

State of the Behavioral Health Workforce, 2024

November 2024

The United States is experiencing a mental health crisis with increased levels of unmet behavioral health needs among people of all ages. 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

- Substantial shortages of addiction counselors, marriage and family therapists, mental health counselors, psychologists, psychiatric physician assistants/associates, psychiatrists, and school counselors are projected in 2037.
- As of August 2024, more than one third (122 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 epidemic¹ and mental health crisis in the United States² have contributed to an increase in overdoses, suicides, and depression in the past two decades.^{3,4,5} The COVID-19 pandemic also exacerbated behavioral health needs.⁶ Even though behavioral health needs have increased, there are persistent challenges with access to behavioral health services and high levels of unmet need.⁷

In 2023, 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 (46%).⁸ Behavioral health services can be difficult to access due to behavioral health provider shortages, high out-of-pocket costs, coverage gaps, and other factors.⁹ For example, 6 in 10 psychologists do not accept new patients,¹⁰ and the national average wait time for behavioral health services is 48 days.¹¹

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.¹² 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	2022	99,771
Marriage and family therapist ^a	2022	28,066
Mental health counselor ^a	2022	135,662
Psychiatric aide ^b	2023	32,310
Psychiatric advanced practice registered nurse ^c	2022	39,354
Psychiatric physician assistant/associate ^d	2023	2,999
Psychiatrist ^e	2022	47,864
Psychologist ^{a, f}	2022	99,030
Social worker ^a	2022	537,338

^a 2022 American Community Survey 5-year Public Use Microdata. ^b 2023 BLS Occupational Employment and Wage Statistics, May 2023. ^c 2022 American Psychiatric Nurses Association's Psychiatric Mental Health Nursing Workforce Survey ^d 2023 National Commission on Certification of Physician Assistants Annual Report. ^e 2022 American Medical Association Physician Professional Data. ^f Psychologist totals include psychologists with a PhD degree.

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),¹³ or nurse practitioners (NPs), are the first health professionals to see patients with behavioral health issues.¹⁴

Primary care providers delivered 32% of mental health related office visits between 2012 and 2014.¹⁵ Approximately 7% of primary care physicians' direct patient care time was spent on providing behavioral health services between 2019 and 2021 which was a 20% increase from five years earlier.¹⁶

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 August 2024, 122 million people in the United States, over one third of the population, live in a Mental Health HPSA.¹⁷

The **current shortages** seen through HPSA data and the **projected future shortages** 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.¹⁸ 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.¹⁹

Substantial shortages are projected for the behavioral health workforce in the future.²⁰ Table 2 shows the projected shortages and percent adequacy in 2037 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 2037, number and percent adequacy^a

Profession	Status Quo	Unmet Need	Elevated Need
Addiction counselors	-113,930 (45%)	-154,860 (37%)	-197,140 (32%)
Adult psychiatrists	-43,660 (43%)	-58,840 (36%)	-93,940 (26%)
Child and adolescent psychiatrists	-6,780 (65%)	-10,580 (54%)	-19,310 (39%)
Child, family, and school social workers	14,490 (108%)	-21,080 (90%)	-22,320 (90%)
Healthcare social workers	-3,070 (97%)	-24,520 (81%)	-31,160 (77%)
Marriage and family therapists	-34,170 (59%)	-50,760 (49%)	-62,100 (44%)
Mental health and substance use disorder social workers	-8,290 (93%)	-30,520 (77%)	-53,280 (66%)
Mental health counselors	-87,840 (57%)	-128,270 (47%)	-175,290 (40%)
Psychiatric nurse practitioners	6,410 (120%)	20 (100%)	-14,810 (72%)
Psychiatric physician assistants/associates	-790 (86%)	-1,950 (71%)	-3,870 (55%)
Psychologists	-79,160 (55%)	-113,830 (45%)	-131,100 (42%)
School counselors	-39,710 (81%)	-80,530 (67%)	

Note. Health Resources and Services Administration's (HRSA) Workforce Projections.

^a Data are expressed in full-time equivalents (FTEs). Negative values indicate a projected shortage. Positive values indicate a projected surplus. 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.²¹

Demographics

A diverse health workforce has been shown to increase access to care and improve quality of care, especially among underserved populations.^{22,23,24} The behavioral health workforce largely identifies as female and non-Hispanic White and may not reflect the U.S. population.^{25,26,27}

Distribution

Behavioral health providers work in many 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 August 2024, over one third (122 million) of the U.S. population lives in a Mental Health HPSA.²⁸ Rural counties are more likely than urban counties to lack psychiatric mental health NPs, psychologists, social workers, and counselors (Table 3).^{29,30,31,32} The short supply of providers in rural areas exacerbates the challenges with access to behavioral health services.³³

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%

Note. Adapted from data briefs by WWAMI Rural Health Research Center at the University of Washington, 2022.

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 2011.³⁴ 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 2021.³⁵ The treatment rate for major depressive episodes among adolescents increased from 57% in 2022 to 60% in 2023.^{36,37}

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.³⁸ The 2022 National Survey on Drug Use and Health (NSDUH) estimated that one in eight older adults aged 60 or older had any mental illness in the past year.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 However, the projected national shortage of 2,070 geriatricians in 2037 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 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 In 2023, behavioral health treatment rates among adults with any mental illness were higher among non-Hispanic Whites (59%, vs. 44% for non-Hispanic Black or African American, 47% for Hispanic or Latino, and 35% for non-Hispanic Asian).⁴⁷

Unmet need

The 2023 NSDUH found that approximately 6.2 out of 27.1 million adults age 18 and older with any mental illness in the past year who did not receive mental health treatment perceived an unmet need for mental health services.⁴⁸ Social determinants of health and barriers to care can hinder an individual's access to services and increase unmet behavioral health needs.^{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. An example of reducing scope of practice barriers is the elimination of the federal requirement for providers to have a waiver to prescribe medications for opioid use disorder (buprenorphine).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 2023 NSDUH, 60% of adults with any mental illness and perceived unmet need for services reported cost as one of the main reasons 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 To help support equitable access to behavioral health care, the departments of Labor, Health and Human Services, and the Treasury issued final rules to add protections against restrictive

treatment limitations for behavioral health benefits as compared to other medical benefits.⁵⁷ Most provisions will take effect for group health insurance coverage starting on or after January 1, 2025.

