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Behavioral Health Care Workforce Development and Innovation

Building and Maintaining New York's Behavioral Health Care Workforce

By Dr. Ann M. Sullivan
Commissioner
New York State Office of Mental Health

New York State has made tremendous investments in mental health treatment and services since 2022 and has made great progress addressing the evolving mental health needs in our State with a series of initiatives, such as expanding prevention and access, embracing innovative treatment methods, and increasing supportive housing. But in this new era of opportunity, demographic trends require creative solutions to ensure the public mental healthcare system has enough trained and talented staff across a range of fields to ensure a high quality of care.

Current population trends impacting the workforce include the ongoing retirement of the Baby Boomer generation, longer lifespans, declining birthrates, and since 2010 declining and shifting college enrollment. To compound these issues, more individuals are seeking behavioral health services. All of this signifies a worsening workforce shortage in the decades ahead.

Ann M. Sullivan, MD

The New York State Office of Mental Health (OMH) is spearheading several diverse initiatives to address the workforce crisis aimed at retaining current staff and attracting new individuals to the public mental health system. The OMH workforce strategy is multifaceted and is grounded in partnerships with other state agencies, education systems, professional associations, and provider agencies.

One of the greatest stressors for individuals working in the public mental health system is student loan debt. With funding from the New York State budget, OMH operates the Community Mental Health Loan Repayment Program. This initiative gives community-based providers an incentive to attract or retain trained mental health professionals by repaying a portion of their student loans for a three-year service commitment. To date, the program has committed roughly $45 million in annual loan repayment on behalf of 1,445 mental health professionals — including 135 psychiatrists, 258 psychiatric nurse practitioners and physician assistants, 32 psychologists, 631 licensed master social workers, 189 licensed mental health counselors, 155 licensed clinical social workers, and 32 licensed creative arts therapists.

An additional $4 million annual investment was added to the Community Mental Health Loan Repayment Program in the last fiscal year. This funding was awarded to OMH and the State Office of Children and Family Services for the purpose of offering loan repayment for licensed professionals providing services to children and youth experiencing behavioral health challenges. Future rounds of this program will target individuals serving traditionally underrepresented communities as well as clinicians who provide multi-lingual services.

The New York State Department of Labor (DOL) is also instrumental in OMH's workforce strategy. OMH is working with the DOL to create registered apprenticeships for the mental health system. Registered apprenticeships allow participants to learn essential skills on the job. Graduates of this program will earn a nationally recognized credential.

Partnerships with institutes of higher education allow OMH to support the future workforce. In the last few years, OMH partnered with the State University of New York and City University of New York to offer a scholarship pathway program for underrepresented or multilingual students in mental health degree programs. Recipients of this funding received tuition assistance, paid internships, and stipends.

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Building Sanctuary: Creating Trauma-Informed Workplaces to Heal Burnout and Secondary Trauma in Behavioral Health

By Susie Branagan, RN, BSN
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Susie Branagan Consulting

The quiet exhaustion in Sarah's eyes told a story that statistics could never capture. After eight years as a behavioral health nurse, she found herself sitting in her car each morning, summoning the strength to walk through the clinic doors. Anxiety pressed in her chest, radiated through her neck, and lingered in the very hands she uses to heal. Her experience mirrors that of countless professionals across behavioral health settings who carry not only their own personal stress but also absorb the trauma of those they serve. This invisible weight has become an unspoken epidemic within our caring professions (National Council for Mental Wellbeing, 2023).

As someone who has walked hospital floors for over 25 years and witnessed firsthand the toll that unaddressed trauma takes on healthcare workers, I understand that transforming our workplaces requires more than policy changes. It demands a fundamental shift in how we recognize, support, and sustain the humans who dedicate their lives to healing others. The journey from a traditional workplace to a trauma-informed environment is about creating spaces where professionals can thrive, recover, and rediscover their sense of purpose and fulfillment.

Understanding the Depth of Professional Trauma

Burnout in behavioral health extends far beyond simple workplace stress. These professionals navigate unique challenges: bearing witness to human suffering, managing crisis situations, working within systems that often feel broken, and carrying the weight of life-and-death decisions. Secondary trauma compounds these challenges. Each story of abuse, each suicide attempt prevented or lost, each child removed from their home leaves an imprint on the professional's psyche (SAMHSA, 2014).

