewer respondents reported that their organizations accepted payments from TRICARE (38.9%) and other federal insurance programs (e.g., VA or CHAMPVA—22.6%).

## Staffing

### *Clinical Staff*

When asked to indicate which types of clinical staff members their organizations employed, nearly all respondents identified licensed professional counselors (90.0%), licensed clinical or certified social workers (84.8%), and substance use/addiction counselors (71.0%). Respondents were less likely to indicate that their organizations employed licensed marriage & family therapists (47.5%) and psychologists (31.8%), the other roles covered by our related Clinical Behavioral Health Workforce Survey. Registered nurses (61.5%), psychiatric nurse practitioners (60.3%), and adult psychiatrists (52.3%) were the other most frequently identified staff, employed at half or more of the respondent organizations. The full range of clinical staff at respondents' organizations is shown in Figure 7.

**Figure 7. Clinical Staff Employed by Survey Respondents' Organizations**



When we compared the likelihood of employing each type of clinical staff member between respondents in CCBHCs and other practice settings, we found statistically significant differences for many roles, including the following:

- Licensed clinical social workers (87.6% in CCBHCs vs. 74.6% in non-CCBHCs, $p < 0.01$)
- Psychiatric nurse practitioners (75.2% vs. 49.0%, $p < 0.01$)
- Substance use/addiction counselors (73.5% vs. 62.7%, $p = 0.04$)
- Registered nurses (71.7% vs. 51.6%, $p < 0.01$)
- Adult psychiatrists (65.5% vs. 42.3%, $p < 0.01$)
- Child & adolescent psychiatrists (59.3% vs. 35.9%, $p < 0.01$)
- Licensed marriage and family therapists (54.0% vs. 40.2%, $p = 0.01$)
- Licensed practical or vocational nurses (46.9% vs. 35.9%, $p = 0.04$)
- Psychologists (38.1% vs. 26.5%, $p = 0.02$)
- Addiction psychiatrists (35.4% vs. 19.2%, $p < 0.01$)
- Addiction medicine specialists (25.7% vs. 16.0%, $p = 0.02$)
- Pharmacists (19.5% vs. 9.3%, $p < 0.01$)
- Occupational or physical therapists (12.4% vs. 6.1%, $p = 0.03$)

For every role where we identified statistically significant differences between CCBHCs and non-CCBHCs, CCBHC respondents were more likely to report employing staff members than non-CCBHC respondents. This finding suggests that CCBHC funding may help support behavioral health services organizations to hire staff members in various roles to provide robust, comprehensive care for their clients. However, CCBHCs still face the same challenges with

