

# **Report on the Behavioral Health Access and Workforce Summit University of Maine, Augusta - September 25, 2024**

## **Introduction**

The Behavioral Health Access and Workforce Summit was initiated by the Behavioral Health Access and Workforce Coalition (BHAWC), under the leadership of NASW Maine, the Alliance of Addiction and Mental Health Services in Maine, Mental Health Counselors Association of Maine, and the Maine Psychological Association. They believed that Maine's gap in access to behavioral health services was reaching crisis proportions and pursued funding to quantify the need, explore contributing factors and the impact, and seek solutions to the access gaps and workforce shortages. The BHAWC received funding from the Maine Health Access Foundation and the Bingham Program to:

- 1) conduct a point-in-time survey to quantify access gaps (January-February, 2024),
- 2) conduct focus groups of behavioral health organizations and independent providers (June-July, 2024),
- 3) explore what other groups are doing to quantify and address service gap and workforce needs (January-October, 2024), and
- 4) bring leaders from diverse groups together (the Summit) to come up with solutions and next steps.

The data from this survey revealed major shortages in the provision of behavioral health services, which the focus group participants confirmed. The most severe shortages were in mental health counseling services. This report summarizes the findings and discussions from the Summit, emphasizing the urgent need for comprehensive improvements in the behavioral health workforce, client care access, and systemic reforms.

## **Overview of Findings**

### ***Increased Demand for Services***

The COVID-19 pandemic catalyzed a dramatic rise in behavioral health cases, forcing many providers to pivot to telehealth and increasing the number of clinicians retiring. This transition increased access to services for some, but not all, clients. Telehealth accounted for approximately 34% of independent provider interactions, yet only 11% of clients

received care in agencies. Clients found themselves waiting for extended periods to receive care, with the highest gap being for access to mental health clinical services. The survey indicated over 10,000 clients were waiting for mental health clinical services, with an average wait time exceeding 32 weeks. Clients were experiencing worsening symptoms, diminished functioning, and higher use of more costly services in emergency rooms and hospitals. At the same time, organizations were closing services, citing contributing factors of reimbursement levels not equaling the cost of care, difficulty hiring clinicians, and difficulties retaining clinicians.

### ***Workforce Challenges***

The survey highlighted significant workforce vacancies for mental health clinicians within behavioral health organizations, estimating over 20% of positions unfilled. The aging workforce exacerbates this issue. Of the 277 independent providers answering the survey, 40% were age 65 or over, with 45% reporting plans to retire within 1-5 years and 67% within ten years. This exacerbation of the current workforce shortages and lack of newly trained providers to replace them will only increase the numbers and length of time it takes to access mental health counseling services, will increase the competition for existing clinicians, will tax already overburdened agency staff caring for those with the most severe mental health issues, will elevate provider burnout, further reducing the capacity to deliver essential services.

### ***Recruitment and Training Barriers***

Despite the pressing need for more providers, recruitment remains hampered by inadequate reimbursement for licensing and educational expenses, high burnout rates due to heavy caseloads, inequity in pay related to comparable health providers, and a bottleneck in providing supervision and internships for behavioral health students. Licensing challenges also disproportionately affect diverse professionals, with extreme biases in exam passing rates creating inequitable barriers to entry in the field.

## **Proposed Solutions**

### ***Support for Providers and Students***

The plenary on Maine's Behavioral Health Access Gaps and Workforce Shortages reviewed what Maine was doing and presented key examples from other states that showed major promise for Maine. The Behavioral Health Education Center in Nebraska documented a 44% increase in its behavioral health clinical workforce since its inception in 2011 through mentorship programs, creating a workforce dashboard, developing a career ladder app, providing student and supervisor stipends, and funding innovative programs. Washington state's behavioral health teaching community organizations and teaching hospitals are excellent models for Maine. Specifications can be incorporated to keep clinicians working in agencies and in Maine for specific periods of time, ensuring that we don't lose clinicians to other states and that clients with the most severe illnesses are cared for by well-qualified clinicians.

Additionally, the importance of diversity in the workforce was stressed, with initiatives like Northern Light's pilot program to recruit physician assistant providers from historically Black colleges underscoring the need to build trust within diverse communities. Efforts to develop alternative pathways to licensure away from passing a licensure exam have been proposed, such as demonstrating competency through increased supervision hours (the Illinois model) or an oral interview with a panel of seasoned licensed providers. These strategies have demonstrated success in increasing the numbers of social work providers in states such as Illinois and Rhode Island and have implications for increasing the numbers and diversity of social work providers in Maine.

