Maine's Behavioral Health Access and Workforce Challenges:

Solutions to a Growing Problem

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A Report of the Behavioral Health Access and Workforce Coalition

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Executive Summary

This report presents the findings from a point-in-time survey, a series of focus groups, and a policy scan assessing the status of behavioral health (BH) access and workforce issues in Maine, which the BH Access and Workforce Coalition conducted. The coalition's concern emerged from the national twenty-year increased prevalence of suicides and BH diagnoses, the increased BH access issues experienced during COVID-19, and Maine's aging population and workforce.

The objectives of this work were to 1) quantify the extent of BH access limitations in Maine, 2) understand contributing factors and impact for the area of greatest need, and 3) identify strategies for improving the access challenges and the workforce in that area of greatest need moving forward. The results from this work reveal access challenges across the board for persons seeking BH care in Maine, with the greatest gaps in access to mental health counseling and prescribing services. Challenges will worsen in the upcoming years and will be most problematic for those with more severe mental health conditions who seek care from the network of BH agencies across the state. An increasing number of clinicians are nearing retirement, with fewer younger clinicians available to fill their positions. In addition, telehealth services provide more opportunities for mid-career clinicians to move out of BH organizations and into positions that offer more control, greater flexibility, and a higher income.

The point-in-time survey provides a snapshot of access and workforce data for the continuum of BH services as of January/February 2024. Fifty organizational leaders and 277 independent providers who responded reported access challenges across all BH service categories, from peer support services to medication prescribers, reporting an average wait period for services between 5 and 33 weeks. The area reported to have the most severe access challenges was mental health services, with 10,012 persons waiting for mental health counseling and 2,819 waiting for mental health prescribing services. Twenty organizations reported a 32-week average wait time for mental health counseling, with 69% waiting ten months or more. For those independent providers who kept wait lists, 57 reported a 33-week average wait time, with 38% waiting 10 months or more. Ten organizations reported 2,819 persons waiting an average of 33 weeks wait time for mental health prescribing, with 59% waiting ten months or more.

Organizational vacancy rates (computed as the total vacancy number divided by the number of employed FTEs and vacancies) ranged from 6% to 21% across the continuum of the BH workforce, with 24 organizations reporting 21% vacancy rates for mental health clinicians and 19% vacancy rates for dual-licensed clinicians. Of the independent providers, 40% were aged 60 or above, with

45% planning to retire in five years and 67% in ten years. Appendix B lists the responding organizations, the survey questions, and detailed results.

During June and July 2024, 34 participants in five focus groups provided their perspectives on the access and workforce data from the point-in-time survey. They discussed the contributing factors, impact, and potential solutions to the mental health clinical workforce identified in the survey as the area of greatest need. Most participants reported that the access and workforce numbers from the point-in-time survey were on target or too low. Table 1 describes the four primary goals that framed the twenty-five proposed solutions that emerged from the focus groups.

The remainder of this report provides more details on the point-in-time survey and focus group findings on the extent of the BH service gap, contributing factors, impact, and recommendations to address and alleviate the BH workforce shortage in Maine. The Appendices provide information on the BH Access and Workforce Coalition members (A), the point-in-time survey responding organizations, questions, and more detailed information on results (B), focus group participants, and more detailed information on the focus group results (C).

Table 1: Focus Group Themes Related to Mental Health Clinical Services

Theme	Description
Enhance the Financing of Services	The number one issue raised across all focus groups was insufficient reimbursements and wages.
Collaborate to Improve Paperwork and Regulations	Providers face regulatory obstacles and feelings of futility in communicating with insurers and regulators.
Enhance BH Career Pathways	Undergraduate and graduate training programs are experiencing a drop in enrollment and retention of students.
Promote Retention of Providers in Community BH Organizations	The employment trend for mental health clinicians in BH organizations is to leave shortly after they get their license to practice independently.

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BH workforce policy efforts. Malory Shaughnessy, MPPM, recognized the timeliness and importance of this work, made funding possible, and ensured that we were not duplicating the efforts of others. Caitlyn Rush, LMSW, the NASW Maine's social work intern from the University of Southern Maine (USM), helped us enter the survey into Qualtrics, send, and take the first pass at analyzing the data. Chelsea Johnson, our graduate research assistant from USM and co-author of this report, helped organize and facilitate the focus groups, analyze the results, and write up the focus group results. The BH Access Coalition provided their wisdom, guidance, and support. The National Association of Social Workers (NASW) Maine chapter provided student intern time and the expertise and time of their board. The Alliance for Addiction and Mental Health Services and the Maine BH Foundation provided organizational support and guidance. Joy Gould and colleagues from the DHHS reviewed and provided vital feedback on the department and other BH initiatives in Maine. Lastly, thanks to the many facilitators, survey respondents, and focus group participants who donated their time to this project.

Introduction, Purpose, and Methods

Background

Maine is experiencing a critical BH workforce crisis. Nationally, there is a shortage of BH providers at the same time that demand is increasing; from BH provider organizations in Maine, we are hearing stories of nine-month wait lists for outpatient mental health care, mental health inpatient beds closing, and teens lingering for weeks in emergency rooms, waiting for intensive services not available in our state. Yet national projections of Maine's supply and demand of BH providers don't equate to what providers and patients are experiencing.[1]

The prevalence of BH conditions in Maine has been increasing, with accompanying risks. From 2011 to 2021, Maine's age-adjusted death rate due to opioid overdose increased from 6.7/100,000 to 42.4/100,000.[2] In 2021, Maine's suicide rate was 19.8/100,000, the second highest in the New England states.[3] In the early years of the COVID pandemic, depression and anxiety rates tripled across the country, rising from 36.8% to 41.5%.[4]

Since the COVID pandemic, Maine reports:

1) depression and anxiety rates of 33.8%, slightly higher than the US rate of 32.3%,[5]
2) telehealth BH services have become more common, particularly for commercial insurers at 34% of total

BH care payments, as opposed to 11% of total Medicaid payments,[6] and

3) our aging BH workforce is contributing to the workforce shortage. As the oldest state in the nation, our BH workforce is likely to worsen. A recent Massachusetts study reports that there are not enough BH clinicians to replace our aging workforce in mental health agencies.[7]

At the same time, the Bureau of Labor Statistics reports that behavioral health clinicians are among the top twenty fastest-growing U.S. occupations, growing three times the rate of all U.S. jobs over the next decade.[8]

No treatment or inadequate treatment of mental health and substance use disorders negatively impacts a person's overall health, longevity, family relations, and abilities to work and contribute to their community. Lack of access to outpatient treatment impacts other parts of the health and BH system, increasing the use of more costly services in emergency rooms, residential care, and hospitals.

The factors contributing to the access challenges and workforce shortage are multiple and complex, as are the solutions. We need to learn from and build on existing data within the state[9] [10] [11] and nation[12] [13] [14] [15] [16] [17] [18] [19] to better understand the extent and characteristics of the workforce shortage in Maine, including challenges, barriers, and solutions to support strategies that can address the need.

Purpose:

Maine's BH Access and Workforce Coalition sought to understand the extent of this issue better and explore what other BH data the various departments and agencies in Maine were collecting. See Appendix A for a list of organizations and leaders in the workforce coalition.

This coalition of BH leaders in Maine received funding from the Maine Health Access Foundation (MEHAF) to:

1) understand the extent, challenges, and barriers to BH access,
2) identify geographic, programmatic, and other areas where shortages exist, and
3) identify strategies for improving the current and future BH workforce in the state of Maine

Point-in-Time Survey Methodology

Between January and February 2024, a 15-question BH Access and Workforce point-in-time survey was created, informed by the University of Michigan's recommended data sets for the BH workforce.[20] The questionnaires were slightly different for each group. Both questionnaires asked about client and organizational

demographics and waitlist data. The organization questionnaire had questions on the number of FTEs, vacant positions, and the number of clients waiting across the range of BH providers. Providers included peer support workers, clinicians, supervisors, and prescribers for mental health and substance use disorders. The provider questionnaire included questions about the provider's age and retirement plans. Both questionnaires had a question for additional comments, whether anyone would like to participate in a follow-up interview/focus group, and if they wanted to be sent survey results. See Appendix B for questions and tables that provide more detailed information and data.

The Alliance and other state-level coalitions and associations emailed the questionnaire to members and organizations with BH licenses (when emails were available). State-level professional organizations emailed the questionnaire to their members and all licensed organizational and individual providers (if emails were available). Individual providers were asked to respond only if they were NOT working in large organizations to prevent duplication in responses.

The online survey was developed and distributed in Qualtrics. Survey results were initially analyzed in Qualtrics and then exported to Excel. Two research team members cross-validated the results using major questions/themes. Survey questions and tables that provide more detailed results can be found in Appendix B.

Table 2 describes respondent numbers, showing that 50 organizational providers and 277 providers completed the survey questions (82% of the total number of respondents).

Table 2. Response Numbers by Type of Respondent

	Organizations	Individuals	Total
Number of surveys submitted	87	314	401
Duplicates	9	0	9
Partial/Incomplete	28	37	65
Number of surveys analyzed	50	277	327

Duplicates were removed if two respondents were from the same organization or if a respondent had completed the survey more than once. Partial/incomplete surveys were also removed if no more than 37% of the questions were completed.