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 with physical health care providers, behavioral health providers are less likely to accept insurance.⁵⁸ In 2017, only 46% of psychiatrists accepted Medicaid payments from new patients.⁵⁹ 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.⁶⁰

Low reimbursement rates and administrative burdens have been cited as the main reasons why mental health providers choose not to participate in insurance plans.^{61,62,63} In many states, primary care physicians have higher reimbursement rates than psychiatrists for the same behavioral health services.^{64,65}

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.⁶⁶ Health support workers, such as peer providers, also face insurance challenges. As of 2023, 8 U.S. states and territories do not offer reimbursement for peer support services through Medicaid.⁶⁷ Newly finalized in 2024, Medicare payment reforms have now increased coverage of services provided by community health workers and peer providers.⁶⁸

Retention

While it is difficult to estimate precise turnover rates for the behavioral health workforce,⁶⁹ they are believed to be high.⁷⁰ It has also been suggested the turnover among the behavioral health workforce is higher in rural areas.⁷¹ Many individual, organizational, and system-level factors can impact a behavioral health provider's intent to leave the workforce⁷² 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.^{73,74}
- Restrictive and inconsistent scopes of practice and policies can restrict a provider from practicing at their fullest ability and limit their mobility across states.⁷⁵
- Behavioral health providers are experiencing large workloads, large caseloads, workplace violence, and a lack of organizational support.^{76,77}

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.⁷⁸ 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.^{79,80}

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.^{81,82} However, there is minimal literature describing how burnout varies across different types of behavioral health providers and behavioral health practice settings post pandemic.⁸³

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.⁸⁴

There is a large body of work by agencies and organizations^{85,86} documenting the benefits of integrated care.⁸⁷ 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.⁸⁸

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.⁸⁹

Patients are already seeking behavioral health services from their primary care providers.^{90,91} According to the National Ambulatory Medical Care Survey, 16% of primary care visits in 2016-2018 included a behavioral health component, an increase of 49% from 2006-2007.⁹²

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.^{93,94,95,96}

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.^{97,98,99} 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.¹⁰⁰

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.¹⁰¹ The health support worker workforce also faces challenges with burnout, low compensation, and reimbursement.^{102,103,104}

Using telebehavioral health

Less than 1% of behavioral health outpatient visits were conducted via telehealth prior to the COVID-19 pandemic.¹⁰⁵ 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.^{106,107,108}

Telebehavioral health services can help overcome accessibility barriers to behavioral health services for individuals in underserved areas and provide benefits for urban dwellers as well.¹⁰⁹ 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,¹¹⁰ 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.^{111,112}
- 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.^{113,114}
- Telebehavioral health may not be cost effective for organizations without the necessary infrastructure.¹¹⁵

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.¹¹⁶ Several private insurers also expanded their coverage of telebehavioral health services and payment parity during the COVID-19 pandemic.¹¹⁷ Many but not all plans still cover some form of telehealth.¹¹⁸
- 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.¹¹⁹
- 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, 2023.¹²⁰
- 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.¹²¹

Conclusion

The United States is experiencing an opioid epidemic and mental health crisis.^{122,123} Behavioral health needs continue to rise.¹²⁴ The behavioral health workforce is anticipated to suffer from significant shortages in the future including pronounced shortages of addiction counselors, marriage and family therapists, mental health counselors, psychologists, psychiatric physician assistants/associates, psychiatrists, and school counselors.¹²⁵ 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.

¹ Centers for Disease Control and Prevention. (2023). *Understanding the opioid overdose epidemic*. U.S. Department of Health and Human Services. Retrieved June 20, 2024, <https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html>

² The White House. (2023). *FACT SHEET: President Biden to announce strategy to address our national mental health crisis, as part of unity agenda in his first state of the union*. 2022. Retrieved June 18, 2024, <https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/>

³ Spencer, M.R., Garnett, M.F., & Miniño, A.M. (2024). Drug overdose deaths in the United States, 2002–2022. *NCHS Data Brief*, 491. <https://dx.doi.org/10.15620/cdc:135849>

⁴ Garnett, M.F., & Curtin, S.C. (2023). Suicide mortality in the United States, 2001–2021. *NCHS Data Brief*, 464. <https://doi.org/10.15620/cdc:125705>

⁵ Goodwin, R.D., Dierker, L.C., Wu, M., Galea, S., Hoven, C.W., & Weinberger, A.H. (2022). Trends in U.S. depression prevalence from 2015 to 2020: The widening treatment gap. *American Journal of Preventive Medicine*, 63(5), 726–733. <https://doi.org/10.1016/j.amepre.2022.05.014>

⁶ Panchal, N., Saunders, H., Rudowitz, R., & Cox, C. (2023). *The implications of COVID-19 for mental health and substance use*. Kaiser Family Foundation. Retrieved May 22, 2024, <https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/>

⁷ Substance Abuse and Mental Health Services Administration. (2024). *Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health*. U.S. Department of Health and Human Services, <https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report>

⁸ Substance Abuse and Mental Health Services Administration. (2024). *Key substance use and mental health indicators in the United States: Results from the 2022 National Survey on Drug Use and Health*. U.S. Department of Health and Human Services. <https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report>

⁹ United States Government Accountability Office. (2022). *Mental health care: Access challenges for covered consumers and relevant federal efforts*. <https://www.gao.gov/assets/gao-22-104597.pdf>