Research reveals that up to 70% of behavioral health workers experience high levels of burnout, while secondary trauma affects nearly half of all mental health professionals (National Council for Mental Wellbeing, 2023). These numbers represent real people with families, dreams, and their own histories of resilience and struggle. When we fail to address these realities, we create environments where the helpers themselves become wounded, where compassion fatigue replaces the calling that brought them to this work (Maslach & Leiter, 2016).

The physical manifestations are equally concerning. Chronic stress activation leads to inflammation, cardiovascular strain, immune suppression, and disrupted sleep (The Joint Commission, 2019). Emotionally, professionals may experience numbness,

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Do Higher Wages, Benefits, and Career Development Reduce Turnover in Behavioral Health?

By Isaac Mawuko Adusu, DHA, MSNPM
Assistant Vice President of Adult Services
Seven Hills Foundation, Rhode Island

The sector that is responsible for the care and treatment of individuals with behavioral health conditions is vital. It is directly involved with the patients and their families. Yet, this sector faces an extraordinary problem that is not seen in other healthcare sectors: very high and persistent turnover rates. Staff members in the behavioral health sector often are satisfied with their jobs. Yet, several specialists and direct care staff leave their positions long before they reach retirement age (Hallett et al., 2023).

From the counselor to the president of a large organization, staff members in the behavioral health sector are a hardworking, dedicated group of individuals who are committed to improving the organizational lives of their patients and their families.

In response, numerous behavioral health organizations are considering alternatives to boost retention, a key goal in workforce development. Several of these, often discussed alternatives include raising pay, improving benefits, and expanding career development opportunities. But how much, if at all, do these influences affect individuals' intentions to stay within the organization and, thus, reduce turnover? This article explores the evidence, pays some necessary attention to pipeline development, and offer some practical recommendations for managers to address retention challenges effectively.

The Retention Crisis in Behavioral Healthcare

People who work in the field of behavioral healthcare operate in emotionally demanding environments, often managing the kinds of complex cases that require more time and attention than even the most dedicated professional can give. We know from recent studies that behavioral healthcare organizations are struggling to retain staff. According to Miriam Delphin-Rittmon, assistant secretary for mental health and substance use at HHS and the administrator of Substance Abuse and Mental Health Services Administration (SAMHSA), by 2025, the U.S. will be short about 31,000 full-time equivalent mental health practitioners (Plescia, 2023).

There are lots of reasons employees might choose to leave, but pay, perks, and professional growth opportunities are consistently top of mind. Here's how those three significant factors influence retention.

The Impact of Higher Wages on Retention

Pay is basic to job satisfaction. That is especially true for behavioral healthcare workers, who often make less than people in other healthcare sectors, even though the demands on them are just as high, if not higher, in terms of emotion and intellect. Up to now, studies have found only one antidote to this problem: competitive pay.

Previous research has shown that salary levels play a significant role in job turnover and retention among behavioral health care employees, including clinicians. Similarly, a study by Athman et al. (2025) found that clinicians' perceptions of being fairly compensated are connected to their intentions to stay in their jobs. Evidence from other health care professions indicates that perceived pay fairness is a stronger predictor of expected turnover than the actual

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hypervigilance, intrusive thoughts about client situations, and gradual erosion of hope. The ripple effects extend into personal relationships and overall quality of life.

The Foundation of
Trauma-Informed Transformation

Creating a trauma-informed workplace begins with acknowledging that trauma lives within our walls, shapes our policies, and influences every interaction (SAMHSA, 2014). A truly trauma-informed organization recognizes that healing happens in relationships and that safety must be felt, not just spoken of.

The transformation starts with leadership embodying vulnerability and authenticity. When leaders share their own struggles with secondary trauma and demonstrate genuine care for staff wellbeing, they give permission for others to acknowledge their humanity (The Joint Commission, 2014). This cultural shift moves us away from the harmful myth that professional strength means emotional invulnerability.