Focus Group Methodology

Five focus groups were conducted between June and July 2024 to investigate the mental health clinical workforce shortage, the highest area of need identified in the point-in-time survey. The authors developed the initial interview guide and questions in consultation with the group facilitators. Six questions guided the focus group discussions, asking about participants' reactions to the Point-in-Time wait list and workforce results presented in a PowerPoint presentation, contributing factors, the impact, and solutions. See

Appendix C for the questions and slides presented during questions 1 and 2.

Focus group participants were recruited to participate from survey respondents, BH program chairs, and organization members of the Alliance. Efforts were made to have all BH disciplines and schools represented. The groups were comprised of BH undergraduate faculty (n-4), graduate faculty (n=8), independent providers (n=5), organizational leaders (n=10), and clinical directors (7) in the state of Maine. The groups were facilitated by members of the BH Access Coalition, who underwent focus group facilitation training led by the principal investigator.

All focus groups were conducted on Zoom, videotaped, and transcribed by an AI notetaking app, Fathom. A research assistant reviewed the videos and corrected each transcript. Additional comments from each group's Zoom chat were added to the respective transcripts.

The principal investigator and research assistant used the qualitative analysis software Dedoose to analyze data and together with our consultant to interpret the results. The focus group study was informed by grounded theory techniques, using inductive coding by each PI, sharing of codes to build meaning, and ongoing comparative building of subthemes. Each focus group's transcript was analyzed independently, and then the primary themes and subthemes across all groups were identified collaboratively through weekly meetings immediately following the first focus group. Dedoose descriptive charts and filtering functions created data sets according to each theme and subtheme, which were exported and further analyzed using Excel.

The Extent of BH Access and Workforce Shortages in Maine

Point-in-Time Survey

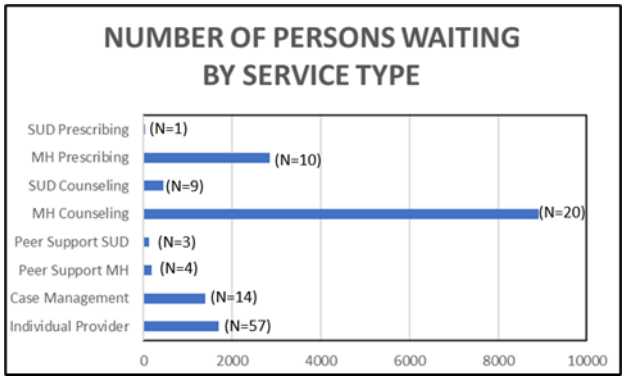
Survey respondents provided care to all age groups across the state, including mental health and substance use services. Based on employee numbers, organizational respondents represented small and large organizations across the state. A high percentage (40%) of independent providers were aged 60 and above. See Tables 3, 4, and 5 in Appendix C for more details on survey respondent demographic information.

Access Gaps

The greatest unmet need identified by the survey was for mental health counseling and mental health medication evaluations. Twenty organizations reported 8,913 people waiting an average of 32 weeks for mental health counseling, with 69% waiting ten months or more. Fifty-seven of the individual providers who kept wait lists reported 1,099 persons waiting an average of 33 weeks for mental

health counseling, with 38% waiting ten months or more.

Chart 1: Persons Waiting by Service Type



N=the number of respondents reporting waitlist numbers

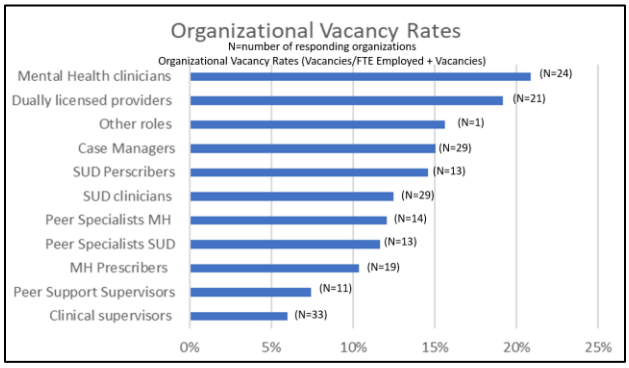
Ten organizations reported 2,819 persons waiting an average of 33 weeks wait time for mental health prescribing, with 59% waiting ten months or more (Table 7). More complete data on wait list numbers and wait times can be found in Appendix B.

Workforce Shortages

Organizations reported workforce vacancy rates between 6-21% depending on the specific workforce position. The severest shortages were reported for mental health and dual-licensed clinicians.

Organizational vacancy rates were computed as the total number of vacancies divided by the total number of full-time employees (FTEs) and vacancies. Twenty-four organizations reported 21% vacancy rates for mental health clinicians and 19% for dual-licensed clinicians (Chart below and Table 8).

Chart 2: Organizational Vacancy Rates



Of the independent provider respondents, 40% were aged 60 or above, with 45% planning to retire in five years and 67% in ten years (Table 9).

Focus group participants believed the mental health clinical access and workforce numbers from the point-in-time survey were either right on target (20 of the 34 participants) or too low (11 of the 34 participants).

Contributing Factors

Focus group participants described the following factors contributing to the limited access and shortage of mental health clinicians, with.

1. Financing of Services
2. Paperwork and Regulations
3. BH Career Pathways
4. Retention of Providers in Behavioral Health Organizations

Financing of Services

Insufficient Reimbursement

The number one contributing factor to poor access raised across all focus groups was insufficient reimbursement levels. Too often, reimbursement rates do not cover the cost of care, explicitly mentioning outpatient counseling, group counseling, family counseling, residential care, and detox services. Fee-for-service (FFS) rates don't consider team meetings and consultations that are part of school-based and health-clinic-based care. Many participants reported that the rates do not reflect the current cost of living and historically have not been updated to do so. The value-based payment model was perceived as more financially sustainable than the FFS model. Collection rates were reported as being really low.

"Commercial insurance reimbursement rates and…collection rates are really low."

"The biggest impact for a single sort of intervention…for therapy services would be adjustments in [reimbursement] rates through MaineCare."

"We are completely held to whatever MaineCare is willing to pay us, which is not a lot of money for all services."

"I think a deep dive into how MaineCare looks at rate-setting…would be really helpful."

"Often payers just don't understand the costs of [living in a geographic area, clinical overhead, and our admin team]…needed to provide our services."

"Many private insurers…slash group rates or have much lower group rates."

"Daily rates for residential care…fall well short of…the actual cost of delivering the care."

"The detox rate per day is…$200 a day less than what it costs us to run the program."
"…the health home model…has been a game changer for us in terms of…financial sustainability…We can compensate staff… lead[ing] to consistency for clients…so they're not falling off care. It supports the higher level…as well as the lower level of care."

"[The per member per] month rate as opposed to the 15-minute unit rate… has allowed us to make some gains with wages…. [and] better opportunities for hiring [and retaining] case managers."

Low wages for BH Professionals

Wages for BH professionals were reported as too low and didn't reflect variations in the cost of living or the investment needed for bachelor's and master's level programs required to work in these roles. Participants repeatedly mentioned how low wages for BH professionals dissuade people from joining the field. They called out the high cost of living in Maine and the

lack of affordable housing, with a need for rates to be regularly updated to reflect this.

"I've had a master's degree since 2011. I was a single mom and had a "side hustle" my whole career.... living paycheck to paycheck and having to have multiple jobs when I invested all this money, time, and energy....."

"We need to pay our social workers more because they can make just as much money as a bartender, a McDonald's provider, or somebody working at Target."

"When my daughter graduated as a physical therapist with zero years of experience, she is making more money than her mother after 35 years of working in this field....All mental health professions [need to] begin looking at really organizing around pay equity for us all."

"Maine has a minimum teacher salary... which could be a very concrete [solution]."

"We've had to...negotiate with insurance companies and...express that...our rent is about as high as Boston rent, and our providers are paying this much for living expenses."

"The Portland area has always been where we had the easiest time hiring...and has now flip-flopped. We have so many openings in our greater Portland community sites and schools....that's been an ironic twist...people are saying now, I can't afford to get an apartment or live here."

Paperwork and Regulation Obstacles

Regulatory Obstacles

Providers face regulatory obstacles that contribute to provider burden and client access delays, like being unable to discharge no-show clients to reduce wait times for MaineCare clients with severe and persistent mental illness who fall under the consent decree regulations. Cumbersome paperwork and audits create additional barriers to effective care. They called for streamlining documentation, improving data collection, and ensuring fair regulations. Facilitating clients' access to needed services is crucial for enhancing client relationships and managing wait times.

"We need....to have a real conversation with DHHS to say, 'This is too much. You're doing too much control when you make us jump through hoops to get [client] services.' [For example], we say that they have severe persistent mental illness, and three months later, they're asking us how they've progressed and for our [discharge] plan for them. That is unrealistic when it pulls clinical staff out of the field to do that work."

"I would just go back to allowing us to discharge [people with serious mental illness who never show up for services] sooner than

two months….so we can move people off our waitlist and… [open up treatment slots for other] people."

"The no-show rate [for MaineCare clients] is just too high. We don't [get paid] and [cannot] pay our providers…when people don't show up."