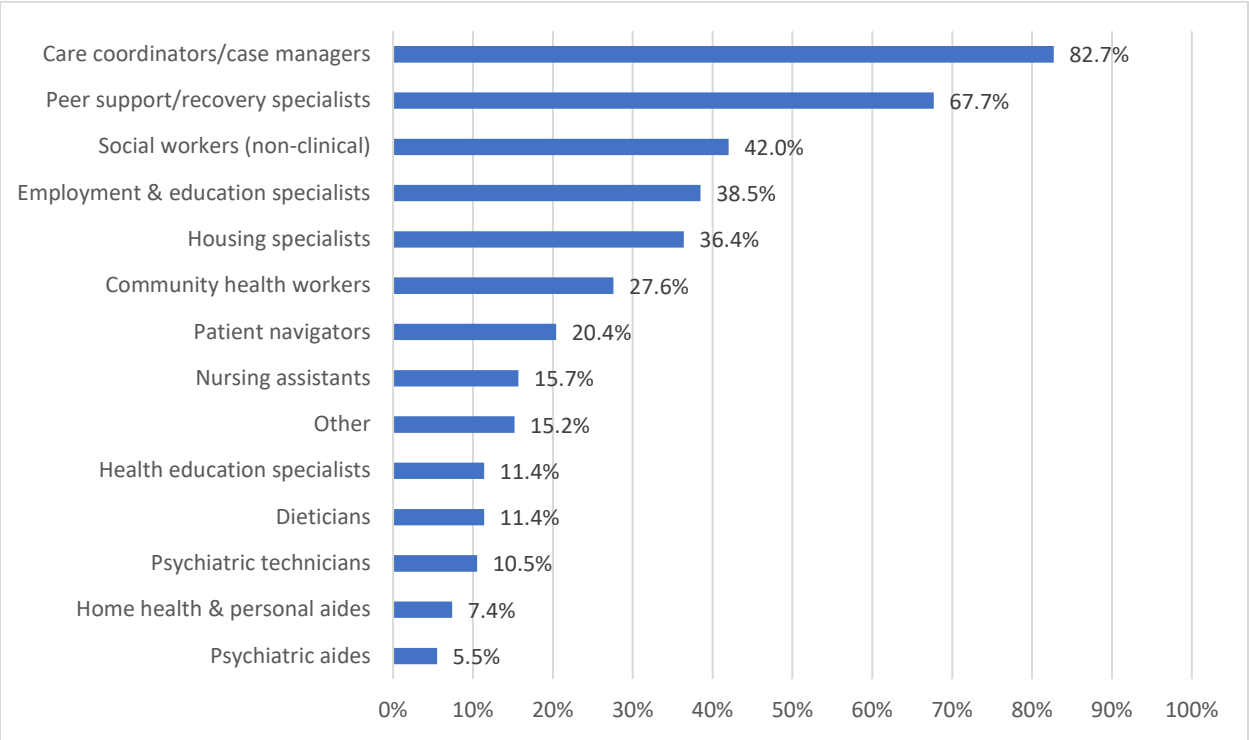
### *Support Staff*

When survey respondents were asked to identify which types of support staff their organizations employed, the only categories mentioned by a majority of respondents were care coordinators/case managers (82.7%) and peer support/recovery specialists (67.7%). Given the heightened emphasis on value-based care and the rising demand for peer support specialists over the past decade,[4] it is not surprising that these roles are widely employed in behavioral health settings. The remaining categories ranged from non-clinical social workers (42.0%) to psychiatric aides (5.5%).

The full distribution is shown in Figure 8.

[4] Ziemann MP, Dent RB, Schenk ED, Strod D, Luo Q, Banawa RA, Westergaard S, Erikson CE. Documenting a Decade of Exponential Growth in Employer Demand for Peer Support Providers. *The Journal of Behavioral Health Services & Research*. 2023; 50(3): 1-12. https://doi.org/10.1007/s11414-023-09832-9

**Figure 8. Support Staff Employed by Survey Respondent Organizations**




When we compared the likelihood of employing each type of support staff member between respondents in CCBHCs and other practice settings, we found statistically significant differences for several roles, including the following:

- Peer support specialists (76.1% vs. 57.7%, $p < 0.01$)
- Non-clinical social workers (48.7% vs. 35.3%, $p = 0.01$)
- Housing specialists (47.8% vs. 28.6%, $p < 0.01$)
- Employment and education specialists (45.1% vs. 32.1%, $p = 0.01$)
- Patient navigators (31.9% vs. 14.3%, $p < 0.01$)

These findings signal that CCHBC funding is leading to increased hiring for these important roles, which can help ensure that clients with mental health or substance use disorder have the support they need for recovery, including assistance with addressing social determinants of health.

### *Assertive Community Treatment Teams*

The survey asked respondents who indicated that their organizations provided assertive community treatment (ACT) for detailed information about the composition of their ACT teams. ACT is designed to provide individuals with severe, persistent mental illness with coordinated and multidisciplinary support, including case management, crisis response, symptom and medication management, and social support.[5]

[5] What is Assertive Community Treatment (ACT)? Pennsylvania Department of Human Services. https://www.dhs.pa.gov/Services/Mental-Health-In-PA/Pages/ACT.aspx

Among respondents (n = 149) who indicated that their organizations provided ACT, the average number of teams per organization was 2 (median = 1, range = 0.5 to 15). The most frequently reported roles included on ACT teams were licensed counselors or therapists (82.5%), case managers (77.5%), registered nurses (77.5%), peer support specialists/recovery coaches (71.8%), and psychiatrists (68.3%). The largest number of respondents by far reported that their ACT teams were supervised by licensed counselors or therapists (83.3%), with a few reporting teams led by psychiatrists (10.0%), psychiatric nurse practitioners (5.8%), and psychiatric clinical nurse specialists (1.7%). Among respondents with ACT teams that provided caseload estimates, the average caseload per ACT team was 54 clients (median = 50, range = 4 to 150).