### ***Legislative and Policy Recommendations***

The Summit panelists emphasized the need for bipartisan support for solutions to the current behavioral health crisis, as behavioral health is a nonpartisan issue affecting all families in Maine. Priority recommendations from the roundtable discussions fell into four themes: financial reimbursement and wages, collaboration to streamline paperwork and regulations, supporting career pathways, and recruiting and retaining clinicians. Table 1

depicts the legislative recommendations from low to high cost and large versus medium impact.

- **Comprehensive Funding:**
  - Develop *a financial framework that covers the cost of services* and incorporates cost-of-living increases and competitive compensation for providers.
- **Streamline Paperwork and Licensing Processes:**
  - *Reevaluate the existing licensure framework* to facilitate smoother transitions for new providers, particularly those from diverse backgrounds.
  - *Create an alternative pathway to the ASWB exam for social work licensure*, which has proved biased and has no evidence of determining competence or protecting client safety.
  - *Increase the number of behavioral health providers on the MaineCare Advisory Committee* and subcommittees.
- **Enhanced Collaboration:**
  - Develop *a task force to identify issues and ways to collaborate with insurers* and regulators.
  - *Foster dialogues between newly funded department initiatives and existing behavioral health community organizations* to ensure they have the staffing capacity to support expanded services.
  - *Ensure “nonpartisan” support of behavioral health bills*, as behavioral health issues equally impact every family.
- **Investment in Training and Resources:**
  - *Fund loan forgiveness, tuition support, student stipends* for behavioral health internships, and financial support for student supervisors.
  - *Allocate funds for ongoing training and clear career pathways*, which will help retain professionals within the behavioral health field.
  - *Develop working group(s) to seek funds for innovative programs*, such as the behavioral health teaching community organizations or a Center for Behavioral Health Workforce Excellence.

**Table 1: Behavioral Health Access and Workforce Summit Legislative Recommendations According to Impact and Costs**

	<b>No/Minimal Cost (\$5,000 or less)</b>	<b>Moderate Cost (\$1 million or less)</b>	<b>High Cost (over \$1 million)</b>
<b>High Impact</b>	<ul style="list-style-type: none"> <li>- Insurance parity across insurers for services such as reimbursement for non-independent licensed clinicians</li> <li>- Legislate behavioral health license reciprocity between states, with an automatic Maine license after two years of experience and a clean record</li> <li>- Create a Task Force (or require) formal collaborative structures between insurers and providers to address rules and regulations that limit care and to streamline documentation, such as:               <ul style="list-style-type: none"> <li>- minimizing documentation disparities between Section 65 (behavioral health agencies) and Section 90 (behavioral health based in medical care)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- Create alternative pathways to the ASWB licensing exam for social workers (<i>TBD minimal or medium cost</i>)</li> <li>- Fund the existing social work education loan repayment program</li> <li>- Allocate funds for ongoing training and clear career pathways for all behavioral health providers, including clinicians</li> <li>- Fund a 'pilot' behavioral health teaching community organization</li> </ul>	<ul style="list-style-type: none"> <li>- Fund stipends for student placements and financial support for student supervisors/ organizations</li> <li>- Fund behavioral health scholarships, tuition supports, and loan repayment programs for all levels of behavioral health service providers</li> <li>- Create a financial reimbursement framework that covers the cost of services and ensures cost-of-living increases and competitive salaries for behavioral health providers -</li> </ul>
<b>Medium Impact</b>	<ul style="list-style-type: none"> <li>- Create a Behavioral Health Workforce Task Force investigating behavioral health (BH) teaching community organizations, BH teaching hospitals, and innovative retention strategies for behavioral health organizations</li> <li>- Increase the number of behavioral health providers on the MaineCare Advisory Committee and associated subcommittees</li> </ul>		

Table 1 describes the legislative recommendations from the Behavioral Health Summit. It does not include recommendations that could be pursued by provider organizations, training institutions, or state departments such as DHHS, DOL, or others, such as seeking matching funds for social work loan repayment, tuition support, and student and supervisor stipends.

### **Next Steps**

The Summit report and recommendations will be vetted by stakeholders within the legislature, behavioral health advocacy organizations, and patient communities to develop a multi-sector and multi-pronged path to address Maine's behavioral health workforce shortages and access issues in the years to come.

### **Conclusion**

The NASW Behavioral Health Summit highlighted critical issues facing the behavioral health sector, including service access gaps, workforce shortages, and systemic barriers to entry for new professionals. A multi-faceted approach that includes legislative support, enhanced recruitment efforts, and a commitment to diversity is essential for fostering a robust and responsive behavioral health workforce. As stakeholders work towards these goals, it is crucial to maintain a collaborative effort across sectors, ensuring that the needs of both providers and clients are met effectively.

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