Communication and transparency

Participants highlighted the need for more communication and collaboration to improve the rate-setting process. Independent providers and organizational leaders expressed a desire for greater ease in working with insurance companies to get clients the care they need.

"…We are still vulnerable to the whim of the insurance company [who say], 'I don't think that's medically necessary."

"During COVID, they flicked the switch on telehealth and [gave] us a green light and do everything we can to keep going…. As soon as the pandemic's over, program integrity wants to audit your entire outpatient therapy program, and they're only going to look at telehealth visits and narrow right in on portions of the rule that were never discussed [such as] treatment location site and where the client is."

Paperwork burdens

Cumbersome requirements, prior authorizations, and paperwork emerged as barriers to connecting clients with care.

"The amount of administrative legwork that it takes to engage somebody fully in service when the issue is immediate takes so much time. As a small agency… we don't have the administrative infrastructure to chase all these parts down."
"…the administrative burden [isn't fully appreciated] by…MaineCare, as to what has to happen to…..meet requirements. There seem[s] to be a…disconnect between the [requirements] and what's really happening in organizations."

Difficulties and delays in payment

Organizational leaders and independent providers report reimbursement denials, reimbursement delays, and long waits to negotiate claims, so they give up even trying to reach insurance providers.

"We are fighting for the money that has been agreed to from insurers, paying to get that money, not getting enough of it, but then…feeling pretty overworked."

"It's taking more work from us to get the money we used to get from insurance companies. Lack

Lack of collective understanding of access and workforce trends

Participants expressed the need to collect meaningful data without burdening

providers routinely. This would include the cost-savings of receiving care in the community, such as case management, counseling, and crisis care in lessening the use of higher-cost services such as emergency room visits and hospitalizations.

"I'm hearing more and more about workforce shortages in the urban areas of our state than I ever have."

"Not only are people getting better and therefore less likely to use these other [higher cost] services, but we're also costing you less... We're saving you money..."

Cumbersome requirements limit care

Participants recommended reworking requirements that posed serious obstacles to access. Teens were reported not qualifying for residential care because they did not have prior outpatient counseling or home-based treatment, which was not available due to the long wait lists. Telehealth auditing felt punitive to many post-COVID. During the pandemic, the relationship between providers and regulators felt more collaborative.

"The burden of clinical documentation doesn't meet program integrity requirements."

"One of our residential programs is now required to have 24-hour staff. The rate does not cover [the huge cost increase associated with this requirement]."

BH Career Pathways Threats

High educational debt

High education costs result in educational loans that can fall short of wages. Students perceive that the return on investment in higher levels of education doesn't make up for its cost. Several creative solutions were mentioned for schools and organizations to decrease student debt.

"The student loan debt problem is enormous. A lot of students won't enter higher education because they don't want to take out the loan debt. They can't afford it."

"People are hesitant to come into a field where the reimbursement compensation is low and the cost of education is just as high as other graduate programs."

"Tuition support draws in students more than we think. ...We have a number of students who said, [before] I got this tuition support. I wasn't sure about this [program].....but this program was so close by, we thought we'd try it out."

"..If agencies could... get funding to pay down a certain amount of, student debt, that would be an incentive for students to choose those organizations to work for."

Lack of field placements

Faculty reported students' trouble entering and completing graduate programs due to a lack of field sites for required practicums. While BH organizations reported the costs of providing supervision, training, space, and lost income of billing for services for organizations were too high to take field placements.

"We need financial incentives for practicing clinicians who provide supervision and [for the] students."

"I've seen…competitiveness around paid internships, there aren't many people who can commit that time without compensation."

"One of our [field placement] organizations is supporting clinicians who supervise student interns by having that time count towards their… metric, the billable hours that they're expected to reach."

"[Students] can't do a full-time internship, go to school, and maintain employment unless they work during the day, in the evenings, and on the weekends. If you have families, that's just not feasible."

Lack of clarity of BH career pathways and the different BH professions

Participants reported a general lack of understanding about BH professions, career pathways, and roles in students and the general public. Non-BH organizations, such as schools or health care, lacked an understanding of the training, skills, and specific roles of the different BH clinical professions, resulting in confusion for everyone.

"We need to be promoting and marketing, helping professions in high school. We need a high school to college track for mental health workers that is very well incentivized."

"You're in settings where people don't understand what your skills, strengths, and potential contributions are."

Barriers for persons with a criminal justice history from entering the BH workforce

Participants suggested providing assistance navigating licensing to those with a criminal justice history.

"There are the rules around getting a BH license or being hired within organizations [for people reentering society after living in jails and prisons], which is preventing upward mobility or [a career] trajectory."

"There's no specific liaison to help support people [with a felony conviction or history of incarceration] through the licensing process… people tend to shy away and say, well, I will never be able to because of my criminal history."

Barriers to hiring and retaining BH providers

Organizations report difficulty recruiting and keeping staff. Heavy caseloads and higher acuity cases are contributing to provider burnout. Providers often leave organizations for private practice once they obtain their license for independent practice, impacting service continuity for clients and resulting in high costs due to high turnover rates and constant hiring and training of new providers.

"It's hard to attract providers when we can't pay as much as we would like to."

"We see a lot of folks who come in to do a couple of years of clinical practice get their independent license and then that's where they go and their income skyrockets."

"It's such a challenge to find clinicians in rural areas, even in good times."

Lack of meaningful data

Participants expressed the need to collect meaningful data without routinely burdening providers. Explicit data is the first step in understanding the extent of the problem, where to focus attention, and the impact of policies and other solutions.

"We have to....figure out how to look at our outcomes better....People are getting better and therefore [are] less likely to use these other [high cost, high intensity] services....We're saving you money."

" [Data that can] break down [workforce shortage areas] down a bit more so that we have a better sense of [geographic] need] would be worthwhile."

Compassion Fatigue and Burnout

Faculty and clinical supervisors often mentioned burnout and programs they were working on to prevent or ameliorate it.

"...There needs to be more support for resilience, like more access to your supervisor, group supervision, or teams that are functional, strong, and with good leadership and organizational support of resilience, which is really tough in this climate."

"We are fighting for the money that has been agreed to from insurance, paying to get that money, not getting enough of it, but then we're also feeling pretty overworked."

Lack of collective bargaining

Faculty reported the need for more consistent conversations, collaboration, or collective bargaining to address the conditions that lead students to leave the state post-graduation for higher-paying jobs and more educational debt support. Participants highlighted a need for more consistent and collaborative conversations to improve the field overall and improve

reimbursement, work conditions, burnout, and pay.

"...unfortunately, the [BH professional] silos operate in a vacuum. And how do we really bring people together more to have consistent conversations about how we could improve as an overall field?"

"We need to be involved in politics. [...] But we need to be at the big tables where the money is. We need to be able to talk the money language, write the money language, push the money language, and be involved at that level if we [want] to bring the funding to the profession."

"The mental health [professions] can lobby or somehow work together to push the insurance because I feel like the tail is wagging the dog here. They're telling us whether or not they will pay [for services provided]. And their goal is to make money."

The Impact of the Mental Health Workforce Shortage

Focus group participants reported on how the long wait times for mental health services affected clients and families, providers and staff, and BH organizations.

Impact on Clients and Families

Participants described persons' symptoms worsening and lives devolving as they waited for services, resulting in people experiencing increased isolation, hopelessness, disability, and increased risk of losing their jobs, insurance, and homes. Without an income or safe housing, there was an increased potential of losing their children to the child welfare system. Without timely access to outpatient care, many patients' symptoms and functioning worsened, ending some in crisis care, emergency rooms, and inpatient care in hospitals or residential treatment. Long treatment delays for children had huge implications on their development and learning.

"In the absence of a primary mental health, we're going to see higher acuity and the need for more expensive treatment."

"[A recent client reported] 'I've called 17 clinics, and no one can get me in.'"

"A child who's four years old having to wait in a
year for an evaluation than to access services is really significant."

"The most rural and most isolated person is waiting the longest for care."

Impact on Providers and Staff

Participants repeatedly highlighted the

lack of work-life balance and burnout associated with high caseloads and high acuity cases. The housing crisis is contributing to provider burnout on top of client stress. Independent providers report leaving insurance panels, accepting cash for payment, and giving clients "super-bills" to pursue reimbursement for services provided, creating a two-tiered system of care for clients with means and those without.

"The stressors of this for those of us in the field and our staff is moral distress. I often hear myself saying [to my supervisees]…'This is a complicated system; it's an under-resourced system. I'm so sorry I can't be more helpful to you.'"

"There's a lot of moral injury. The disconnect between social work values and what actually happens in the practice settings because of the corporatization of mental health practice creates….tension for people."

"I'm seeing the highest [number] of leaves of absences, paid medical leaves, surgical procedures that I've ever seen before."

"The impact …of this housing crisis that we're in …contributes to burnout."

Impact on Students

Social Work faculty reported drops in enrollment in on-site programs. Older students, rural students, and those needing more flexibility are opting for online programs to continue working their full-time jobs, taking classes, doing internships, and taking care of their families. This overcommitted schedule contributed to "psychic overload" and negatively impacted student learning.

Students become disillusioned during their studies and internships. Students are leaving the state for higher-paying jobs and more support to repay their education loans.

