Behavioral Health Workforce, 2023

December 2023

The United States is experiencing a mental health crisis with increased levels of unmet behavioral health needs among people of all ages.[1] The capacity of the behavioral health workforce to meet the demand is limited by supply and distribution challenges. However, the challenges facing the behavioral workforce extend beyond the supply and demand issues and include:

- **Patient-level barriers**, such as stigma and ability to pay that both hinder access to care
- **Provider-level barriers,** such as limited scopes of practice, reimbursement challenges, and clinician burnout all of which limit the ability to provide high-quality care.

This report provides an overview of the current behavioral health workforce supply and distribution in the United States as well as factors impacting the workforce and access to behavioral health care services.

About the National Center for Health Workforce Analysis

The National Center for Health Workforce Analysis informs public and private sector decision makers on health workforce issues by expanding and improving health workforce data, disseminating workforce data to the public, and improving and updating projections of the supply and demand for health workers.

For more information, visit the Health Workforce Analysis webpage.

Highlights include:

- Substantial shortages of addiction counselors, marriage and family therapists, mental health counselors, psychologists, and psychiatrists are projected in 2036.
- As of December 2023, more than half (169 million) of the U.S. population lives in a Mental Health Professional Shortage Area (Mental Health HPSA).
- Rural counties are more likely than urban counties to lack behavioral health providers. Residents of rural counties are also more likely to receive behavioral health services from primary care providers.
- The majority of the behavioral health workforce identifies as female and non-Hispanic White and may not be representative of the communities they serve.
- The lack of uniformity in behavioral health providers' scope of practice, reimbursement challenges, and increased burnout hinder the accessibility of the behavioral health workforce.
- Expanding integrated care, leveraging health support workers, and using telebehavioral health may help alleviate behavioral health workforce shortage and maldistribution.

Describing the Behavioral Health Care Workforce

The opioid epidemic[2] and mental health crisis in the United States[3] have contributed to an increase in overdoses, suicides, and depression in the past two decades.[4,5,6] The COVID-19 pandemic also exacerbated behavioral health needs.[7] Even though behavioral health needs have increased, the number of individuals receiving behavioral health services has not.[8]

In 2022, approximately 59 million U.S. adults (23% of all U.S. adults) had a mental illness and nearly half of them did not receive treatment.[9] Behavioral health services can be difficult to access due to behavioral health provider shortages, high out-of-pocket costs, coverage gaps, and other factors.[10] For example, 6 in 10 psychologists do not accept new patients,[11] and the national average wait time for behavioral health services is 48 days.[12]

Behavioral Health Occupations

The traditional behavioral health workforce comprises many different occupations including licensed professionals and health support workers. These occupations have different education, training, and licensure requirements that can vary by state and accrediting body.[13] Table 1 shows the current supply in typical behavioral health occupations.

Table 1. Current Supply of the Behavioral Health Workforce

Profession	Year	Supply
Addiction counselor [a]	2021	86,794
Marriage and family therapist [a]	2021	26,763
Mental health counselor [a]	2021	112,948
Psychiatric aide [b]	2022	30,590
Psychiatric nurse practitioner [c]	2022	22,023
Psychiatric physician assistant/associate [d]	2021	2,262
Psychiatrist [e]	2021	50,376
Psychologist [a, i]	2021	95,865
Social worker [a, ii]	2021	552,890

Note: [i] Psychologist totals include psychologists with a PhD degree. [ii] Social worker totals include child, family and school social workers; healthcare social workers; and mental health and substance abuse social workers.
Source: [a] 2021 American Community Survey 5-year Public Use Microdata. [b] BLS Occupational Employment and Wage Statistics, May 2022. [c] 2022 American Psychiatric Nurses Association's Workforce Report. [d] 2021 National Commission on Certification of Physician Assistants Annual Report. [e] 2021 American Medical Association Physician Master File.

The occupations in the behavioral health workforce are not homogeneous. Different occupations provide different levels of care. For example, psychiatrists can prescribe medication, psychologists can provide psychological assessments and therapy, and peer providers can offer support based on their training and lived experiences.