¹⁰ American Psychological Association. (2022). *Psychologist struggle to meet demand amid mental health crisis*. <https://www.apa.org/pubs/reports/practitioner/2022-covid-psychologist-workload.pdf>

¹¹ National Council for Mental Wellbeing. (2024). *2024 CCBHC impact report*. <https://www.thenationalcouncil.org/resources/2024-ccbhc-impact-report/>

¹² Behavioral Health Workforce Research Center. (2021). *Scopes of practice for behavioral health professionals [Dashboard]*. University of Michigan. Retrieved November 3, 2023, <https://www.behavioralhealthworkforce.org/tableau-embed-new/>

- ¹³ Mauldin, S.G., Morton-Rias, D., Barnhill, G.C., Kozikowski, A., & Hooker, R.S. (2020). The role of PAs in providing mental health care. *Journal of the American Academy of Physician Assistants*, 33(12), 34-41. <https://doi.org/10.1097/01.JAA.0000694988.35913.1a>
- ¹⁴ Balestra, M.L. (2019). Family nurse practitioner scope of practice issues when treating patients with mental health issues. *The Journal for Nurse Practitioners*, 15(7), 479-482. <https://doi.org/10.1016/j.nurpra.2018.11.007>
- ¹⁵ Cherry, D., Albert, M., & McCaig, L.F. (2018). Mental health-related physician office visits by adults aged 18 and over: United States, 2012-2014. *NCHS Data Brief*. 311. <https://www.cdc.gov/nchs/data/databriefs/db311.pdf>
- ¹⁶ Health Resources and Services Administration. (2024). IX. Cross-occupational specialty areas components. U.S. Department of Health and Human Services. Retrieved November 7, 2024, <https://bhwh.hrsa.gov/data-research/projecting-health-workforce-supply-demand/technical-documentation/cross-occupational-specialty-areas-components>
- ¹⁷ Health Resources and Services Administration. (2024). *Health workforce shortage areas [Dashboard]*. U.S. Department of Health and Human Services. Retrieved August 8, 2024, <https://data.hrsa.gov/topics/health-workforce/shortage-areas>
- ¹⁸ Health Resources and Services Administration. (2023). *What is shortage designation?* U.S. Department of Health and Human Services. Retrieved December 11, 2023, <https://bhwh.hrsa.gov/workforce-shortage-areas/shortage-designation#hpsas>
- ¹⁹ Health Resources and Services Administration. (2024). *Technical document for HRSA's health workforce simulation model*. U.S. Department of Health and Human Services. Retrieved November 7, 2024, <https://bhwh.hrsa.gov/data-research/projecting-health-workforce-supply-demand/technical-documentation>
- ²⁰ Health Resources and Services Administration. (2024). *Workforce projections [Dashboard]*. U.S. Department of Health and Human Services. Retrieved November 7, 2024, <https://data.hrsa.gov/topics/health-workforce/workforce-projections>
- ²¹ Health Resources and Services Administration. (2024). *Workforce projections [Dashboard]*. U.S. Department of Health and Human Services. Retrieved November 7, 2024, <https://data.hrsa.gov/topics/health-workforce/workforce-projections>
- ²² Andrilla, C.H.A., Garberson, L.A., Patterson, D.G., & Quigley, T.F. (2021). Comparing the health workforce provider mix and the distance traveled for mental health services by rural and urban Medicare beneficiaries. *Journal of Rural Health*, 37(4), 692-699. <https://doi.org/10.1111/jrh.12504>
- ²³ Wilbur, K., Snyder, C., Essary, A.C., Reddy, S., Will, K.K., & Saxon, M. (2020). Developing workforce diversity in the health professions: A social justice perspective. *Health Professions Education*, 6(2), 222-229. <https://doi.org/10.1016/j.hpe.2020.01.002>
- ²⁴ Grumbach, K., & Mendoza, R. (2008). Disparities in human resources: Addressing the lack of diversity in the health professions. *Health Affairs*, 27(2), 413-422. <https://doi.org/10.1377/hlthaff.27.2.413>
- ²⁵ American Psychological Association. (2022). *Data tool: Demographics of the U.S. psychology workforce [Dashboard]*. Retrieved November 3, 2023, <https://www.apa.org/workforce/data-tools/demographics>
- ²⁶ Association of American Medical Colleges. (2022). *2022 Physician specialty report*. <https://www.aamc.org/data-reports/workforce/report/physician-specialty-data-report>
- ²⁷ U.S. Census Bureau. (2024). *American Community Survey 5-Year Public Use Microdata Sample (PUMS)*. U.S. Department of Commerce. Retrieved August 19, 2024, <https://www2.census.gov/programs-surveys/acs/data/pums/2022/5-Year-CSV-PUS/>
- ²⁸ Health Resources and Services Administration. (2024). *Health workforce shortage areas [Dashboard]*. U.S. Department of Health and Human Services. Retrieved August 8, 2024, <https://data.hrsa.gov/topics/health-workforce/shortage-areas>
- ²⁹ Andrilla, C.H.A., Woolcock, S.C., Garberson, L.A., & Patterson, D.G. (2022). *Changes in the supply and rural-urban distribution of psychiatric nurse practitioners in the U.S., 2014-2021*. WWAMI Rural Health Research Center, University of Washington. https://familymedicine.uw.edu/rhrc/wp-content/uploads/sites/4/2022/10/RHRC_DBOCT2022_PSYCHNP_Andrilla.pdf
- ³⁰ Andrilla, C.H.A., Woolcock, S.C., Garberson, L.A., & Patterson, D.G. (2022). *Changes in the supply and rural-urban distribution of psychologists in the U.S., 2014-2021*. WWAMI Rural Health Research Center, University of Washington. https://familymedicine.uw.edu/rhrc/wp-content/uploads/sites/4/2022/10/RHRC_DBOCT2022_PSYCHOLOGIST_Andrilla.pdf
- ³¹ Andrilla, C.H.A., Woolcock, S.C., Garberson, L.A., & Patterson, D.G. (2022). *Changes in the supply and rural-urban distribution of social workers in the U.S., 2014-2021*. WWAMI Rural Health Research Center, University of Washington. https://familymedicine.uw.edu/rhrc/wp-content/uploads/sites/4/2022/10/RHRC_DBOCT2022_SOCIALWORKER_Andrilla.pdf
- ³² Andrilla, C.H.A., Woolcock, S.C., Garberson, L.A., & Patterson, D.G. (2022). *Changes in the supply and rural-urban distribution of counselors in the U.S., 2014-2021*. WWAMI Rural Health Research Center, University of Washington. https://familymedicine.uw.edu/rhrc/wp-content/uploads/sites/4/2022/10/RHRC_DBOCT2022_COUNSELOR_Andrilla.pdf
- ³³ Frogner, B.K., Patterson, D.G., & Skillman, S. (2023). The workforce needed to address population health. *The Milbank Quarterly*, 101(S1), 841-865. <https://doi.org/10.1111/1468-0009.12620>
- ³⁴ Center for Disease Control and Prevention. (2023). *Youth Risk Behavioral Survey data summary & trends report 2011-2021*. U.S. Department of Health and Human Services. https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf
- ³⁵ Center for Disease Control and Prevention. (2023). *Youth Risk Behavioral Survey data summary & trends report 2011-2021*. U.S. Department of Health and Human Services. https://www.cdc.gov/healthyyouth/data/yrbs/pdf/YRBS_Data-Summary-Trends_Report2023_508.pdf