### *Assisted Outpatient Treatment Teams*

The survey also asked respondents who indicated that their organizations provided assisted outpatient treatment (AOT) for more details about the composition of their AOT teams. AOT refers to court-ordered (sometimes involuntary) outpatient treatment for individuals with severe mental illness. As of 2018, it was authorized by law in 47 states.[6]

Among respondents (n = 81) who indicated that their organizations provided AOT, the most frequently reported roles included on AOT teams were licensed counselors or therapists (65.5%), case managers (56.9%), psychiatrists (48.3%), registered nurses (43.1%) and peer support specialists/recovery coaches (41.4%). The average number of clients served by organizations' AOT teams per month was 111 (median = 63, range = 0 to 600). (However, more than half of respondents who answered this question indicated they did not know how many clients their organizations' AOT teams served.)

### *Peer Support Staff Certification, Activities & Financing*

Among respondents who indicated that their organizations provided peer support services, nearly half (49.6%) reported that their peer support or recovery specialists were certified. Another 38.9% said some of their organizations' peer support/recovery specialists were certified, and only 10% said they were not certified. (A few respondents [1.5%] said they did not know.) Most respondents (67.8%) whose organizations employed peer support/recovery specialists said they pursued certification while working at their organizations.

Respondents were most likely to report that their organizations' peer support/recovery specialists worked with patients with substance use disorder (80.2%) followed by serious mental illness (75.0%). Some also reported that peer support/recovery specialists worked with patients facing homelessness (45.5%) or other conditions (13.8%), including justice involvement, family challenges, or veterans' issues.

Nearly all respondents (93.3%) whose organizations included peer support/recovery specialists said they were paid employees. In contrast, a few said their organizations had a combination of paid and volunteer specialists on staff (4.4%) or that all their specialists were volunteers (0.7%). Respondents were most likely to report that their organizations received financial support for peer support/recovery specialists through Medicaid (66.4%), followed by state grant funding (45.5%), federal grant funding (24.6%), and other types of grant funding (19.4%). They were much less likely to report receiving support from private insurance (5.6%) and other payers (e.g., TRICARE—5.2%).

[6] Cripps SN, Swartz MS. Update on Assisted Outpatient Treatment. Current Psychiatry Reports 2018; 20: 112. https://doi.org/10.1007/s11920-018-0982-z

### *Case Manager/Care Coordinator Roles*

Among respondents who reported that their organizations employed case managers/care coordinators, the largest group (61.6%) said these roles were filled by non-clinical social workers, followed by community health workers (39.3%) and licensed clinical social workers (23.2%). They were less likely to report having case managers/care coordinators who were licensed practical/vocational nurses (9.8%), registered nurses (9.2%), or medical assistants (5.8%). Among the 33.2% of respondents who said these roles were filled by personnel with other qualifications, frequent responses included individuals with bachelor's degrees in psychology, social or human services, and various other qualifications. (NOTE: respondents could select more than one response option.) This variety is consistent with other literature on the wide range of provider types used for case manager/care coordinator roles.[7]

### *Pharmacist Certification & Activities*

Among respondents who indicated that their organization employed pharmacists, 30.6% reported that some pharmacists were board-certified psychiatric pharmacists. (46.9% said they did not have board-certified psychiatric pharmacists on staff, and 22.5% did not know.) Respondents were most likely to say that their organizations' pharmacists engaged in patient education (81.6%), medication management and review/reconciliation (61.2%), and monitoring medication adherence (61.2%). Smaller groups reported that their organizations' pharmacists dispensed Naloxone using standing orders (30.6%) or prescribed medications (8.2%).