"There's this sort of disillusionment that happens when, you know, you have this kind of broad training, all of these potential areas, and then your roles don't align with… your vision for professional work."

"Many school administrators don't fully understand the difference between a school social worker, a school counselor, a school psychologist…that lack of understanding sometimes translates to people feeling a lack of respect for their professional role."

Impact on Organizations

As mentioned previously, the higher levels of acuity and greater levels of disability occurring in persons while waiting for services resulted in higher utilization of crisis services, hospitalizations, and a higher cost of care. Rural organizations are seeing internship and employee applicants dwindling. Multiple organizations reported closing or reducing services in

some areas. Clinicians are leaving community organizations once they get their license for independent practice. Online counseling, health homes, Federally Qualified Health Centers (FQHCs), and integrated primary care sites are competing with community BH clinics for licensed clinicians. Reimbursement discrepancies among service providers were perceived as making some organizations more competitive than others.

"The impact has been a reduction in services to people who need them the most."

"There is this new..... epidemic or pandemic ...of [what I call] ...silent quitting. People quit actually before they even show up to orientation.... I've never seen this before...or they'll just quit on the spot, sorry, I got another job."

"We had to shut down our outpatient therapy program because I could literally not hire. I posted a position for 12 months and maybe had one applicant that entire time, but that wasn't a viable fit."

"[It's] really hard to compete with... hospitals. They have way more money to offer people."

What Maine is Already Doing

Although this section is not meant to be comprehensive, it reports on select initiatives occurring in Maine that address the key focus group themes.

Improving BH Workforce Data and Tracking

Like other states, Maine has created several dashboards to track BH access challenges and workforce needs, including a Children's BH Dashboard,[21] a Drug Data Hub.[22] and a Direct Service Worker dashboard.[23]

Public Law 2021, Chapter 603,[24] An Act Regarding Reporting on Spending for Behavioral Health Care Services and To Clarify Requirements for Credentialing by Health Insurance Carriers, also requires the Maine Quality Forum (MQF) to submit an annual report on behavioral health (BH) care spending in Maine to the Joint Standing Committee on Health Coverage, Insurance and Financial Services and the Commissioner of the Department of Health and Human Services. The second and most recent report included county comparisons of BH and tele-behavioral health spending. In 2022, BH spending accounted for approximately 13% of total spending overall by public and private insurers in Maine and

one-third (33%) of MaineCare spending. In 2022, behavioral telehealth represented approximately one-third of commercial BH claims payments (34% in 2022), 19% of Medicare, and 11% of MaineCare.

Enhancing Financing of Services

MaineCare Rate System Reform[25] [26] was initiated in 2019. A Comprehensive Rate System Evaluation found many rates to be outdated and inconsistent and developed the following recommendations that were codified into law in P.L. 2021 Ch 639.

1. Sets a schedule for regular rate review and adjustment, including routine cost-of-living adjustments for eligible services.
2. Establishes the MaineCare Rate Reform Expert Technical Advisory Panel (TAP) for consultative purposes.
3. Establishes a rate system sub-committee to the MaineCare Advisory Committee (MAC).
4. Formalizes a clear and transparent process for rate determination via public notice, presentation, and comments (as well as public response to comments) on proposed rates.
5. Ensures review of relevant state and national data to inform rate amounts and payment models, with emphasis on models that promote high value services by connecting reimbursement to performance.

Rate increases began to be implemented in FY 2022 and 2023, with ongoing and imminent future plans posted on their Rate Systems Reform website.

Recent DHHS behavioral health financial strategies include:

- Maine Care rate increases: SUD Residential, Intensive Outpatient, Medication Management, Children's Residential
- HCBS Worker Bonus Initiative: $126 M, payments starting January 2022
- MaineCare "Ramp" payments
- Behavioral Health rate studies 2022[27]

The Office of Behavioral Health (OBH) conducted an initiative to expand access to Medication Management Services in Maine. OBH established a workgroup and met with 9 Medication Management Providers to get feedback and identify opportunities to expand service access. This effort identified additional billing codes available through MaineCare to support providers who frequently provide expert professional consultation. As a result of this engagement, the Department made funding available to expand Assertive Community Treatment (ACT) Teams to support high-acuity individuals accessing ACT services, including Medication Management, thus opening more appointment time for those waiting for services. Additionally, the legislature appropriated $2.5M in the previous legislative session to support funding for

recruiting and retaining staff providing Medication Management Services.

Collaborate to improve paperwork and regulations

Licensing Support

Maine has passed interstate licensing compacts for mental health counselors, psychologists, and, most recently, social workers. Given the pass rate disparities, particularly for people of color and older populations, a task force is considering alternatives to the licensing exam for social workers to propose for the upcoming legislative session.

Stakeholder Collaboration

In May 2021, Maine created a Comprehensive Behavioral Health Work Plan,[28] articulating strategies to deliver a continuum of health services, with annual reports from 2020-2022, with the service delivery and infrastructure sections most pertinent to access and workforce issues. The service delivery section focuses on the crisis continuum of care, community-based care, care management, substance use disorder services, peer support, and family support services. Key workforce development across the continuum of BH services are listed under the Infrastructure section of the work plan (pages 59-64) and in the Career Pathways and Recruitment and Retention sections described below.

The Office of Behavioral Health contracts with the Maine Behavioral Health Workforce Development Collaborative[29] (MBHWDC) to build capacity, assess needs, plan, implement, evaluate, and sustain training programs.

Maine's Department of Health and Human Services (DHHS) Office of Behavioral Health has several behavioral health advisory committees, including the Statewide Quality Improvement Council[30] (Maine's BH Planning Council), the Substance Use Disorder Commission[31] (21 members), the Consumer Council System of Maine[32] and Maine Continuum of Care.[33] The Office of MaineCare has a MaineCare Advisory Committee[34] (MAC) (26 members). The Office of Child and Family Services has a Behavioral Health and Supportive Services Workforce Collaborative[35] that came up with a list of recommendations and a roadmap (inoperable links as of 8/28/24).

Obtaining information about membership, meetings, or the work of the above advisory groups is difficult except for the MAC and the SUD Commission. None of the above seem to be charged or have the necessary funding for a comprehensive analysis of the behavioral health workforce.

BH Career Pathways

Provider Loan Repayment and Scholarship programs

Providing loan support is a key strategy to counteract the high educational debt and low wages. Yet, the tendency to lump behavioral health into the healthcare

workforce "pool" for loan support produces the risk that behavioral health workers are not recognized[36] or don't receive their share of awards. Table 3 reports results from a 2022 NASW study of 473 Maine social workers responding to questions about their education loan debt.

Table 3: Average Loan Debt of Maine Social Workers

NASW ME Social Work Student Loan Survey, 2022[37]

Bachelors Level	MSW Level	DSW Level
$50,624 (N = 31)	$74,557 (N = 311)	$117,500 (N = 7)

Support programs to alleviate behavioral health providers debt exist, yet are no guarantee to students who are considering entering the field and becoming clinicians.

- Maine's Health Care Provider Loan Repayment Pilot Program[38] ($25,000 per year or, in aggregate, the lesser of $75,000 or 50% of the recipient's outstanding loan balance). Unfortunately, in the first year this program was initiated, only three social workers received the award (personal conversation with FAME staff). Additional programs and monies are available specifically for Maine students studying medicine,[39] nursing[40] and dentistry.[41] To date, the social work loan repayment program has not been funded.
- Maine passed a Student Loan Repayment Tax Credit,[42] $2,500 annually, for up to $25,000 lifetime
- National Health Service Corps Loan Repayment Program,[43] (federal) $50,000 loan repayment after a 2-year full-time initial term; $25,000 after a 2-year half-time term, after serving at least 2 years in a Health Professional Shortage Area. Ten of Maine's 16 counties are designated Mental Health Professional Shortage areas
- The Public Service Loan Forgiveness Program[44] (federal) forgives the remaining balance of your Direct Loans after you have made 120 qualifying payments while working for a qualified employer
- The recent SAVE program[45] of the Biden Administration has promise for students but has been held up in court proceedings.

Support for special populations

- Connecting with Opportunities: [46]for those impacted by the opioid epidemic
- Expanding Access in School Environments (EASE) Maine is a $9 million investment by the Maine Department of Education (DOE) to increase school-based mental health staff and services in Maine. Grants were given to nine high-need school administrative units (SAUs) to support efforts to recruit and retain

mental health providers and expand student services.

As part of the Maine Jobs & Recovery plan, Governor Mills awarded $475,000 to the University of Maine System[47] to increase the placement of students pursuing Masters in Social Work (MSW) degrees in rural health care sites, increase the number of trained practitioners who can supervise MSW students, and encourage current health care staff to consider pursuing an MSW degree by providing the opportunity for field placements in rural communities.

In 2021, University of Maine received a $1.4 million HRSA grant for their Rural Integrated Behavioral Health in Primary Care training program,[48] providing $10,000-$25,000 stipends for up to 87 social work and doctoral psychology students.