- ³⁶ Substance Abuse and Mental Health Services Administration. (2023). *Key substance use and mental health indicators in the United States: Results from the 2022 National Survey on Drug Use and Health*. U.S. Department of Health and Human Services. <https://www.samhsa.gov/data/report/2022-nsduh-annual-national-report>
- ³⁷ Substance Abuse and Mental Health Services Administration. (2024). *Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health*. U.S. Department of Health and Human Services. <https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report>
- ³⁸ U.S. Census Bureau. (2023). *2023 national population projections tables: Main series. Table 2, projected age and sex composition of the population*. U.S. Department of Commerce. <https://www.census.gov/data/tables/2023/demo/popproj/2023-summary-tables.html>
- ³⁹ Substance Abuse and Mental Health Services Administration. (2024). *Behavioral health among older adults: Results from the 2021 and 2022 National Surveys on Drug Use and Health*. U.S. Department of Health and Human Services. <https://www.samhsa.gov/data/sites/default/files/reports/rpt45341/2022-nsduh-older-adult-info.pdf>
- ⁴⁰ World Health Organization. (2023). *Mental health of older adults*. Retrieved November 3, 2023, <https://www.who.int/news-room/fact-sheets/detail/mental-health-of-older-adults>
- ⁴¹ Moyer, J., Karel, M.J., Stamm, K.E., et al. (2019). Workforce analysis of psychological practice with older adults: Growing crisis requires urgent action. *Training and Education in Professional Psychology*, 13(1), 46-55. <https://doi.org/10.1037/tep0000206>
- ⁴² Committee on the Mental Health Workforce for Geriatric Populations, Board of Health Care Services, Institute of Medicine. (2012). *The mental health and substance use workforce for older adults: In whose hands?* National Academies Press. <https://www.ncbi.nlm.nih.gov/books/NBK201407/>
- ⁴³ Lester, P.E., Dharmarajan, T.S., & Weinstein, E. (2020). The looming geriatrician shortage: Ramifications and solutions. *Journal of Aging and Health*, 32(9), 1052-1062. <https://doi.org/10.1177/0898264319879325>
- ⁴⁴ Committee on the Mental Health Workforce for Geriatric Populations, Board of Health Care Services, Institute of Medicine. (2012). *The mental health and substance use workforce for older adults: In whose hands?* National Academies Press. <https://www.ncbi.nlm.nih.gov/books/NBK201407/>
- ⁴⁵ Health Resources and Services Administration. (2024). *Workforce projections* [Dashboard]. U.S. Department of Health and Human Services. Retrieved November 7, 2024, <https://data.hrsa.gov/topics/health-workforce/workforce-projections>
- ⁴⁶ Center for Behavioral Health Statistics and Quality. (2021). *Racial/ethnic differences in mental health service use among adults and adolescents (2015-2019)*. U.S. Department of Health and Human Services. <https://www.samhsa.gov/data/sites/default/files/reports/rpt35327/2021NSDUHMHChartbook.pdf>
- ⁴⁷ Substance Abuse and Mental Health Services Administration. (2024). *Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health*. U.S. Department of Health and Human Services. <https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report>
- ⁴⁸ Substance Abuse and Mental Health Services Administration. (2024). *Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health*. U.S. Department of Health and Human Services. <https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report>
- ⁴⁹ Mojtabai, R., Olfson, M., Sampson, N.A., et al. (2011). Barriers to mental health treatment: Results from the National Comorbidity Survey Replication (NCS-R). *Psychological Medicine*, 41(8), 1751-61. <https://doi.org/10.1017/s0033291710002291>
- ⁵⁰ Coombs, N.C., Meriwether, W.E., Caringi, J., & Newcomer, S.R. (2021). Barriers to healthcare among U.S. adults with mental health challenges: A population-based study. *SSM – Population Health*, 15. <https://doi.org/10.1016/j.ssmph.2021.100847>
- ⁵¹ Misra, S., Jackson, V.W., Chong, J., et al. (2021). Systematic review of cultural aspects of stigma and mental illness among racial and ethnic minority groups in the United States: Implications for interventions. *Community Psychology*, 68(3-4), 486-512. <https://doi.org/10.1002/ajcp.12516>
- ⁵² Frogner, B.K., Fraher, E.P., Spetz, J., et al. (2020). Modernizing scope-of-practice regulations — Time to prioritize patients. *New England Journal of Medicine*, 382, 591-593. <https://doi.org/10.1056/NEJMp1911077>
- ⁵³ Substance Abuse Mental Health Services Administration. (2023). *Removal of DATA Waiver (X-Waiver) requirement*. U.S. Department of Health and Human Services. Retrieved November 3, 2023, <https://www.samhsa.gov/medications-substance-use-disorders/removal-data-waiver-requirement>
- ⁵⁴ Substance Abuse and Mental Health Services Administration. (2024). *Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health*. U.S. Department of Health and Human Services., <https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report>
- ⁵⁵ MACPAC. (2021). *Implementation of the Mental Health Parity and Addiction Equity Act in Medicaid and CHIP*. <https://www.macpac.gov/wp-content/uploads/2021/07/Implementation-of-the-Mental-Health-Parity-and-Addiction-Equity-Act-in-Medicaid-and-CHIP.pdf>
- ⁵⁶ U.S. Departments of Labor, Health and Human Services, and Treasury. (2022). *2022 MHPAEA report to congress: Realizing Parity, Reducing Stigma, and Raising Awareness*. <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf>