## Recruitment & Retention

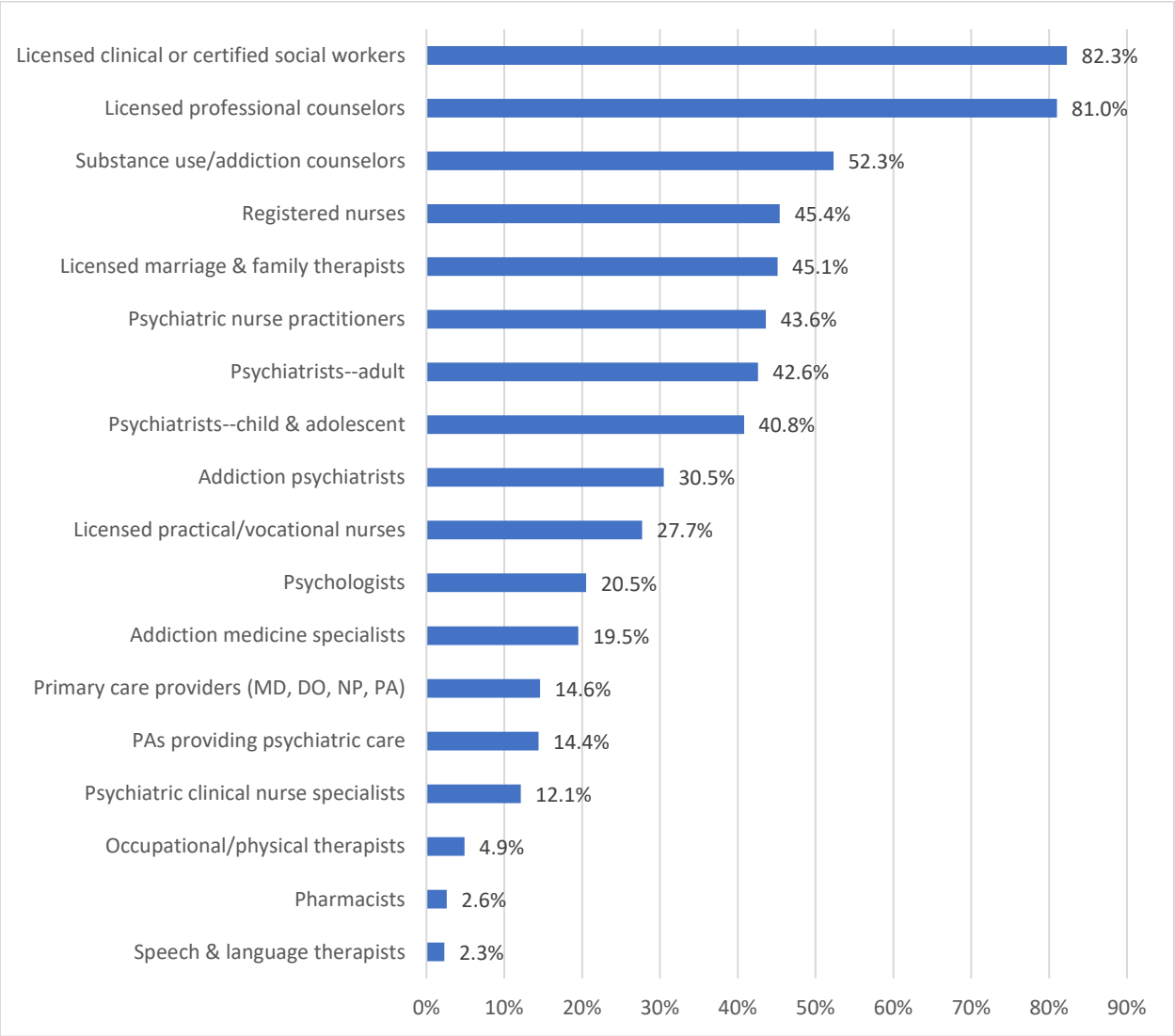
### *Clinical Staff*

When asked which clinical staff roles their organizations had difficulty recruiting or retaining, respondents most frequently cited licensed clinical or certified social workers (82.3%) and licensed professional counselors (81.0%)—roles employed in most responding organizations. The percentage of respondents who reported difficulties hiring for each clinical role is shown in Figure 9.