Other Occupations Providing Behavioral Health Services

Not all behavioral health services are provided by those working in behavioral health occupations. In many cases, primary care providers, such as primary care physicians, physician assistants/associates (PAs)[14], or nurse practitioners (NPs), are the first health professionals to see patients with behavioral health issues.[15]

Primary care providers delivered 32% of mental health related office visits between 2012 and 2014.[16] Approximately 6.7% of primary care physicians' direct patient care time was spent on providing behavioral health services between 2018 and 2019 which was a 16% increase from just four years earlier.[17]

Current and Future Shortages

Health Professional Shortage Areas (HPSAs) are one method to measure the extent of current provider shortages. HPSAs are used to identify a shortage of health professionals in geographic areas, facilities, or populations. As of December 2023, 169 million people in the United States, over half of the population, lives in a Mental Health HPSA.[18]

The **current shortages** seen through HPSA data and the **projected future shortages** noted below are generated using two completely different concepts. HPSAs are a "real-time" designation, and a Mental Health HPSA is specific to mental health care providers.[19] By contrast, projections come from the Health Resources and Services Administration's (HRSA) Health Workforce Simulation Model (HWSM). This model projects the future supply of and demand for over 100 health care occupations, including behavioral health occupations.[20]

Substantial shortages are projected for the behavioral health workforce in the future.[21] Table 2 shows the projected shortages and percent adequacy in 2036 across different scenarios. The percent adequacy is the percentage of demand that supply will meet in that year.

Table 2. Projected Shortages of Selected Behavioral Health Providers in 2036, number and percent adequacy

Profession	Status Quo	Unmet Need	Elevated Need
Addiction counselors	-87,630 (53%)	-125,010 (45%)	-153,190 (40%)
Adult psychiatrists	-37,980 (45%)	-51,680 (38%)	-82,920 (27%)
Child and adolescent psychiatrists	-4,150 (75%)	-7,470 (63%)	-20,050 (39%)
Child, family, and school social workers	25,270 (112%)	-15,250 (94%)	-15,920 (93%)
Healthcare social workers	-3,920 (96%)	-26,080 (80%)	-31,640 (77%)
Marriage and family therapists	-27,450 (64%)	-42,840 (54%)	-51,140 (49%)
Mental health and substance use disorder social workers	-8,250 (93%)	-32,350 (78%)	-61,120 (65%)
Mental health counselors	-69,610 (62%)	-105,950 (52%)	-138,670 (45%)
Psychiatric physician assistants/associates	530 (111%)	-490 (92%)	-2,190 (71%)
Psychologists	-62,490 (63%)	-95,970 (52%)	-110,600 (49%)
School counselors	-21,030 (89%)	-60,010 (74%)	-

Note: Data are expressed in full-time equivalents (FTEs). Negative values indicate a projected shortage. Positive values indicate a projected surplus. Dashes indicate that projections were not available. Percent adequacy is calculated by dividing supply by demand. Unmet Need assumes increased demand and Elevated Need assumes both increased demand and improved access. Full descriptions of scenarios are found on the HRSA Workforce Projections Dashboard.[22]
Source: Health Resources and Services Administration's (HRSA) Workforce Projections.

Demographics

A diverse health workforce has been shown to increase access to care and improve quality of care, especially among underserved populations.[23,24,25] The behavioral health workforce largely identifies as female and non-Hispanic White and may not be reflective of the U.S. population.[26,27,28]

Distribution

Behavioral health providers work in many different environments including community behavioral health centers, Federally Qualified Health Centers (FQHCs), hospitals, inpatient facilities, schools, criminal justice systems, and other private office-based settings.

Maldistribution of the workforce leaves high-need areas without access to behavioral health services. As of December 2023, over half (169 million) of the U.S. population lives in a Mental Health HPSA.[29] Rural counties are more likely than urban counties to lack psychiatric mental health NPs, psychologists, social workers, and counselors (Table 3).[30,31,32,33] The short supply of these providers in rural areas exacerbates the challenges with access to behavioral health services.[34]

Table 3. Percentage of U.S. Rural and Urban Counties Without Behavioral Health Providers, 2021

Profession	Rural Counties	Urban Counties
Psychiatric mental health nurse practitioner	69%	31%
Psychologist	45%	16%
Social worker	22%	5%
Counselor	18%	5%

Source: Data Briefs by WWAMI Rural Health Research Center at the University of Washington.