Recruitment and Retention

The 2021 Maine Jobs and Recovery Plan[49] includes several programs for supporting students and recruiting them into health careers, including behavioral health. Current DHHS Healthcare workforce development initiatives[50] are centered around the following strategies:

Strategy #1: Recruitment

- Creating healthcare Career Pathway Navigators, helping students and front-line workers understand what is needed and support for advancement
- Health Workforce Marketing Campaigns to educate high school and undergraduate students about health professional fields
- Recruitment and Retention Bonuses for Home Care Based Services (HCBS)

Strategy #2: Training and Education

Healthcare Training for ME[51] initiative is a partnership of the Maine Department of Labor, the Maine DHHS, Maine Department of Education, Maine Community College System, and the University of Maine System. It is supported **by $21 million** from the Maine Jobs & Recovery Plan, which includes **$8.5 million allocated to DOL and $12.5 million allocated to the Maine Community College System** for workforce training. It also leverages private foundation funding provided by the Harold Alfond Foundation. The tuition remission program is designed to upskill 1500 healthcare workers, including Mental Health Rehabilitation Technicians, Certified Alcohol and Drug Counselors, Certified Clinical Supervisors, and others. To date, more than 1400 training slots have been funded.

The Career Pathways program includes education, mentorship, and counseling support including:

- Curriculum alignment: aligning training/certification with college credit courses and stackable credentials to licensure
- CTE expansion
- Maine Community College System/ UME degree and workforce programs

$950,000 was awarded to the MERGE Collaborative to expand Graduate Medical Education (GME) opportunities for physicians in training in hospitals and physician practices in rural and underserved communities across Maine.

$1.3 Million was awarded to expand access to clinical placements for trainees and preceptors in rural communities across the healthcare continuum, including behavioral health providers.

Workforce Development and Retention

Strategy #3 of the DHHS development strategies involves Workforce and Retention strategies[52] and include:

- Apprenticeships
- Retention & Career Ladder Supports – to advance BHPs, recovery coaches, Mental Health Rehabilitation Technicians

(MHRTs), crisis responders to LCSW or mental health clinicians

- Tuition Support

Additionally, the legislature appropriated $2.5M in the previous legislative session to support funding for recruiting and retaining staff providing Medication Management Services.

Organizational Strategies

According to a 2023 CCSME Survey[53] of BH providers in Maine, 65% of the 219 respondents reported including the following recruitment strategies: flexible hours, family or parental leave, paid educational opportunities, Employee Assistance Programs, and paid professional development. 19% of the 218 respondents reported recruitment and retention providing student educational loan assistance. The most common reasons staff provided for leaving BH organizations included financial concerns, career advancement, workload and stress, organizational factors, transition to private practice, and geographical or life changes.

Examples of BH Workforce Policy Efforts in Other States

Many other states are facing BH workforce shortages, similar to Maine. While a comprehensive review of other state efforts to address BH access gaps was beyond the scope of this report, the research team did conduct a limited policy scan of other state efforts based on best practice national reports and/or state examples referenced in focus group discussions. The following represent some select state examples highlighted in national reports as strategies Maine policymakers may wish to consider implementing and/or expanding on existing efforts.

Improving BH Workforce Data and Tracking

Colorado,[54] Illinois,[55] Maryland,[56] Minnesota,

[57] Oregon,[58] Pennsylvania,[59] Washington,[60] and others have enacted legislation in the last several years to study BH trends to which inform strategies to address workforce challenges. States such as Minnesota have dashboards for SUDs,[61] Children Mental Health[62] and Health Trends[63] across communities, including behavioral health. Ohio's Integrated Behavioral Health Dashboard[64] features over 50 metrics at both county and state levels, as an ongoing step toward understanding the extent of the ongoing challenges and needs of specific populations.

Enhancing the Financing of Services

Medicaid and Medicare Efforts to Increase/Expand BH Services and Reimbursement

Medicaid agencies have taken actions to address BH workforce shortages and low participation rates in their states and to help attract and retain workers. A Kaiser Family Foundation (KFF) study[65] found that in FY 2022 and 2023, two-thirds of responding states (28 out of 44), including Maine, implemented Medicaid FFS rate increases. Some states implemented increases that were more continuous and widespread. For example, Missouri and Oklahoma increased some BH provider rates to align with Medicare rates. Oregon provided incentive "differentials" in the increases, providing a 30% increase for providers who received 50% or more of their revenue through Medicaid, only 15% for those who received less than 50%, and additional differential for certain types of care (e.g., culturally or linguistically specific services).

Other state Medicaid programs, such as Indiana,[66] have extended the BH workforce by reimbursing new provider types, adding provider types that can bill without a supervising practitioner, loosening restrictions on in-person requirements to receive telehealth, or reimbursing for care delivered by trainees or the license-eligible workforce. KFF, 2023)

Massachusetts[67] incentivizes different levels of integrated BH into its per-member-per-month reimbursements, paying more for those with higher levels of integrated care, including case managers, BH clinicians, and psychiatry consultations.

As of January 2024, the following Medicare physician fee schedule[68] updates were enacted to improve access and help recruit and retain BH clinicians by:

- Expanding reimbursement codes for the diagnosis and treatment of mental health conditions to include marriage and family therapists
- Allowing clinical social workers, marriage and family therapists, and mental health counselors to be reimbursed for health and behavior codes
- Creating new psychotherapy codes for crisis services in various service sites
- Expanding who can provide BH services in FQHCs and Rural Health Clinics to

Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs)
- Adjusting Relative Value Units (RVUs) for psychotherapy to address distortions in valuing time-based BH services

Federal and State Efforts to Enforce Commercial Insurance BH Payment Parity

States continue to address gaps in parity [69]through legislation and regulatory, enforcement, and compliance efforts. They require insurance companies to 1) demonstrate and report on compliance, 2) cover a full range of mental illnesses and substance use disorders, and 3) have greater transparency.

The State of Washington created an Office of BH Advocacy[70] to promote compliance with applicable federal and state law. It promotes access to services, establishes a statewide uniform reporting system, investigates complaints, informs patients about their rights, and trains and certifies consumer advocates.

In 2020, CA passed a Health Coverage: Mental Health and Substance Use law[71] that requires commercial insurers in the state to cover the full range of mental illnesses and substance use disorders, ensure "medically necessary treatment" and "medical necessity" determinations be consistent with generally accepted standards of care, and that health plans and insurers use specified clinical criteria and guidelines for level of care determinations prohibiting the application of additional, different, or conflicting criteria. The law also prohibits limiting benefits or coverage for mental health and substance use disorders to short-term or acute treatment, denying medically necessary services on the basis that they should be or could be covered by a public entitlement program, and provides for administrative or civil penalties by the Department of Managed Health Care in the Department of Insurance.

Washington passed The Emergency Services Act[72] to help ensure commercial plans pay for out-of-network emergency services, including BH crises, care in crisis stabilization units, evaluation and treatment facilities, and mobile rapid response crisis teams. The law also defines a "BH emergency services provider," which allows for increased flexibility in the range of provider types that cover the crisis continuum of care.

Collaborate to improve paperwork and regulations

Paperwork and Administrative Burdens

Provider administrative burden refers to a wide range of administrative activities. It can include prior authorization,[73] lengthy forms or documentation requirements, unclear processes to navigate, lengthy credentialing processes, and unclear reasons for denials or auditing. About three-quarters of responding states to a KFF Survey[74] reported at least one strategy in place or planned for FY 2022/2023 to reduce provider

administrative burden in FFS and/or Managed Care Organizations. States most frequently reported seeking BH provider feedback on administrative processes, followed by implementing centralized or standardized credentialing. Multiple states, such as Ohio[75] and California[76] reported plans to implement centralized or standardized provider credentialing in FY 2023. Fewer states reported standardized prior authorization, treatment plan forms, or initial number of units or days for prior approved services.

Licensing Support

Licensing laws and regulations can help or hinder the BH workforce. As of August 2024, 22 states have passed the social work licensing compact to promote interstate counseling of patients and increase access to services. Other states have provided support for licensing fee for some groups. Illinois,[77] Utah,[78] North Dakota, and Washington[79] have passed legislation on alternatives to the social work licensing exam, which has been shown to have disparity in pass rates for older populations and people of color. North Dakota's bill allows their licensing board to suspend, waive, or create an alternative to the ASWB licensing exam. Utah and North Dakota removed the examination requirement for the Bachelor's and Master's level licenses but still have the exam requirement for clinical licenses.

Enhance BH Career Pathways

Many states have used the American Recovery and Prevention Act (ARPA), state, and private funds to develop programs supporting BH career pathways. In Washington state,[80] a private foundation gifted $38 million to address the state's behavioral health workforce shortages to fund a demonstration project to recognize, describe, and test a formal BH teaching clinic[81] classification for behavioral health agencies, including an actuarial study that proposes an enhancement rate, provider reimbursement strategies, and a fiscal impact analyses for such teaching clinics. Washington is also developing a behavioral health teaching hospital[82] designation, similar to medical residencies, to help train the next generation of behavioral health providers.

Nebraska,[83] Illinois,[84] North Carolina,[85] and others have created Centers for BH Excellence in their university systems. Established in the 1980s, Nebraska's Center has shown an impact in recruiting mentors across the state for students in BH, researching nuances of the workforce (e.g., finding that over 30% of clinical BH providers do not transition to get their independent licenses), creating a BH dashboard across the state that reflects challenges for all age groups and issues, paying supervisors for student interns and those with provisional licenses, and providing funds for innovative workforce programs across the state.