> *"A lot of social workers, a lot of counselor staff are going to work for these online, virtual counseling telehealth—sit in your pajamas and do your counseling and get paid double what you would get paid to travel into an office and see folks. So that's been our biggest most significant obstacle lately is trying to just retain good staff who have frankly other sometimes better options."*
> – Chief Operating Officer

[7] Erikson CE, Pittman P, LaFrance A, Chapman SA. Alternative payment models lead to strategic care coordination workforce investments. *Nursing Outlook*. 2017; 65(6): 737-45. https://doi.org/10.1016/j.outlook.2017.04.001

**Figure 9. Percentage of Survey Respondents Reporting Clinical Staff Recruitment & Retention Challenges**




All focus group participants expressed extreme frustration with the difficulty in hiring licensed counselors and social workers and were extremely concerned about the implications for clinical care. While other positions were also challenging, counselor and social worker recruitment and retention challenges were most front of mind during the focus groups, consistent with the survey results presented below. Focus group participants' reports about other types of providers varied—some said they found it almost impossible to find psychiatric nurse practitioners or psychiatrists. In contrast, others said these were relatively easy to find compared with counselors and social workers (which were universally difficult to hire and retain).

*Reasons for Difficulty Recruiting Clinical Staff*

Respondents were most likely to cite general shortages (84.2%), non-competitive wages (71.9%), and challenging patient/client populations (54.9%) as reasons for their organizations' clinical staff recruitment and retention challenges. Focus group participants provided further context that telehealth organizations could attract many counselors and therapists who could make more money while working from their homes. During focus groups, sites indicated that salaries were higher than ever and now offered hiring and retention bonuses.

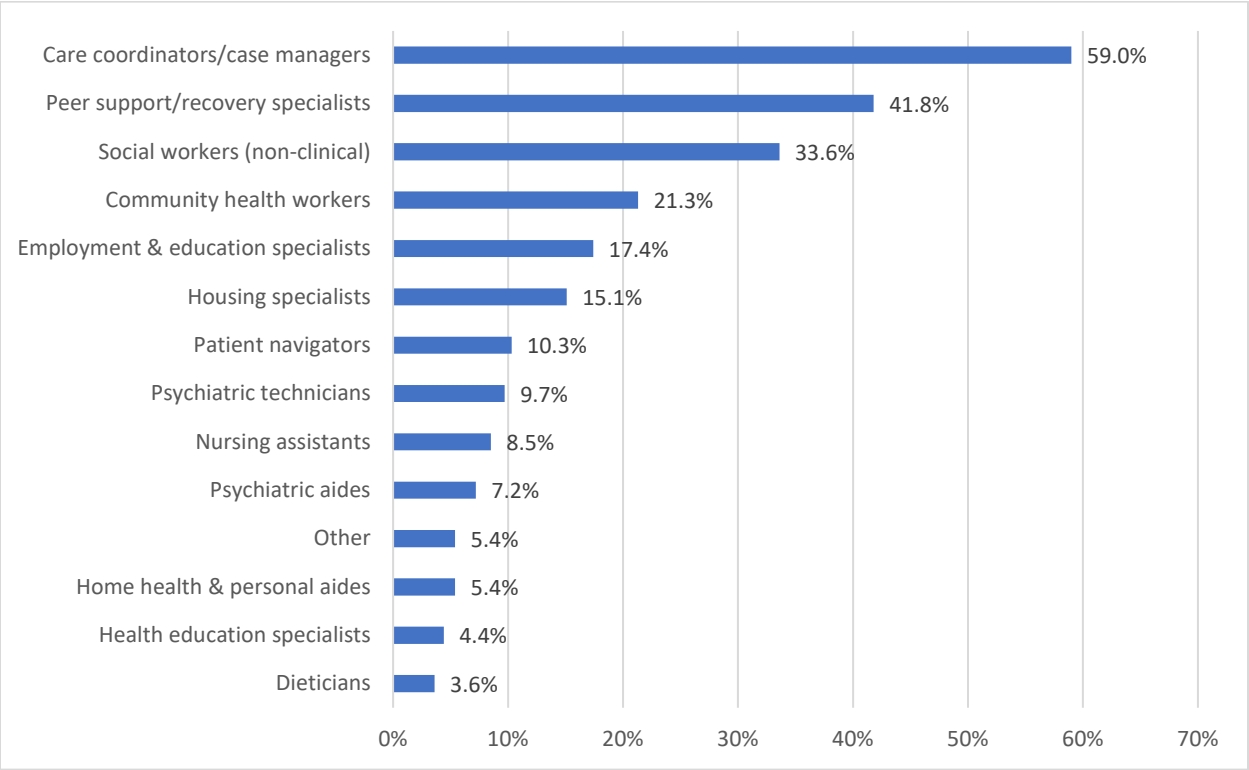
> *"I can't find LCSWs. It's beyond belief and we've done everything. We've [been] looking at recruiters who keep telling us that our salaries are too low and we've increased them. I mean, we spent a million dollars in the last year, increasing salaries and it's still too low. Or they come in and they interview us and tell us they don't like working with this population. It's just too hard. So they're gonna go into private practice. And what do you say to that?"* – CEO