Challenges for the Behavioral Health Workforce

Several factors affect the ability of the behavioral health workforce to provide quality care. These factors range from population demographics and the unmet need in those populations to various aspects of providing care, such as scopes of practice, cost, reimbursement, and insurance coverage. In addition, other factors affect burnout, well being, and turnover rates among the workforce.

Population Demographics

Youth behavioral health concerns have been on the rise since 2011.[35] The COVID-19 pandemic further increased this need with 60% of female high school students experiencing persistent feelings of sadness or hopelessness and nearly 25% making a suicide plan in 2021.[36] The treatment rate for major depressive episodes among adolescents increased from 41% in 2021 to 57% in 2022, a rate similar to adults (62%).[37,38]

There are also growing and unique behavioral health needs among older adults. By 2060, the number of adults aged 65 and older is projected to increase by 54%, compared with only a 9% increase in the total U.S. population.[39] Behavioral health needs among older adults are often under-identified by both providers and patients.[40] Many behavioral health providers are not adequately trained to work with older adults.[41] Geriatricians are uniquely positioned to be the first point of contact for behavioral health care needs for older adults.[42] The projected national shortage of 1,740 geriatricians in 2036 will further limit the accessibility of behavioral health care for older adults in the future.[43,44,45]

The use of mental health services also differs by gender as well as race and ethnicity. From 2015 to 2019, non-Hispanic White adolescents used behavioral health services more than adolescents in other racial or ethnic groups.[46] Behavioral health treatment rates among adults with any mental illness are higher among females (57% vs. 42% for males) and non-Hispanic Whites (56%, vs. 38% for non-Hispanic Black or African American, 40% for Hispanic or Latino, and 36% for non-Hispanic Asian).[47]

Unmet Need

The 2022 National Survey on Drug Use and Health (NSDUH) found that approximately 7.6 out of 29.3 million adults age 18 and older with any mental illness in the past year perceived an unmet need for mental health services in 2021.[48] Unmet behavioral health needs are linked to social determinants of health and barriers to care that hinder an individual's access to services.[49,50] Stigma at the individual, interpersonal, and structural level affects the perceived need for care and ability to access care, especially for racial and ethnic minority groups.[51] Together these factors present significant challenges to access behavioral health services despite the present need.

Scopes of Practice

A scope of practice is the description of roles and services a credentialed health care provider is qualified and allowed to perform under the state law. Inconsistent scopes of practice make it more difficult for clinicians to move to and practice in different states or provide telehealth services across state lines. They also can contribute to burnout and hurt retention when providers cannot practice to the full scope of their training. Other challenges include:

- Scope of practice laws can lack standardization and uniform definitions, be overly restrictive and not based on evidence, not clearly delineate the services that can be provided, and lack clear definitions for health support workers.[52]
- Scopes of practice can vary across states. One state may authorize the provision of services while another state may not allow these same services.

Expanding and harmonizing scopes of practice make it easier to provide high-quality care. One recent development related to scope of practice that can serve as an example of a reduced barrier occurred when the federal requirement for providers to have a waiver to prescribe medications for opioid use disorder (buprenorphine) was eliminated.[53] The removal of the Drug Addiction Treatment Act (DATA) or X-Waiver now permits providers with an active Drug Enforcement Agency (DEA) registration to prescribe Schedule III medications for opioid use disorders as allowed by state law. Removal of this waiver eliminates the time-consuming process for providers to obtain the ability to prescribe medications for opioid use disorders and may provide more flexibility to prescribers to provide these services.