In 2023, the Ohio General Assembly[86] invested $85 million to grow their BH workforce for:

- Paid internship and scholarship opportunities for BH students
- Removing financial and other barriers to obtaining licenses, certifications, and exams
- Financially supporting providers to supervise and offer internships to students
- Establishing a technical assistance center to help students navigate the federal and state funding opportunities

Colorado passed legislation and invested $36 million in a work plan[87] to reinforce the BH workforce needed across age groups. The work plan aims to strengthen the career pipeline and publicly fund BH providers, remove barriers for those entering the field, reduce administrative burdens, and coordinate outreach and marketing efforts to promote professions in the BH field by:

- Expanding peer support and piloting a BH aide model
- Paid internships and pre-licensure stipends
- Career pipeline development grants
- BH Learning Academy
- BH apprenticeships

Washington's previously cited legislation (2019) created a workgroup and appropriated $1.5 million to establish apprenticeship programs, compensate providers and apprentices, develop on-the-job training, and provide incentives for providers in communities serving rural communities and communities of color. WA also launched a campaign to increase interest in BH careers and a pilot and training program to encourage BH providers to increase internships (KFF, 2023)

Idaho[88] created a BH Council that developed a comprehensive workforce plan[89] to increase the number of licensed and certified BH professionals. The plan includes recommendations for promoting careers in BH and providing more resources for training and in-state degrees. It also recommends expanding tuition reimbursement opportunities for those studying to work in the BH field and expanding BH care options.

Massachusett's BH Trust Fund[90] is using ARPA and state funds by allocating:

- $100 million to expand the existing BH loan forgiveness program,
- $25 million for BH scholarships, internships, field placements, and practicums
- $20 million for a BH clinical supervision incentive program
- $3 million for an interagency program on licensure/certification and waiving fees for those entering the field
- $1.8 million for a workforce development center and

- $1 million) for BH research activities operated through the MA Health Policy Commission

Vermont[91] has created a "licensed intern" category, where BH organizations are able to bill for the clinical work of masters and doctoral level BH students at a rate comparable to a LMSW-Cc.

Other creative solutions[92] include reimbursement for supervision required for licensure, if not available from the employer, and Career Impact Bonds for education, financed through federal, state, private, and university systems, and incentives to diversify the workforce.

Promote Recruitment and Retention

States have also used ARPA, state, and private funds to retain clinicians providing care in community mental health agencies to help reduce worker turnover and burnout, incentivize hiring, and increase access to services. Washington's Workforce Training and Education Coordinating Board and BH Workforce Advisory Committee (BHWAC) have invested more than $131 million through loan repayment in return for working at approved BH sites to incentivize BH provider retention in facilities serving low-income patients. Washington State[93] and Illinois[94] have created task forces to examine the impact of the background check process on the BH Workforce and are working to establish a Certificate of Restoration of Opportunity and Expungement clinics to address the barriers for those with a history of incarceration from entering and advancing in the BH workforce.

Many, if not most, state-level initiatives work with stakeholders to collaborate on addressing the BH workforce challenges in their state. Oregon's Recruitment and Retention Recommendations[95] lists over 50 strategies and provides case studies of 9 other programs in various U.S. states. developed Colorado's work plan[96] has strategies to reduce the administrative burdens that impede entry and retention of workers, as well as coordinate outreach and marketing efforts to promote all professions in the BH field by:

- Innovative retention grants and recruitment strategies for BH employers
- Community engagement and promotion of workforce opportunities

Other creative solutions[97] include elevating BH clinicians' ability to approve treatment plans, approve/certify diagnoses and commitment criteria, teach BH provider skills on culturally responsive care, and provide incentives to diversify the workforce.

Recommendations to Address Access and Workforce Shortages

Goal 1: Enhance financing of services

- Establish reimbursement levels that cover the costs of care (group therapy, outpatient therapy, residential care)
- Upgrade rates on a routine reasonable basis to reflect cost-of-living increases and geographic variations
- Establish a baseline livable wage on par with other bachelor's and master's-level professions in healthcare
- Restructure reimbursement rates that cover collaborative, family contacts, and team-based care
- Form/expand/empower the existing MaineCare collaborative that includes policymakers, state administrators, and organizational leaders to ensure innovative financing and service delivery models
- Establish enhanced payments for geographic variability (i.e., housing is unattainable for social workers in Southern Maine)
- Create a BH "licensed intern" category with the ability to bill MaineCare
- MaineCare incentivize integrated BH in Primary Care to improve access
- Leverage funding opportunities, such as expanding state opioid monies to enhance BH services
- Require insurance companies to demonstrate compliance with BH parity laws routinely
- Require insurance payment for out-of-network emergency services
- Offer tax credits to employers who hire providers who meet specific criteria or qualifications (Goal 4)

Goal 2: Collaborate to improve paperwork and regulations

- Establish pathways of trust and transparency between insurers and providers to reduce the complexity and burden of care, such as routine BH provider feedback on administrative processes
- Streamline mental health prior authorizations and report on the number of denials and limits to care
- Establish prompt payment requirements
- Standardize forms across insurers (e.g., prior authorizations, treatment plans, treatment recertifications)
- Remove requirements that limit care, such as retaining clients who no show or denying high-level care when a lower level is not available
- Centralize provider credentialing across insurers
- *Create a dashboard on adult behavioral health trends*
- *Establish reasonable data reporting and transparency on workforce shortages, utilization, wait times, and patient-centered outcomes across the continuum of care*
- *Use provider and organizational licensing applications to gather data about the BH workforce*

Goal 3: Enhance behavioral health career pathways

- Fund BH scholarships (preferred) and education debt relief programs, such as the social work education loan repayment program
- Invest in field placements by providing student stipends and paying supervisors and organizations, similar to medical residencies
- Create behavioral health teaching organizations and hospitals
- Enhance Maine's career pathways program capacity to support BH provide and support new Mainers to diversify the workforce
- Streamline licensing processes to reduce licensing delays and enhance early entry into the workforce
- Waive licensing fees for new BH graduates
- Reduce barriers and provide support to those entering the BH workforce who have a criminal justice history (e.g., "Expungement Clinics in Illinois)
- Integrate BH care and primary care to improve access
- Support interstate compact licensures and other licensing programs to address barriers that impede entering the workforce
- *Create a Behavioral Health Center of Excellence in the university system for research and education that advances the behavioral health workforce (e.g., numbers leaving the state post-graduation, numbers earning their license for independent practice, and length of time providers stay in community organizations after receiving their license for independent practice)*

Goal 4: Promote retention of providers in BH organizations

- Create a uniform system on Maine's BH data with routine updates on the BH workforce gap, including job vacancies, turnover, work conditions, exit surveys
- Enhance career ladders and other incentives that attract providers to stay in organizations providing services to clients with higher acuity of need
- Provide training and opportunities for supervision and other ways to build flexibility into the work
- Establish reasonable caseload numbers and a cap that takes acuity into consideration
- Take steps to address concerns of faculty and licensed providers who are discussing organizing as a solution to their challenges

Discussion/Conclusion

Addressing the challenges identified in the BH Access and Workforce point-in-time study and focus groups is necessary for improving Maine's BH system. The point-in-time study wait list and vacancy numbers indicate that we are nearing, if not in, a BH crisis. The focus group participants supported the numbers and

unanimously highlighted that enhancing the financing of services is imperative. Insufficient reimbursements and wages have created barriers that undermine the ability of professionals to provide high-quality care and sustain their involvement in the field. To address this, increasing and restructuring reimbursement rates and establishing livable wages are essential to attract and retain qualified professionals while ensuring that organizations can continue delivering critical services.

Collaboration to streamline paperwork and regulations also emerged as a key need. Providers face significant obstacles due to regulatory inefficiencies and burdensome documentation requirements. Simplifying these processes, improving data collection, and ensuring that regulations support rather than hinder effective care are vital for enhancing client relationships and managing wait times more effectively.

Further, strengthening BH career pathways is necessary to address the current pipeline issues. With declining enrollment and challenges in completing programs, mainly due to a shortage of field sites and the high cost of education, increasing financial support and expanding internship opportunities can make BH careers more accessible and sustainable for future professionals. Scholarships are preferred over loan repayment to attract students into the field, as repayments are never guaranteed. Multiple opportunities are available to shore up internships, from allowing organizations to bill for the clinical work student interns to developing designated behavioral health training organizations and hospitals along with funding and reimbursement incentives.

Promoting provider retention within BH organizations is crucial. High caseloads and acuity drive providers towards private practice, exacerbating the workforce shortage. Implementing protections and incentives, such as caps on caseload numbers, can improve job satisfaction and stability, thereby supporting the retention of skilled providers within the organizations that need them most.

It's essential to acknowledge the limitations of this work, including data measuring only one point in time, a small sample size, and relying on self-reported data, which does not have a vigorous validation process. Furthermore, how providers define wait times and manage their waitlists varies considerably from provider to provider. We could not extrapolate if providers were duplicating individuals across agencies and services or if individuals were receiving other services while waiting for services.