When probed, focus group participants indicated this was the first time their organizations had ever offered retention bonuses, in some cases using American Rescue Plan Act funding, which led to questions about the long-term sustainability of new salaries and bonuses when those funds are no longer available. Employers reported using flexible work hours and telecommuting options more than before to make their sites more attractive to potential recruits and to retain providers. Still, they faced stiff competition for licensed clinical staff (especially counselors and social workers) due to the growth of opportunities in private practice and/or working for telehealth providers.

*Support Staff*

When respondents were asked to indicate which support staff roles their organizations had difficulty recruiting and retaining, the top three by far were care coordinators/case managers (59.0%), peer support/recovery specialists (41.8%), and non-clinical social workers (33.6%)—also the most frequently employed types of support staff, in the same order. The percentage of respondents who reported difficulties hiring for each support role is shown in Figure 10.

**Figure 10. Percentage of Survey Respondents Reporting Support Staff Recruitment & Retention Challenges**




*Reasons for Difficulty Recruiting Support Staff*

Survey participants' most frequently identified challenges for recruiting support staff were similar to those for clinical staff. Respondents were most likely to cite general shortages (69.4%), non-competitive wages (68.1%), and challenging patient/client populations (49.0%) as reasons for their organizations' support staff recruitment and retention challenges.

> *"We can't find direct care staff at a bachelor's level and with all the licensure and the oversight…without having the people on the pavement to carry out those directives, then those chronic populations aren't being served. And everything that's been said about trying to recruit, we're doing it here too. We can't get applications. We can't get people to show up for interviews. We can't get people to take the job after they've been hired. They won't show up for their first day."* – Clinical Director

Focus group participants explained that they faced difficulties at every step of the hiring process for support staff in the current environment, despite their efforts to raise wages and compete with other employers. The competition for support staff with other employers was so stiff that even employees who had been hired successfully sometimes did not attend their first days of work. Focus group participants also expressed a desire for greater access to career ladders for support personnel such as peer support specialists, whose access to educational opportunities was sometimes limited by their history of substance use and/or criminal justice system involvement.

*COVID Impact on Staffing*

When asked about the impact of the COVID-19 pandemic on their organizations' staffing, most respondents (71.8%) said their organizations did not need to furlough any employees. (Nearly half of these [34.0%] said keeping all employees on was financially challenging.) Among those who said their organizations had furloughed employees (28.2%), most (18.5% of all respondents) said they had rehired all or most of the furloughed employees by the time of the survey in late 2021.

*Strategies for Addressing Staffing Shortages*

When asked which staffing strategies their organizations had used in the past six months due to recruitment and retention challenges, respondents were most likely to say they had contracted with outside providers (41.5%), used psychologists or counselors in training (29.9%), used locum tenens providers (25.9%) and substituted other professions (25.9%). Among the 15.9% of respondents who indicated they had used other strategies besides those specifically queried, responses ranged from increased pay and/or incentives, increased caseloads or use of other staff members or supervisors to cover, adjusted qualifications for certain positions, closing programs or using wait lists, reducing services, and using temp agencies or search firms as additional strategies they had used to address recruitment or retention challenges.