Physical safety forms the first layer, but psychological safety runs deeper. Team members need to trust that mistakes will be met with curiosity rather than punishment, that asking for help signals wisdom rather than weakness, and that their whole selves are welcome in the workplace. This requires dismantling the perfectionism and stoicism that traditional healthcare cultures often demand.

Building Blocks of a
Supportive Infrastructure

The practical implementation of trauma-informed principles requires intentional structure and consistent investment (SAMHSA, 2014). Regular supervision that goes beyond case management to include emotional processing becomes essential. These sessions offer space for professionals to explore how client work affects them personally and to develop personalized coping strategies.

Peer support programs create network of understanding. When colleagues can share experiences without fear of judgement, isolation dissolves and collective wisdom emerges. These conditions remind us that struggling with this work's weight is not personal failure but a shared human response to witnessing suffering.

Training must evolve beyond clinical skills to include self-awareness, emotional regulation, and trauma stewardship. Professionals need practical tools for managing their nervous systems, processing difficult emotions, and maintaining boundaries without losing compassion.

Susie Branagan, RN, BSN

Unrealistic caseloads create conditions where burnout becomes inevitable (Maslach & Leiter, 2016). Organizations must advocate for sustainable practice models, even when facing financial pressures. Turnover and staff burnout cost more in the long run than short-term productivity gains (National Council for Mental Wellbeing, 2023).

Innovative Solutions:
The Role of Technology in Support

Within this framework of transformation, innovative tools like ObservSMART's suite of solutions demonstrate how technology can support human connection in trauma-informed care. ObservSMART's proximity-required rounding promotes staff engagement with patients. Case studies show after using ObservSMART, patient satisfaction improved, aggression decreased, and patient-related employee injury decreased by 60%.

Their SMARTsense technology provides discrete, flush-mounted ceiling nodes in patient bedrooms and bathrooms. Staff can be alerted to immediate concerns without cameras or privacy issues. These silent alerts quickly communicate that staff are needed before escalation occurs, creating an additional layer of safety for everyone in behavioral health settings.

The system's request assistance feature silently summons support during escalating situations, reducing the traumatic impact of crisis interventions. Staff members know help is at their fingertips, decreasing the hypervigilance that contributes to burnout. This backup allows professionals to remain present and regulated even in challenging moments.

ObservSMART's approach aligns with trauma-informed principles by prioritizing dignity and respect. The discrete nature prevents situations from escalating due to visible security responses. When professionals feel safer, they maintain the calm, compassionate presence that trauma-informed care requires.

Data collected through such systems supports organizational learning. Patterns in alert usage identify environmental or systemic factors contributing to crisis situations, allowing organizations to address root causes rather than managing symptoms.

Creating Rituals of
Resilience and Recovery

Sustainable trauma-informed practice requires intentional rituals that help professionals metabolize difficult experiences. Beginning shifts with brief grounding exercises help teams center themselves before entering clinical work intensity. These moments create a buffer between personal life and professional demands.

Closing rituals are equally important. Taking five minutes at shift end to acknowledge what was witnessed, accomplished, and what can be released prevents accumulation of unprocessed experiences. Some teams light candles for struggling clients, while others share gratitude or sit in silent acknowledgment.

Regular debriefing after critical incidents must become standard practice. These sessions help teams process traumatic events collectively, preventing isolation and promoting post-traumatic growth. The focus extends beyond what happened to explore how team members make meaning of experiences and what support they need.

Sustaining the Journey Together

The path toward a truly trauma-informed workplace isn't linear. There will be setbacks and moments when old patterns feel easier. This is where collective commitment becomes essential. When organizations embed trauma-informed principles into their mission, policies, and daily practices, transformation becomes sustainable.

Regular assessment using validated tools helps track progress and identify areas needing attention. Staff surveys measuring psychological safety, secondary trauma symptoms, and job satisfaction provide concrete data to guide interventions (Maslach & Leiter, 2016). Creating multiple feedback channels ensures those most affected by policies have voice in shaping them.

A Vision of Transformation

Imagine walking into a behavioral health facility where the atmosphere conveys safety and care. Where staff faces reflect presence rather than exhaustion. Where trust has been carefully cultivated. This is achievable when organizations commit to trauma-informed transformation.