Cost, Reimbursement, and Insurance Coverage

The accessibility of behavioral health services is also limited by reimbursement barriers. According to the 2022 NSDUH, nearly 60% of adults with any mental illness and perceived unmet need for services reported cost as a reason for not receiving behavioral health services.[54]

In 2008, Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA) to require health insurance companies to provide comparable benefits for behavioral health services as they do for medical or surgical procedures. This parity law did not alleviate the access barriers because, in part, the law did not require coverage of specific behavioral health services.[55] The Department of Labor's 2022 MHPAEA Report to Congress noted low compliance with reporting requirements by insurance companies and the necessity of both stronger enforcement and clearer statutory language.[56]

As a result of reimbursement challenges, many behavioral health providers do not participate on insurance panels and require payment at the time of service. Compared to physical health care providers, behavioral health providers are less likely to accept insurance.[57] In 2017, only 46% of psychiatrists accepted Medicaid payments from new patients.[58] In 2016, only 43% of psychiatrists and 19% of nonphysician mental health providers participated in any of the 531 provider networks in the Affordable Care Act marketplace.[59]

Low reimbursement rates and administrative burdens have been cited as the main reasons why mental health providers choose not to participate in insurance plans.[60,61] In many states, psychiatrists were reimbursed for psychiatric services at lower rates than primary care physicians for the same behavioral health services.[62,63]

Not all behavioral health services and behavioral health provider types are covered under different forms of insurance. Medicaid expansion states have higher percentages of covered behavioral health services.[64] Health support workers, such as peer providers, also face insurance challenges. As of 2019, only 37 states cover peer providers through Medicaid, and Medicare currently does not cover peer providers.[65]

Retention

While it is difficult to estimate precise turnover rates for the behavioral health workforce,[66] they are believed to be high.[67] It has also been suggested the turnover among the behavioral health workforce is higher in rural areas.[68] Many individual, organizational, and system-level factors can impact a behavioral health provider's intent to leave the workforce[69] including:

- Low wages put a strain on behavioral health providers and discourage them from staying in the workforce. Financial concerns are especially a challenge for health support workers.[70,71]
- Restrictive and inconsistent scopes of practice and policies can restrict a provider from practicing at their fullest ability and limit their mobility across states.[72]
- Behavioral health providers are experiencing large workloads, large caseloads, workplace violence, and a lack of organizational support.[73,74]

Burnout

Burnout among the health workforce has been a long-standing problem and was exacerbated during the COVID-19 pandemic due to higher stress levels for both clinical and non-clinical staff.[75] The stress also disproportionately affected people of color and is reflected in higher levels of burnout for Black or African American and Hispanic or Latino providers.[76,77]

Prior to the COVID-19 pandemic, estimates ranged from 21% to 67% of behavioral health providers feeling overburdened due to emotionally taxing positions, high stress environments, lack of career advancement, low salaries, and high caseloads.[78,79] However, there is minimal literature describing how burnout varies across different types of behavioral health providers and behavioral health practice settings post pandemic.[80]

Evolving Strategies to Improve Behavioral Health Care Access

Expanding Primary Care and Behavioral Health Integrated Care

The U.S. health care system is traditionally designed to treat physical and behavioral health concerns separately. As this is the case, most training for behavioral health providers also remains separated from traditional medical care. There has been a growing effort to integrate behavioral health services into primary care settings and vice versa.

There is a large body of work by agencies and organizations[81,82] documenting the benefits of integrated care.[83] The critical role of integrated care in addressing the national behavioral health crisis was reflected in the Department of Health and Human Services' (HHS) roadmap on behavioral health integration. The roadmap emphasizes the critical role of behavioral health integration in improving access to affordable and high-quality care as well as the need to deliver culturally and linguistically appropriate integrated care.[84]

Integration can occur in multiple ways. For example, many FQHCs that provide primary care to underserved communities also incorporate behavioral health providers into their model, and Certified Community Behavioral Health Clinics (CCBHC) that provide behavioral health care typically incorporate primary care. Integration can also occur in school-based settings.[85]

Patients are already seeking behavioral health services from their primary care providers.[86] According to the National Ambulatory Medical Care Survey, 16% of primary care visits in 2016-2018 included a behavioral health component, an increase from 11% in 2006-2007.[87]

Despite widespread benefits, the integrated care model has not been widely implemented due to multiple challenges. These include limited adoption of technology, insurance and reimbursement limitations, limited training opportunities, and workflow and logistical barriers.[88,89,90,91]