> *"At the end of this year, I will have no fulltime outpatient therapist in our organization for the first time in 72 years. And everybody's going private practice. I always been very heavy into managed care with Medicaid. We haven't had a rate increase in 12 years. So…when you get 43 cents of an increase in Medicare every year, and it costs you $4 to pay people, it's just a losing proposition and we've done the same thing everybody else has. There just are no good, easy answers."*
> – Executive Director

In response to an open-ended question about improving recruitment and retention, survey and focus group participants focused on ***reimbursement***. Both groups emphasized that higher Medicaid reimbursement, which covered the cost of services provided, was needed to compete with other employers, such as hospitals and federally qualified health centers.

Relatedly, Medicaid paperwork and documentation requirements were cited as overly burdensome, detracting from patient care, and creating unnecessary barriers. The need for sustainable reimbursement and **reduced paperwork** for all levels of professionals (e.g., care managers/coordinators, peer navigators) was important to remain competitive with other employers given rising wages in other settings. Focus group participants and survey respondents also suggested that value-based payments could help align reimbursement to support behavioral health services better. Additional recommended reimbursement strategies included having Medicare pay for visits from licensed professional counselors

> *"I was interviewing a therapist, a counselor today at one of our universities, [and] when it dawned on her that she had 30 to 40 appointments per week and had to do all of her paperwork at home and on the weekends and she said, my husband is always mad at me because I can't give any attention to the family. She literally started crying today, as she realized that her life had become just this endless string of paperwork after her hours that she was being paid, and what she's making is not conducive to 60 hours of work a week."* – Director

and marriage and family therapists – which will begin in 2024 after the passage of the 2023 Omnibus Bill.[8] Many also suggested reimbursement for services provided by associate clinical behavioral health providers under supervision would be helpful, particularly given that they were increasingly relying on associate providers to fulfill patient needs. However, in focus groups, participants indicated that supervision could be challenging during staffing shortages. Further, they indicated associates were often recruited after becoming fully licensed, somewhat limiting the long-term impact of serving as clinical training sites.

Respondents also suggested efforts were needed to ***build the pipeline***, particularly for BIPOC and other underserved populations. Strategies could include 1) a shorter time for full licensure and/or reduced requirements for becoming licensed and 2) making it less costly to obtain credentials, such as providing tuition support for positions requiring certification as well as those requiring licensure, and more funding for the peer workforce pathway, training, technical assistance, and funding to hire additional individuals with lived experiences.

Employers also indicated that more loan repayment options would help them compete with other employers. Many sites indicated they did not know if they were eligible sites or how to pursue loan repayment opportunities for their staff members, which put them at a disadvantage relative to FQHCs and others with the infrastructure to pursue National Health Service Corps site eligibility effectively. Participants also frequently mentioned the need for more incentives to recruit and retain staff, including housing support, given the high cost of living in many locations.

> *"What we're seeing over the last couple of years because of the shortages is that we're hiring staff in general who have less experience might be coming right out of school. Great intentions, lot of energy, need a lot more training than the staff in the past. And so I feel like our supervisors are really burnt out from having to deal with that because it's adding a whole other level to what they've already had to deal with."* – CEO