Now imagine Sarah in a different story. She arrives early, not to steel herself, but to enjoy coffee with colleagues in a sanctuary space featuring warm colors, artwork, and comfortable chairs inviting connection.

Her caseload is sustainable to 20 clients. Leadership advocated data about turnover costs and client outcomes. Sarah has time to breathe between sessions, eat lunch, and document thoughtfully. She ends notes with emotional reflection, encouraged by her supervisor who models vulnerability.

Sarah's family notices too. She comes home with energy for her children, present for dinner conversations. Sunday night dread has been replaced with curiosity about the week ahead. She sleeps through the night. Her therapist observes, "You seem different, not because you've changed, but because you've been given space to be who you always were." This may seem like a pipedream to most healthcare workers, but it IS possible!

Picture Sarah now, sitting in her car, feeling something forgotten, genuine excitement to walk through those doors, join her team, do the work she was called to do. This is the promise of trauma-informed transformation.

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Building the Future: Workforce Innovation in Behavioral Health for Individuals with Developmental Disabilities

By Mark Schwartz
and Richard Anemone, MPS, LMHC
Institute for Community Living (ICL)

As behavioral health needs among individuals with developmental disabilities (DD) become more complex and widespread, the workforce tasked with supporting them is under extraordinary pressure. To ensure quality, continuity, and person-centered care, behavioral health systems must invest in strategic workforce development, retention, and innovation especially in the context of IDD (intellectual and developmental disability) populations. This article outlines key challenges, strategies grounded in evidence, and promising innovations to support behavioral health professionals working in DD contexts.

The Workforce Challenge in DD/Behavioral Health

Elevated Need, Scarce Capacity

Individuals with IDD experience co-occurring mental health and behavioral conditions at far higher rates than the general population. For example, Kalb et al. (2023) notes that roughly 40% of people with IDD have mental health needs, about twice the national average (Kalb, Kramer, Goode, et al., 2023). Yet many outpatient mental health systems lack specialization or flexibility to meet those needs, driving higher reliance on emergency and inpatient services.

Behavioral health provider shortages are pervasive: many areas of the U.S. are designated as "behavioral health workforce shortage areas." These shortages are acute when considering clinicians with expertise in DD, crisis care, and dual diagnosis.

Turnover, Burnout, and Attrition

Even where clinicians and support staff exist, retention is a critical struggle. In a qualitative study of Oregon's public behavioral health system, Hallett et al. (2023) interviewed 24 providers, administrators, and policy experts about why staff leave. Key themes emerged: low wages, heavy documentation and administrative burden, weak infrastructure and leadership, limited opportunity for professional growth, and a chronically stressful, under resourced work environment (Hallett, Simeon, Amba, McConnell, & Zhu, 2023).

That study notes that annual turnover in public behavioral health can reach ~30%, resulting in loss of institutional knowledge, continuity disruptions, and high costs of recruiting/training replacements (Hallett et al., 2023).

Inadequate funding, reimbursement constraints, and regulatory burdens compound these issues at system and organizational levels, making it difficult for frontline staff to feel supported or valued.

Unique Barriers in DD Contexts

Staff supporting individuals with DD often receive limited formal training in behavioral health and dual-diagnosis care. Misconceptions about whether standard therapeutic modalities "work" for people with IDD continue to discourage clinicians from entering the field. Common myths include the beliefs that individuals with IDD cannot meaningfully engage in psychotherapy, that they lack the emotional insight needed for treatment, that they cannot generalize skills, or that their behaviors stem solely from the disability rather than from treatable mental health conditions. These assumptions persist despite research demonstrating that evidence-based practices such as CBT, DBT, trauma-informed care, and positive behavior support *can* be effective when appropriately adapted. As a result, individuals with DD often require clinicians with specialized training in adaptive communication, behavioral interventions, environmental and sensory accommodations, and safety planning competencies many general clinicians have not yet developed.

Because crisis events like **behavioral escalation, self-injury, aggression, and elopement** are more common in DD settings, staff need enhanced training, support, and resilience measures. Without those, burnout is more likely.

Evidence-Informed and Emerging Strategies

To meet these challenges, behavioral health systems must blend foundational workforce investments with innovative approaches. Below are key strategies, supported by research or promising practice.