- ⁵⁷ U.S. Department of Health and Human Services. (2024). *Departments of Labor, Health and Human Services, Treasury issue final rules strengthening access to mental health, substance use disorder benefits*. Retrieved September 10, 2024, <https://www.hhs.gov/about/news/2024/09/09/departments-labor-health-human-services-treasury-issue-final-rules-strengthening-access-mental-health-substance-use-disorder-benefits.html>
- ⁵⁸ Wen, H., Wilk, A.S., Druss, B.G., & Cummings, J.R. (2019). Medicaid acceptance by psychiatrists before and after Medicaid expansion. *JAMA Psychiatry*, 76(9), 981-983. <https://doi.org/10.1001/jamapsychiatry.2019.0958>
- ⁵⁹ MACPAC. (2021). *Physician acceptance of new Medicaid patients: Findings from the National Electronic Health Records Survey*. <https://www.macpac.gov/wp-content/uploads/2021/06/Physician-Acceptance-of-New-Medicaid-Patients-Findings-from-the-National-Electronic-Health-Records-Survey.pdf>
- ⁶⁰ Zhu, J.M., Zhang, Y., & Polsky, D. (2017). Networks in ACA marketplaces are narrower for mental health care than for primary care. *Health Affairs*, 36(9). <https://doi.org/10.1377/hlthaff.2017.0325>
- ⁶¹ Busch, S.H., Ndumele, C., Foster, C., & Kyanko, K.A. (2019). Patient characteristics and treatment patterns among psychiatrists who do not accept private insurance. *Psychiatric Services*, 70(1), 35-39. <https://doi.org/10.1176/appi.ps.201800014>
- ⁶² Saunders H, Guth M. (2023). *A look at strategies to address behavioral health workforce shortages: Findings from a survey of state Medicaid programs*. Kaiser Family Foundation. Retrieved November 3, 2023, <https://www.kff.org/medicaid/issue-brief/a-look-at-strategies-to-address-behavioral-health-workforce-shortages-findings-from-a-survey-of-state-medicaid-programs/>
- ⁶³ Zhu, J.M., Renfro, S., Watson, K., Deshmukh, A., & McConnell, K.J. (2023). Medicaid reimbursement for psychiatric services: Comparisons across states and with Medicare. *Health Affairs*, 42(4), 556-565. <https://doi.org/10.1377/hlthaff.2022.00805>
- ⁶⁴ Mark, T.L., Parish, W., Zarkin, G.A., & Weber, E. (2010). Comparison of Medicaid reimbursements for psychiatrists and primary care physicians. *Psychiatric Services*, 71(9), 947-950. <https://doi.org/10.1377/hlthaff.2017.0325>
- ⁶⁵ Mark, T.L., Olesiuk, W., Ali, M.M., Sherman, L.J., Mutter, R., & Teich, J.L. (2017). Differential reimbursement of psychiatric services by psychiatrists and other medical providers. *Psychiatric Services*, 69(3), 281-285. <https://doi.org/10.1176/appi.ps.201700271>
- ⁶⁶ Guth, M., Saunders, H., Corallo, B., & Moreno, S. (2023). *Medicaid coverage of behavioral health services in 2022: Findings from a survey of state Medicaid programs*. Kaiser Family Foundation. Retrieved November 3, 2023, <https://www.kff.org/medicaid/issue-brief/medicaid-coverage-of-behavioral-health-services-in-2022-findings-from-a-survey-of-state-medicaid-programs/>
- ⁶⁷ Earley, J., Roberts, S., & Nichols, M. (2024). *Medicaid reimbursement for peer support services: A detailed analysis of rates, processes, and procedures*. Peer Recovery Center of Excellence. <https://peerrecoverynow.org/wp-content/uploads/2024-MAY-15-prcoe-prss-medicaid.pdf>
- ⁶⁸ Seshamani, M., & Jacobs, D. (2023). *Important new changes to improve access to behavioral health in Medicare*. Centers for Medicare & Medicaid Services; U.S. Department of Health and Human Services. Retrieved August 14, 2024, from <https://www.cms.gov/blog/important-new-changes-improve-access-behavioral-health-medicare-0>
- ⁶⁹ Herschell, A.D., Kolko, D.J., Hart, J.A., Brabson, L.A., & Gavin, J.G. (2020). Mixed method study of workforce turnover and evidence-based treatment implementation in community behavioral health care settings. *Child Abuse & Neglect*, 102, 104449. <https://doi.org/10.1016/j.chiabu.2020.104419>
- ⁷⁰ Brabson, L.A., Harris, J.L., Lindhiem, O., & Herschell, A.D. (2020). Workforce turnover in community behavioral health agencies in the USA: A systematic review with recommendations. *Clinical Child and Family Psychology Review*, 23(3), 297-315. <https://doi.org/10.1007/s10567-020-00313-5>
- ⁷¹ Substance Abuse and Mental Health Services Administration. (2013). *Report to congress on the nation's substance abuse and mental health workforce issues*. U.S. Department of Health and Human Services. https://mhttcnetwork.org/sites/mhttc/files/2019-02/SAMHSA%20Report%20to%20Congress%202013_2.pdf
- ⁷² Schoebel, V., Girma, N., Buche, J., Ginsberg, I., Smith, N., & Grazier, K. (2022). *Factors influencing behavioral health providers entry to and exit from the workforce: A synthesis of survey data*. Behavioral Health Workforce Research Center, University of Michigan. https://www.behavioralhealthworkforce.org/wp-content/uploads/2023/05/Y7P9_Full-Report_Factors-Influencing-Behavioral-Health-Providers-Entry-to-and-Exit-from-the-Workforce.pdf
- ⁷³ Videka, L., Neale, J., Page, C., et al. (2019). *National Analysis of Peer Support Providers: Practice Settings, Requirements, Roles, and Reimbursement*. Behavioral Health Workforce Research Center, University of Michigan. <https://behavioralhealthworkforce.org/wp-content/uploads/2019/10/BHWRC-Peer-Workforce-Full-Report.pdf>
- ⁷⁴ Bates, T., & Chapman, S. (2022). *Measuring the financial contribution of peer providers*. UCSF Health Workforce Research Center on Long-Term Care, University of California San Francisco. https://healthworkforce.ucsf.edu/sites/healthworkforce.ucsf.edu/files/HWRC_Research%20Brief_Financial%20Contribution%20Peer%20Providers_March%202022.pdf
- ⁷⁵ Health Workforce Technical Assistance Center. (2022). *Health professions regulation in the US*. Retrieved November 3, 2023, <https://www.healthworkforceta.org/health-professions-regulation-in-the-us/>
- ⁷⁶ Yang, Y., & Hayes, J.A. (2020). Causes and consequences of burnout among mental health professionals: A practice-oriented review of recent empirical literature. *Psychotherapy*, 57(3), 426-436. <https://doi.org/10.1037/pst0000317>