To avoid duplicating the recent efforts of others, we did not include detailed questions about categories of people who either receive services or provide support and are part of the BH workforce. These groups include school-age children and teens with BH needs (Sweetser), peer support workers (Maine Center for Rural BH Development), and the direct care workforce (Maine Center for Economic Policy). We did not include BH students' perspectives, as captured in Sweetser's interview with over 90 students. These limitations highlight the need for more resources spent on data tracking and/or transparency of data that tracks our BH workforce, access, and utilization rates.

The study results enhance our knowledge of the BH access and workforce landscape, helping to clarify a roadmap for moving forward.

Appendix A: BH Access Coalition Members

Table 4: BH Access Coalition Members

Name	Role	Organization
Julie Schirmer, LCSW	President, Board of Directors	National Association of Social Workers, Maine Chapter
Malory Otteson Shaughnessy, MPPM	Executive Director, Retired as of June, 2024	Alliance for Addiction and Mental Health Services, Maine & Maine BH Foundation
Adam Bloom- Paicopolos, MPP	Executive Director, as of June, 2024	Alliance for Addiction and Mental Health Services, Maine & Maine BH Foundation
Chris McLaughlin, LCSW	Executive Director	National Association of Social Workers, Maine Chapter
Jeri Stevens, LCPC	Member, Board of Directors and Legislative Committee	Mental Health Counselors Association of Maine
Randy Moser	Executive Director	Maine Psychological Association
Arthur Phillips	Economic Policy Analyst	Maine Center for Economic Policy
Kate Marble, LCSW	Case Management Program Director	Health Affiliates of Maine
Catherine Chichester, APRN	Executive Director	Co-Occurring Collaborative Serving Maine

Kristen Erickson, MPH	Assistant Director	Co-Occurring Collaborative Serving Maine
Joanne Grant, LCPC	Chief Growth Officer	Sweetser
Kristan Drzewiecki	Planning Grant Coordinator	Sweetser
Catherine Sanders, PhD	Senior Program Manager and Lead	Rural BH Workforce Center (RBHWC) MCD Global Health
Kristen Erikson, MPH	Distance Learning Coordinator	Co-Occurring Collaborative Serving Maine
Catherine Ryder, LCPC, NCC, MS	Vice President of Special Projects	Spurwink Services
Kimberly Fox, MPH	Private Consultant	Muskie Institute
Betsy Sweet	Legislative Advocate	Moose Ridge Associates
Ashlee Eikelboom, LMFT, ACS	Clinical Supervisor	Brighter Heights
Tom Early, PhD	Member, Legislative Committee	Mental Health Counselors Association of Maine
Deanne Ochoa-Durrell	Clinical Director	Assistance Plus
Abby Stivers	Director	Workforce Development & Retention, OADS
Deb A. Johnson	Director	Office of Community Development, OADS

Appendix B: Point-in-Time Survey Questions, Tables, and Organizational Respondents

Organizational questions:

1. Service type:
   - Peer support services
   - Private outpatient individual or group practice
   - BH home
   - Crisis services
   - Residential treatment
   - Psychiatric in-patient or partial
   - Community outpatient
   - Community support services
   - Child welfare
   - Integrated BH care in medical outpatient
   - Group home
   - Medical in-patient

Hospitalization
Detox, outpatient, residential, community addiction
University/college
Community policing
Veterans services
Medication-assisted withdrawal management
School social work & counseling K-12
BH care home care
Corrections, court system, re-entry programs
Other (please describe):

2. Primary County of service location of your organization
3. All other counties served by your organization (including a "statewide" option)
4. Populations served
   Age groups: Infants, Children, Teens, Adults, Seniors
   Persons with [the following conditions]: Mental health, Alcohol, Opiates, Other substance use disorders
5. How many of the following full-time provider or non-clinical support positions is your organization currently operating with?
   Service provider options:
   - Case managers/care coordinators
   - Peer specialists, Substance Use Disorder
   - Mental health clinicians (eg, LCSWs, LCPCs, LMFTs, Psychiatric APRNs, PhDs, PsyDs)
   - Addiction specialist prescribers (MDs, Dos, NPs)
   - Peer specialists, Mental Health
   - Peer support supervisors
   - Substance use clinicians (eg, CADCs, LADCs)
   - Psychotropic prescribers (MDs, DOs, NPs)
   - Other (please describe)
6. Are you currently accepting new clients for the following services?
   Service options:
   - Case management/care coordination
   - Substance Use treatment with peer Support specialist
   - Peer support supervisors
   - Substance use treatment with clinicians (eg, CADCs, LADCs)
   - Psychotropic prescription (MDs, DOs, NPs, PAs)
   - Mental Health services with peer support specialist
   - Mental health services with clinicians (LCSWs, LCPCs, LMFTs, Psychiatric APRNs, PhDs, PsyDs)
   - Addiction treatment with specialist physicians
   - Other (please describe):
7. Do you have a waitlist for the following services? (options listed in Question 6)

7a. If so, what is the current number of clients on your waitlist size for the following services? (options listed in Question 6)

7b. What is the average length of time on the waitlist for each service provided? (options listed in Question 6)

8. How many more FTE positions would be needed to meet the current demand for services, if appropriate? (options listed in Question 6)
9. Reimbursements accepted for which type of payer:
   Options: Commercial, MaineCare, Medicare, Self-pay
10. If your organization has been impacted by gaps in the BH workforce, please

describe below.
Options: Reduction of services, Closing of services, Other:

11. Additional comments Write in: _____

Provider questions

1. Let us know your practice setting:

Self-employed in individual or group practice	Schools
Corrections	Community Policing
Mixed	Other (please specify):

2. What is the county of your primary office setting? (check one of all 16 Maine Counties listed)
3. What other counties are being served by your practice? (check all that apply, including a "statewide" option)
4. What is your current role and license, if appropriate (check all that apply): (positions listed in provider questionnaire)

4a. If you are a BH clinician, please indicate which license(s) you have.
4b. If you are a substance use counselor, please indicate which license(s) you have:.
4c. If you are a medical provider, please indicate which license(s) you have.

5. Populations served (check all that apply, with response options listed in provider questionnaire):
6. Types of insurances accepted (check all that apply). Response options listed in provider questionnaire.
7. Hours/week seeing clients.
8. Are you currently accepting new clients?

8a. If yes, how many openings do you currently have?

9. Number of clients on your waitlist
10. Waitlist time for new clients
11. Additional comments
12. Please list your age

Point-in-Time Tables

Table 6: Survey Respondent Populations Served, Services Provided, and Location of Services

	Individual Providers (n = 277)	Organizational Providers (n=50)
Predominant Services Provided	71% - mental health clinicians	68% - outpatient, community, and home
Populations Served - Infants - Children - Teens - Adults - Seniors	3% 22% 48% 92% 59%	28% 74% 76% 92% 68%
Services Provided - 1 county only - Statewide	20% 57%	28% 44%
Percent Treating Addiction	40%	76%

Table 7: Respondents by County

County or Area Reported as Primary or Additional Location for Services	Individual Providers (N=277)	Organizational Providers (N=50)
Services Provide in Only 1 County	20%	28%
Statewide	57%	44%
Androscoggin	13%	32%
Aroostook	4%	22%
Cumberland	55%	42%
Franklin	4%	24%
Hancock	8%	20%
Kennebec	10%	34%
Knox	4%	20%
Lincoln	5%	8%
Oxford	6%	18%
Penobscot	13%	22%
Piscataquis	4%	12%
Sagadahoc	4%	10%
Somerset	3%	18%
Waldo	5%	22%
Washington	8%	4%
York	23%	26%
Total Responders	277	50

Table 8: Organizational Respondents by Number of Full-Time Employees

Range	FTE Number
Less than 10 FTEs	17
11-25 FTEs	16
6-49 FTEs	5
50-149 FTEs	7
Over 150 FTEs	5

Table 9: Age of Independent Provider Respondents

Age Span	Provider Number	% of Respondents
18-29	6	2%
30-39	30	11%
40-49	64	23%
50-59	63	23%
60 and over	111	40%

Table 10: Potential Client Average Wait Time for Services

Service Type	Number of Clients Waiting*	Mean Wait Time*	Percentage of Respondees Reporting Wait Time AND Numbers Waiting
Individual Provider	1099	33 weeks	21%
Case Management	1340	25 weeks	28%
Peer Support MH	189	16 weeks	8%
Peer Support SUD	125	5 weeks	6%
MH Counseling	8812	32 weeks	40%
SUD Counseling	418	14 weeks	18%
MH Prescribing	2819	33 weeks	20%
SUD Prescribing	25	8 weeks	2%

*Waitlist and mean wait time numbers reflect only those responders who reported both the numbers of clients waiting AND the actual wait times.