Competency-Based Training and Career Ladders

Rather than relying solely on generic behavioral health credentials, developing IDD-specific competency training can ensure staff are equipped with the skills required in this specialized domain. Such training might include modules on positive behavior support, communication with non-speaking individuals, trauma-informed practice, and crisis intervention tailored to DD.

Training also creates career pathways that allow staff (e.g., DSPs) to progress to roles such as behavioral support specialist, clinical coordinator, or supervisor, thereby creating a sustainable trajectory and reducing drift to unrelated jobs.

A good example of a structured modular training is embodied by The College of Direct Support (a national DSP training initiative) which strengthens workforce competency and retention (Boggs Center, n.d.).

Mentorship, Apprenticeship, and Embedded Supervision

Pairing less experienced staff with veteran mentors or supervisors enables hands-on learning and provides emotional support. Apprenticeship models, where staff deliver care under supervision while learning, help build pipelines without compromising service quality.

Embedding regular supervision, peer reflection groups, and clinical coaching reduces isolation and helps staff process difficult cases, especially in remote or rural settings.

Tele-Behavioral Health and Hybrid Service Models

Telehealth offers a compelling option to expand both service access and workforce flexibility. A major upcoming trial (within the START model) is comparing tele mental health interventions vs. in-person crisis care for people with IDD in a noninferiority trial (Kalb, Kramer, Goode, et al., 2023). In that design, components such as outreach and consultation are delivered remotely, while assessment and crisis response remain in person (Kalb et al., 2023).

The telehealth adaptation of START has also been studied qualitatively: staff and families identified the importance of rapport building, flexible scheduling, multimodal communication, and hybrid approaches (video + in-person) to maintain trust and engagement.

Telehealth also has workforce advantages: it enables clinicians to work remotely or flexibly, which may improve retention, reduce travel burden, and make roles more attractive in underserved areas.

Technology-Aided Training, Support & Decision Tools

- **Simulation, Virtual Reality (VR), and role-play platforms**: These can provide staff with experiential practice in crisis de-escalation, behavioral interventions, or communication strategies in a safe environment.
- **E-learning / microlearning platforms**: Bite sized, asynchronous modules allow staff to learn at their own pace and re-engage for refreshers.
- **Clinical decision-support tools / AI aids:** Systems that assist with behavioral assessment scoring, documentation prompts, risk flagging, or tailored intervention recommendations can reduce the administrative burden and cognitive load.
- **Assistive robotics / social robots**: In some pilots, socially assistive robots (SARs) are being explored to support prompting, engagement, or reminders augmenting but not replacing human staff (The Role of Healthcare Financing and Delivery Systems to Advance Health Equity, 2024).

While the evidence base is still emerging, digital health tools (especially telehealth) are the most well studied in IDD contexts (The Role of Healthcare Financing and Delivery Systems to Advance Health Equity, 2024).

Co-Design, Inclusion, and Lived Experience

A sustainable workforce ecosystem should include people with DD as staff, peer mentors, trainers, or advisors. Their lived experience fosters cultural competence, authenticity, and deeper empathy.

Training curricula and service redesign should employ co design methods, involving DSPs, clinicians, self-advocates, families, and administrators in developing content and systems.

The START telehealth trial integrates stakeholder engagement: its leadership includes individuals with lived disability experience, and its engagement team includes people with IDD, caregivers, and providers (Kalb et al., 2023).

Policy, Financing, and Incentive Factors

Even the most proficient workforce model requires sustainable funding and supportive policy.

Key components include:

- **Loan forgiveness, tuition assistance, stipends** for clinicians who commit to serving in DD/behavioral health settings
- **Reimbursement reform** to pay for telehealth, care coordination, supervision time, and non–face-to-face tasks
- **Workforce stabilization funds or grants** to support recruitment, training,

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ICL's Care Coordination Serving Children

The program offers:

- Comprehensive care coordination
- Care transition services
- Advocacy for recovery goals
- Connection to resources
- Personalized support

Institute for Community Living (ICL)'s Care Coordination Serving Children helps children and families navigate the complexities of the health care system. Our culturally competent, trauma-informed care team ensures that each child receives the services they need to thrive.