- ⁷⁷ Hilton, N.Z., Addison, S., Ham, E., Rodrigues, N.C., & Seto, M.C. (2021). Workplace violence and risk factors for PTSD among psychiatric nurses: Systematic review and directions for future research and practice. *Journal of Psychiatric and Mental Health Nursing*, 29(2), 186-203. <https://doi.org/10.1111/jpm.12781>
- ⁷⁸ Prasad, K., McLoughlin, C., Stillman, M., et al. (2021). Prevalence and correlates of stress and burnout among U.S. healthcare workers during the COVID-19 pandemic: A national cross-sectional survey study. *EClinicalMedicine*, 35, 100879. <https://doi.org/10.1016/j.eclinm.2021.100879>
- ⁷⁹ Ross, A.M., Cederbaum, J.A., de Saxe Zerden, L., Zelnick, J.R., Ruth, B.J., & Guan, T. (2022). Bearing a disproportionate burden: Racial/ethnic disparities in experiences of U.S.-based social workers during the COVID-19 pandemic. *Social Work*, 67(1), 28-40. <https://doi.org/10.1093/sw/swab050>
- ⁸⁰ Prasad, K., McLoughlin, C., Stillman, M., et al. (2021). Prevalence and correlates of stress and burnout among U.S. healthcare workers during the COVID-19 pandemic: A national cross-sectional survey study. *EClinicalMedicine*, 35, 100879. <https://doi.org/10.1016/j.eclinm.2021.100879>
- ⁸¹ Kelly, R.J., & Hearld, L.R. (2020). Burnout and leadership style in behavioral health care: A literature review. *The Journal of Behavioral Health Services & Research*, 47, 581-600. <https://doi.org/10.1007/s11414-019-09679-z>
- ⁸² Morse, G., Salyers, M.P., Rollins, A.L., Monroe-DeVita, M., & Pfahler, C. (2011). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health and Mental Health Services Research*, 39, 341-352. <https://doi.org/10.1007/s10488-011-0352-1>
- ⁸³ Morse, G., Salyers, M.P., Rollins, A.L., Monroe-DeVita, M., & Pfahler, C. (2011). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health and Mental Health Services Research*, 39, 341-352. <https://doi.org/10.1007/s10488-011-0352-1>
- ⁸⁴ Centers for Medicare & Medicaid Services. (2024). *Innovation in behavioral health (IBH) model*. U.S. Department of Health and Human Services. Retrieved June 12, 2024, <https://www.cms.gov/priorities/innovation/innovation-models/innovation-behavioral-health-ibh-model>
- ⁸⁵ National Council for Mental Wellbeing. (n.d.). *Integrated health*. Retrieved November 3, 2023, <https://www.thenationalcouncil.org/our-work/focus-areas/integrated-health/>
- ⁸⁶ Agency for Healthcare Research and Quality. (n.d.). *The Academy Integrating Behavioral Health & Primary Care*. Retrieved November 3, 2023, <https://integrationacademy.ahrq.gov/>
- ⁸⁷ Ramanuj, P., Ferencik, E., Docherty, M., Spaeth-Ruble, B., & Pincus, H.A. (2019). Evolving models of integrated behavioral health and primary care. *Current Psychiatry Reports*, 21(4). <https://doi.org/10.1007/s11920-019-0985-4>
- ⁸⁸ Bagalman, E., Dey, J., Jacobus-Kantor, L., et al. (2022). *HHS roadmap for behavioral health integration*. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. <https://aspe.hhs.gov/reports/hhs-roadmap-behavioral-health-integration>
- ⁸⁹ Rural Health Information Hub. (n.d.). *School-based services integration model*. U.S. Department of Health and Human Services. Retrieved November 3, 2023, <https://www.ruralhealthinfo.org/toolkits/services-integration/2/school-based>
- ⁹⁰ Horstman, C.E., Federman, S., & Williams II, R.D. (2022). Integrating primary care and behavioral health to address the behavioral health crisis (explainer). *Commonwealth Fund*. <https://doi.org/10.26099/eatz-wb65>
- ⁹¹ Hines, C.E., Watson, N., Brooks, Z., & Tucker, T. (2024). Review of mental healthcare provision by primary care physicians in the Department of Defense (DoD). *Journal of Public Health*. <https://doi.org/10.1007/s10389-024-02234-x>
- ⁹² Rotenstein, L.S., Edwards, S.T., & Landon, B.E. (2023). Adult primary care physician visits increasingly address mental health concerns. *Health Affairs*, 42(2), 163-171. <https://doi.org/10.1377/hlthaff.2022.00705>
- ⁹³ Bagalman, E., Dey, J., Jacobus-Kantor, L., et al. (2022). *HHS roadmap for behavioral health integration*. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. <https://aspe.hhs.gov/reports/hhs-roadmap-behavioral-health-integration>
- ⁹⁴ Buche, J., Singer, P.M., Grazier, K., King, E., Maniere, E., & Beck, A.J. (2017). *Primary care and behavioral health workforce integration: Barriers and best practices*. Behavioral Health Workforce Research Center, University of Michigan. https://www.behavioralhealthworkforce.org/wp-content/uploads/2017/02/FA2P3_Team-based-Care-Case-Studies_Full-Report.pdf
- ⁹⁵ Knutson, K.H. (2017). Payment for integrated care: Challenges and opportunities. *Child and Adolescent Psychiatric Clinics of North America*, 26(4), 829-838. <https://doi.org/10.1016/j.chc.2017.06.010>
- ⁹⁶ Wallace, N.T., Cohen, D.J., Gunn, R., et al. (2015). Start-up and ongoing practice expenses of behavioral health and primary care integration interventions in the Advancing Care Together (ACT) Program. *Journal of the American Board of Family Medicine*, 28(Suppl 1), S86-97. <https://doi.org/10.3122/jabfm.2015.S1.150052>
- ⁹⁷ Chapman, S., Blash, L., & Spetz, J. (2018). *California peer providers in transitions of care*. UCSF Health Workforce Research Center on Long-Term Care, University of California San Francisco. https://healthforce.ucsf.edu/sites/healthforce.ucsf.edu/files/publication-pdf/California_Peer_Providers_in_Transition_of_Care_0.pdf
- ⁹⁸ O'Keefe, V.M., Cwik, M.F., Haroz, E.E., & Barlow, A. (2021). Increasing culturally responsive care and mental health equity with indigenous community mental health workers. *Psychological Services*, 18(1), 84-92. <https://doi.org/10.1037/ser0000358>