Leveraging Health Support Workers

Health support workers use their lived experiences and community ties to provide behavioral health support services. Peer providers have been shown to have a positive effect in reducing stigma associated with behavioral health treatment, increasing awareness of behavioral health resources, improving treatment engagement, and allowing licensed behavioral health providers to focus on more complex behavioral health services.[92,93,94] Community health workers have been shown to be effective in using their community ties to improve health outcomes, reduce the cost of care, and address social determinants of health.[95]

Using health support workers can increase access to care. However, there is ambiguity in the scopes of practice for these workers and their roles in the behavioral health workforce can vary.[96] The health support worker workforce also faces challenges with burnout, low compensation, and reimbursement challenges.[97,98,99]

Using Telebehavioral Health

Less than 1% of behavioral health outpatient visits were conducted via telehealth prior to the COVID-19 pandemic.[100] From March 2020 through August 2020, the use of telehealth for behavioral health outpatient visits reached 40% of all visits. The use of telebehavioral health services has remained strong.[101]

Telebehavioral health services can help overcome accessibility barriers to behavioral health services for individuals located in underserved areas and provides benefits for urban dwellers as well.[102] Because telebehavioral health offers additional privacy when speaking with a provider, potential barriers associated

with stigma may also be overcome. Despite the evidence demonstrating the quality of telehealth services[103], organizations face many challenges in providing telebehavioral health services:

- Some populations may have difficulties using and accessing telebehavioral health, such as older adults, children, individuals with low income, and individuals with low technological literacy.[104,105]
- Telehealth services do not have service and payment parity. Telebehavioral health services are often not covered or are reimbursed at a lower rate when compared with in-person services.[106]
- Telebehavioral health may not be cost effective for organizations without the necessary infrastructure.[107]

Telebehavioral health services became a necessity during the COVID-19 pandemic since in-person services were limited. In response, state, federal, and private organizations expanded their telehealth policies in support of telebehavioral health services. Yet, the changes that occurred during the COVID-19 pandemic to make services more accessible may not be sustained permanently. Recent changes include the following:

- Most Medicaid programs expanded their coverage of telehealth services during the pandemic with many states allowing service and payment parity. Many states also allowed patients to receive audio-only services and telehealth services in their home.[108] Several private insurers also expanded their coverage of telebehavioral health services and payment parity during the COVID-19 pandemic.[109] Many but not all plans still cover some form of telehealth.[110]
- Legislation provided flexibilities for the use of telehealth during the COVID-19 pandemic. Some of these flexibilities have been permanently authorized by the Consolidated Appropriations Act of 2023 including allowing FQHCs to serve as a distant site provider for behavioral health services, removing geographic restrictions for originating site telebehavioral health services, and allowing Medicare patients to receive telebehavioral health services in their homes.[111]
- Flexibility to offer telehealth services without risk of violating the Health Insurance Portability and Accountability Act (HIPAA) rules expired when the COVID-19 Public Health Emergency ended on May 11, 2023.[112]
- The DEA and the Substance Abuse and Mental Health Services Administration (SAMHSA) issued a temporary rule effective from May 11, 2023, through November 11, 2023, to extend telemedicine flexibilities for prescribing controlled substances. (If a provider and patient have an established relationship by November 11, 2023, then this rule is extended for another year to November 11, 2024.) This rule allows providers to prescribe controlled substances via telemedicine without having an in-person evaluation.[113]

Conclusion

The United States is experiencing an opioid epidemic and mental health crisis.[114,115] Behavioral health needs continue to rise.[116] The behavioral health workforce is anticipated to suffer from significant shortages in the future including pronounced shortages of psychiatrists, psychologists, counselors, and marriage and family therapists.[117] Increasing the supply of the behavioral health workforce is not enough to address systemic, provider, and patient-level barriers. Maldistribution of the workforce is also a major limiting factor to accessing behavioral health services.

Inconsistent scopes of practice, reimbursement challenges, limited training in integrated health and increased levels of burnout prevent behavioral health providers from performing at their full capacity and remaining in

the workforce. Stigma and increased out-of-pocket costs will continue to hinder patients' ability to access behavioral health services.

Behavioral health needs are elevated for children and older adults, as well as in rural and underserved areas. Adequate workforce planning and investments in behavioral health workforce will be important to address these needs.

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