Table 11: Supporting Data for Client Wait Times by Service Type

Service Type	2 weeks	2 -4 weeks	1-3 months	4-6 months	7-9 months	10-12 months	13-18 months	19-24 months	Total Number of Clients Waiting for Service	Total Respondees that have Wait List	Total Number of Respondees Reporting Wait Time AND Numbers Waiting	Mean Wait Time for Those Reporting a Wait List Time AND Numbers Waiting
Individual Provider	25	25	275	311	37	180	246	0	1099	99	57	33 weeks
% Wait Time for Individual Provider Clients	2%	2%	25%	28%	3%	16%	22%	0%				
Organizational Providers by Service												
Case Management	0	176	22	361	750	0	31	0	1340	17	14	25 weeks
% Wait Time for Case Management	0%	13%	2%	27%	56%	0%	2%	0%				
Peer Support MH	0	0	25	164	0	0	0	0	189	5	4	16 weeks
% Wait Time for Peer Support MH	0%	0%	13%	87%	0%	0%	0%	0%				
Peer Support SUD	5	100	20	0	0	0	0	0	125	6	3	5 weeks
% Wait Time for Peer Support SUD	4%	80%	16%	0%	0%	0%	0%	0%				
MH Counseling	0	405	125	1703	506	3665	379	2029	8812	28	20	32 weeks
% Wait Time forMH Counseling	0%	5%	1%	19%	6%	42%	4%	23%				
SUD Counseling	0	46	250	75	46	0	1	0	418	14	9	16 weeks
% Wait Time for SUD Counseling	0%	11%	60%	18%	11%	0%	0%	0%				
MH Prescription	20	243	50	55	798	959	0	694	2819	13	10	33 weeks
% Wait Time for MH Prescribing	1%	9%	2%	2%	28%	34%	0%	25%				
SUD Prescription	0	0	25	0	0	0	0	0	25	5	1	8 weeks
% Wait Time for SUD Prescribing	0%	0%	100%	0%	0%	0%	0%	0%	0			

Table 12: Retirement Plans of Independent Providers Over Age 60

Years to Retirement	Provider Number	% of Age 60+
1-5 years	50	45%
5-10 years	24	22%
10-15 years	4	4%
No plans	7	6%

Table 5: Point-in-Time Survey Organizational Respondents

	Organization Name	
AbleTo	Greater Portland Health	OHI
Acadia Hospital and Acadia Healthcare	Health Affiliates Maine	Pinnacle Health & Rehab
Androscoggin Home Healthcare + Hospice	Health Psych Maine	RSU 18 Special Services
AngleZ Behavioral Services	Higher Ground Services	RSU#24
Aroostook Mental Health Center	Hometown Health Center	Sacopee Valley Health Center
Blue Hill Family Medicine	Island Institute for Trauma Recovery LLC	Searsport Counseling Associates
Borden Cottage	Kennebec Behavioral Health	Spurwink
Catholic Charities Maine	Kids Peace	Spurwink Affiliates

CCS	Maine Behavioral Healthcare	St. Andre Home
Common Ties Mental Health Services	Maine Health	Sweetser
Community Health and Counseling Services	MaineGeneral Community Care	The Dempsey Center
Cross Roads Case Management	MaineGeneral Medical Center	Tri-County Mental Health Services
Crossroads for Women, Inc.	MCH Family Counseling Center	University of New England
Department of Health and Human Services	New Day Counseling	Volunteers of America, Northern New England
Foster Care and Community Programs	Northeast Occupational Exchange	Wabanaki health and wellness
Kids Peace	Northern Light Mercy Cancer Center	Waterville Public Schools
Grace House for Women	Health Affiliates Maine	Wellpath - Department of Corrections
Greater Portland Health	Health Psych Maine	

Appendix C: Focus Group Questions, Slides, and Organizational Respondents

Focus group questions

1) How does the wait list data resonate with you relative to your experience/populations served?
2) How does the staffing data resonate with you?
3) What are the top three factors that contribute to the BH workforce shortage?
4) What is the impact of limited access to BH services?
5) What are your ideas for addressing the issues we have been discussing?
6) For faculty groups. What do BH faculty, BH professionals, or organizations need to do to graduate more BH professionals?

Focus group slides

NASW MAINE CHAPTER

Behavioral Health Access Results for Focus Groups

Final Results

Julie Schirmer, LCSW, Malory Shaughnessy, MPPH
Behavioral Health Access and Workforce Coalition

Overall Objectives*

- understand the extent, challenges, and barriers to behavioral health access,
- identify geographic, programmatic and other areas where shortages exist,
- identify strategies for improving the current and future behavioral health workforce in the state of Maine

Consent

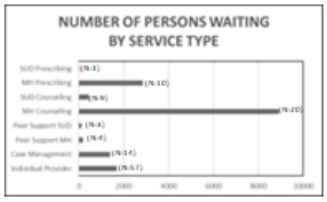
- Your responses will be kept confidential, meaning any reports we write based on what information you've provided us will be divorced from any personal identifying information. If we extract a quote for our final report, we will omit any identifying information from within. All quotes will be representative of general themes. We do not anticipate any direct risks to result from your participation.

Focus Group Rules

- Participation in the focus group is voluntary
- All responses are valid—there are no right or wrong answers.
- Please respect the opinions of others even if you don't agree.
- Try to stay on topic; we may need to interrupt so that we can cover all the material.
- De-identify any case examples that you report.
- Help protect others' privacy by not discussing details outside the group.

Potential Clients Waiting for Behavioral Health Services *

- Organizations:
  - 8,913 for organizational mental health counseling
  - 2,849 for psychiatry
  - 1,395 for case management
- Individual Providers:
  - 1,099 for individual providers



N=number of organizations responding

Potential Client Average Wait Time for Services*

Service Type	Number of Clients Waiting*	Mean Wait Time*	Percentage of Respondents Reporting Wait Time AND Numbers Waiting
Individual Provider	1099	33 weeks	21%
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*Waitlist and mean wait time numbers only reflect those responders that reported both the numbers of clients waiting AND the actual wait times.

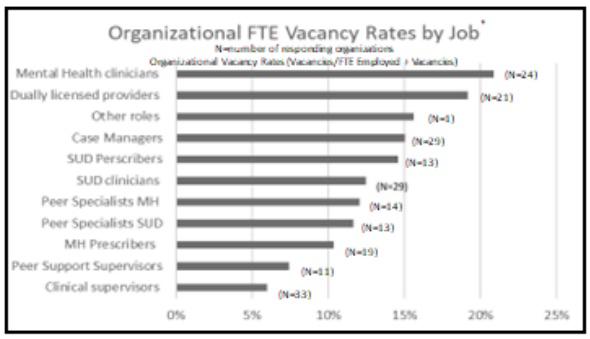

Table 13: Focus Group Participants

Name	Organization	Position, School, or Department
Adam Bloom-Paicopolos*	Alliance of Addiction and Mental Health Organizations	Executive Director
Alexander Katopis (contributor)	University of Southern Maine	Counseling
Amy Cohan	Spurwink	Senior VP of Outpatient and Community Services
Amy Sherman	University of Maine	BSW Internship Coordinator
Beverly Wagner	University of Maine at Presque Isle	BSW Program Director
Blake Hatt	The Northern Lighthouse Inc.	Chief Operations Officer
Brittany Ballard	AMHC	Director of Human Resources
Caitlin Eldridge	Saint Joseph's College	Program Director
Catherine Ryder*	Spurwink	Vice President, Special Projects
Colby Parent	MaineHealth- Supporting Behavioral Health	Director, Human Resources
David Meyer	Health Psych Maine	Clinical Director/Owner
Deanne Ochoa-Durrell	Assistance Plus	Clinical Director
Deborah Drew	Husson University	Emeritus Professor/Adjunct Professor Counseling
Donald Dufour	Spurwink	Sr. Director of Human Resources
Grace Ott*	Independent Provider	Social Work
Helen Mailloux	Community Health and Counseling Services	Director of Quality, Home Health and Hospice Services
Jamie Pratt	University of Southern Maine	Chair: Department of Educational and School Psychology
Jayme Villanueva	Milestone Recovery	Clinical Director
Jeanette Andonian	University of Southern Maine	Associate Dean
Jeff Hecker (contributor)	University of Maine, Orono	Psychology
Jen Waterman	Cumberland County	LCPC-C
Jennifer O'Neil	University of New England	Director School of Social Work
Jeri Stevens*	Husson University	Counseling
Jillian Jolicoeur	Assistance Plus	CEO owner
Judith A Josiah-Martin	University of Maine, Orono	Professor
Kate Marble	Health Affiliates Maine	Clinical Director
Kate White, Ph.D.	Psychology Specialists of Maine	Chief Clinical Officer, Training Director
Kim Tousignant	Hancock & Penobscot counties	PsyD
Kristan Drzewiecki	Sweetser	Grant Coordinator
Kristin Caffier	Brighter Heights Maine	Clinical Director
Lacey Sawyer	University of New England	Assistant Clinical Professor/Practicum Education Coordinator
Leah Maxwell	University of Maine School of Social Work	Internship Director
Lisa Henry	University of Maine, Farmington	Director, MA Counseling Psychology

Lori Wilson	Community Health & Counseling Services	Manager of Community-Based Services, LCSW
Nicole Achey	University of Maine at Farmington	Assistant Professor
Nicole Chase*	Husson University	Counseling
Nora W Morse	Spurwink Services	Director of Best Practices
Sara Berry	Cumberland County	LCSW
Sean Scovil	Community Care	Clinical Director
Shawna Traugh*	University of Maine, Presque Isle	Social Work
Shelly Farmer	Community Health and Counseling Services	HR Manager
Sofie Mattens	Franklin County (school based social worker)	LCSW
Suzanne Fougere	Penobscot	LCPC-C

*Focus group facilitators

End Notes

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