- ⁹⁹ Weaver, A., & Lapidus, A. (2018). Mental health interventions with community health workers in the United States: A systematic review. *Journal of Health Care for the Poor and Underserved*, 29(1), 159-180. <https://doi.org/10.1353/hpu.2018.0011>
- ¹⁰⁰ Association of State and Territorial Health Officials. (n.d.). *Community health workers: Evidence of their effectiveness*. <https://www.astho.org/globalassets/pdf/community-health-workers-summary-evidence.pdf>
- ¹⁰¹ Behavioral Health Workforce Research Center. (2021). *Scopes of practice for behavioral health professionals* [Dashboard]. University of Michigan. Retrieved November 3, 2023, <https://www.behavioralhealthworkforce.org/tableau-embed-new/>
- ¹⁰² Chapman, S.A., Blash, L.K., Mayer, K., & Spetz, J. (2018). Emerging roles for peer providers in mental health and substance use disorders. *American Journal of Preventive Medicine*, 6(3), S267-S274. <https://doi.org/10.1016/j.amepre.2018.02.019>
- ¹⁰³ Choi, Y.H., Amoako, E., St. Pierre, M., Wayment, C., Schoebel, V., & Buche, J. (2021). *Supporting paraprofessionals and strengthening resilience among providers*. Behavioral Health Workforce Research Center, University of Michigan. [C:\Users\jesskay\AppData\Local\Temp\mso6FEE.tmp_\(behavioralhealthworkforce.org\)](C:\Users\jesskay\AppData\Local\Temp\mso6FEE.tmp_(behavioralhealthworkforce.org)).
- ¹⁰⁴ Foundation for Opioid Response Efforts. (2023). *Supporting and building the peer recovery workforce*. <https://forefdn.org/wp-content/uploads/2023/06/fore-prc-survey-report.pdf>
- ¹⁰⁵ Lo, J., Rae, M., Amin, K., Cox, C., Panchal, N., & Miller, B.F. (2022). *Telehealth has played an outsized role meeting mental health needs during the COVID-19 pandemic*. Kaiser Family Foundation. Retrieved November 3, 2023, <https://www.kff.org/coronavirus-covid-19/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/>
- ¹⁰⁶ Lo, J., Rae, M., Amin, K., Cox, C., Panchal, N., & Miller, B.F. (2022). *Telehealth has played an outsized role meeting mental health needs during the COVID-19 pandemic*. Kaiser Family Foundation. Retrieved November 3, 2023, <https://www.kff.org/coronavirus-covid-19/issue-brief/telehealth-has-played-an-outsized-role-meeting-mental-health-needs-during-the-covid-19-pandemic/>
- ¹⁰⁷ FAIR Health. (2024). *Trends in mental health conditions: An analysis of private healthcare claims*. <https://s3.amazonaws.com/media2.fairhealth.org/whitepaper/asset/Trends%20in%20Mental%20Health%20Conditions%20-%20A%20FAIR%20Health%20White%20Paper.pdf>
- ¹⁰⁸ Cantor, J.H., McBain, R.K., & Ho, P. (2023). Telehealth and in-person mental health service utilization and spending, 2019 to 2022. 2023. *JAMA Health Forum*, 4(8), e232645. <https://doi.org/10.1001/jamahealthforum.2023.2645>
- ¹⁰⁹ Bashshur, R.L., Shannon, G.W., Bashshur, N., & Yellowlees, P.M. (2016). The empirical evidence for telemedicine interventions in mental disorders. *Telemedicine and e-Health*, 2(2), 87-113. <https://doi.org/10.1089/tmj.2015.0206>
- ¹¹⁰ Snoswell, C.L., Chleberg, G., De Guzman, K.R., et al. (2021). The clinical effectiveness of telehealth: A systematic review of meta-analyses from 2010 to 2019. *J Telemed Telecare*. <https://doi.org/10.1177/1357633X211022907>
- ¹¹¹ Kruse, C., Fohn, J., Wilson, N., Patlan, Zipp, S., & Mileski, M. (2020). Utilization barriers and medical outcomes commensurate with the use of telehealth among older adults: Systematic review. *JMIR Publications*, 8. <https://doi.org/10.2196/20359>
- ¹¹² Schoebel, V., Wayment, C., Gaiser, M., Page, C., Buche, J., & Beck, A. (2021). Telebehavioral health during the COVID-19 pandemic: A qualitative analysis of provider experiences and perspectives. *Telemedicine and e-Health*, 27(8). <https://doi.org/10.1089/tmj.2021.0121>
- ¹¹³ Weigel, G., Ramaswamy, A., Sobel, L., Salganicoff, A., Cubanski, J., & Freed, M. (2020). *Opportunities and barriers for telemedicine in the U.S. during the COVID-19 emergency and beyond*. Kaiser Family Foundation. Retrieved November 3, 2023, <https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/>
- ¹¹⁴ Center for Connected Health Policy. (2023). *State telehealth laws and Medicaid program policies*. https://telehealthresourcecenter.org/wp-content/uploads/2023/05/Fall2023_ExecutiveSummaryfinal.pdf
- ¹¹⁵ Rural Health Information Hub. (n.d.). *Barriers to telehealth in rural areas*. Retrieved June 12, 2024, <https://www.ruralhealthinfo.org/toolkits/telehealth/1/barriers>
- ¹¹⁶ Health Resources and Services Administration. (2023). *State Medicaid telehealth coverage*. U.S. Department of Health and Human Services. Retrieved November 3, 2023, <https://telehealth.hhs.gov/providers/billing-and-reimbursement/state-medicare-telehealth-coverage>
- ¹¹⁷ Hudman, J., McDermott, D., Shanosky, N., & Cox, C. (2020). *How private insurers are using telehealth to respond to the pandemic*. Kaiser Family Foundation. Retrieved November 3, 2023, <https://www.kff.org/health-costs/issue-brief/how-private-insurers-are-using-telehealth-to-respond-to-the-pandemic/>
- ¹¹⁸ Health Resources and Services Administration. (2023). *Private insurance coverage for telehealth*. U.S. Department of Health and Human Services. Retrieved June 12, 2024, <https://telehealth.hhs.gov/providers/billing-and-reimbursement/private-insurance-coverage-for-telehealth>
- ¹¹⁹ Health Resources and Services Administration. (2023). *Telehealth policy changes after the COVID-19 public health emergency*. U.S. Department of Health and Human Services. Retrieved November 3, 2023, <https://telehealth.hhs.gov/providers/telehealth-policy/policy-changes-after-the-covid-19-public-health-emergency>