## Staffing Needs

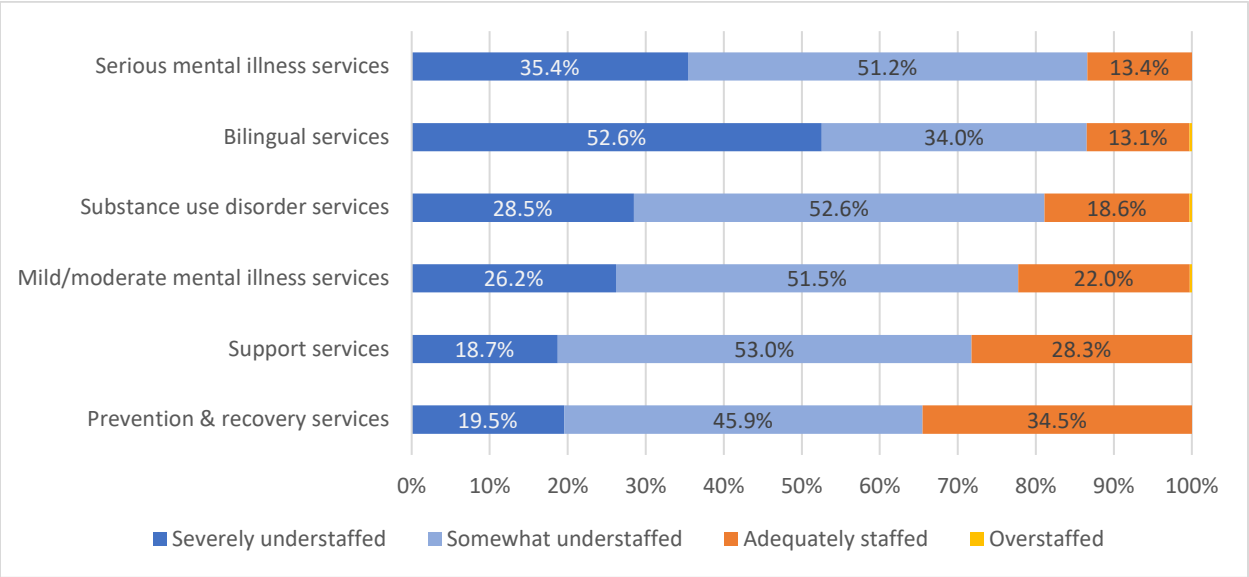
### *Adequacy of Staffing*

When asked to rate the adequacy of their organizations' staffing by service area, 86.6% of respondents indicated their organizations were severely or somewhat understaffed to provide serious mental illness services (35.4% severe and 51.2% somewhat) and bilingual services (52.6% severe and 34.0% somewhat). Respondents' ratings of their organizations' staffing adequacy were low across the board: even for the area they were least likely to indicate was understaffed (prevention & recovery services), more than 65% rated their organizations as severely understaffed (19.5%) or somewhat understaffed (45.9%).

Responses are shown in detail in Figure 11.

[8] Enos G. Expansions in Medicare Payment Rule Could Boost Behavioral Workforce. *Mental Health Weekly* July 21, 2023. https://doi.org/10.1002/mhw.33721

**Figure 11. Respondents' Ratings of Organizational Staffing Adequacy by Service Area**




Survey respondents in CCBHCs were significantly less likely than non-CCBHC respondents to report being severely understaffed in the following service areas:

- Serious mental illness services: 29.7% severely understaffed vs. 38.0% ($p < 0.01$)
- Prevention & recovery services: 9.0% vs. 23.3% ($p = 0.02$)
- Support services (e.g., housing, vocational, food, transportation): 6.3% vs. 23.1% ($p < 0.01$)

These findings suggest that CCBHC status is associated with a lower risk of severe understaffing in key service areas. However, nearly one out of three (29.7%) of CCBHCs reported severe understaffing for serious mental illness services.

# Conclusion

The findings of the Behavioral Health Workforce Employer Survey and a series of behavioral health employer focus groups suggest that behavioral health services providers are facing significant recruitment and retention challenges at a time of high demand for behavioral health services due to low reimbursement and wages, provider training and documentation burdens, and competition for staff with more appealing opportunities including private practice and telehealth jobs. Behavioral health employers view Medicaid reimbursement policies, licensing requirements for trainees, and scope of practice limits as barriers to their ability to recruit and retain the workforce they need. Improved reimbursement rates, reduced documentation burdens, and greater access to loan repayment programs may help to alleviate these challenges. CCHBCs are less likely to report severe staffing shortages, although one out of three respondents from CCBHCs reported severe shortages for serious mental illness services. Importantly, CCBHCs are more likely to have peer support specialists and other providers who can help patients with social determinants of health.