¹²⁰ U.S. Department of Health and Human Services. (2023). *HHS Office for Civil Rights announces the expiration of COVID-19 public health emergency HIPAA notifications of enforcement discretion*. Retrieved November 3, 2023, <https://www.hhs.gov/about/news/2023/04/11/hhs-office-for-civil-rights-announces-expiration-covid-19-public-health-emergency-hipaa-notifications-enforcement-discretion.html>

¹²¹ Substance Abuse and Mental Health Services Administration. (2023). *DEA, SAMHSA extend COVID-19 telemedicine flexibilities for prescribing controlled medications for six months while considering comments from the public*. U.S. Department of Health and Human Services. Retrieved November 3, 2023, <https://www.samhsa.gov/newsroom/press-announcements/20230509/dea-extend-covid19-telemedicine-flexibilities-prescribing-controlled-medications>

¹²² Centers for Disease Control and Prevention. (2023). *Understanding the opioid overdose epidemic*. U.S. Department of Health and Human Services. Retrieved November 3, 2023, <https://www.cdc.gov/opioids/basics/epidemic.html>

¹²³ The White House. (2022). *FACT SHEET: President Biden to announce strategy to address our national mental health crisis, as part of unity agenda in his first state of the union*. Retrieved November 3, 2023, <https://www.whitehouse.gov/briefing-room/statements-releases/2022/03/01/fact-sheet-president-biden-to-announce-strategy-to-address-our-national-mental-health-crisis-as-part-of-unity-agenda-in-his-first-state-of-the-union/>

¹²⁴ Substance Abuse and Mental Health Services Administration. (2024). *Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health*. U.S. Department of Health and Human Services. <https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report>

¹²⁵ Health Resources and Services Administration. (2024). *Workforce Projections* [Dashboard]. U.S. Department of Health and Human Services. Retrieved November 7, 2024, <https://data.hrsa.gov/topics/health-workforce/workforce-projections>