Located at ICL's East New York Health HUB, our person-centered model of care can help children and youth ages 0-17 identify mental health and substance use challenges, provide practical support services to improve well-being, and strengthen family relationships.

Transforming Access Through Strategic Investment in Behavioral Health Workforce Development

By Sophie Pauze, MPA
and Omar Fattal, MD, MPH
NYC Health + Hospitals

In the face of rising demand for behavioral health care and persistent workforce shortages, NYC Health + Hospitals has made workforce development a central lever for system transformation. Through a suite of programs focused on **recruitment, retention, training, and expanded career pathways**, we are reshaping how care is delivered and how public service careers are perceived. Since launching our three-year workforce development strategic plan in 2024, we have made significant progress in strengthening and stabilizing our behavioral health workforce. This comprehensive approach addresses immediate staffing needs while building long-term sustainability—expanding capacity, improving access to care, and laying the groundwork for a resilient, well-supported workforce prepared for future challenges.

Elevating Our Public Role Through Comprehensive Recruitment

Recruitment initiatives have expanded our reach and brought in new talent across disciplines, while enhanced training programs ensure that new staff are equipped with the skills and confidence to deliver high-quality care in a rapidly evolving environment. Externally, NYC Health + Hospitals are gaining recognition as an employer of choice in public behavioral health, a notable shift from pre-pandemic trends. Applications are increasing, hiring timelines are shortening, and the system is drawing attention for its commitment to staff development and wellbeing. In the last 12 months, NYC Health + Hospitals has hired nearly 600 behavioral health staff, filling longstanding vacancies and supporting strategic growth, marking our most effective recruitment season to date and building on a strong performance in the past 2 years. These developments further strengthen our reputation as a public institution capable of innovation and impact.

- **A Mission-Driven, Multichannel Recruitment Strategy:** A key lesson from prior years is that recruitment cannot be passive, it must be intentional, targeted, and visible wherever potential candidates are. Reflecting this, our recent campaigns have leveraged every available channel, from digital outreach to out-of-home advertising to cable media, ensuring broad and consistent visibility. This deliberate approach is producing results. Thanks to the social work campaign and more focused systemwide recruitment efforts, we have been able to hire more than 400 social workers since January of 2024. In fall 2025, we applied these same principles to the refreshed PSYCHDOCS4NYC[1] campaign to recruit psychiatrists and psychiatric mental health nurse practitioners. We sharpened our message to center the core mission of NYC Health + Hospitals, articulating who we are and why our work matters in a way that truly resonated with applicants. A new campaign video featuring behavioral health leadership added authenticity and purpose, helping bring the message to life. Early indicators are strong: interest has increased significantly, with many candidates explicitly citing the mission-driven focus as their reason for applying. This momentum reinforces our growing reputation as an employer of choice in behavioral health, with several facilities now reporting no psychiatrist vacancies.

- **Creative sourcing to build an inclusive workforce:** Alongside traditional recruitment strategies, we are also expanding the pool of who belongs in the behavioral health workforce. Programs like **The Peer Academy** and the **Psychiatric Social Health Technician (PSHT) Care Corps** are creating entry points for individuals with lived experience, offering free training and paid internships that expand both the workforce and the connection to the communities we serve. These programs are already achieving tangible results: on average nearly 70% of our (50) annual Peer Academy graduates are hired into permanent roles in our system, and 50% of the (30) PSHT Care Corps graduates to date have secured employment within just two months of program completion, with more hires underway.

- **Building a Behavioral Health Physician Assistant (PA) Pipeline:** To address a long-standing challenge in behavioral health hiring—namely, that physician assistants graduate with strong general training but little to no experience in psychiatry—NYC Health + Hospitals developed the Psychiatric Physician Assistant Fellowship in partnership with the NYS Office of Mental Health. Behavioral health leaders have historically been hesitant to hire new PAs because they lack the specialized skills needed to step into these roles. This fellowship was intentionally designed to bridge that gap: it provides early-career PAs with the hands-on experience, clinical competencies, and supervised practice necessary to be successful in behavioral health settings. By creating a structured pathway into the field, the program not only expands the pool of PAs who are ready to work in our system today but also builds a future bench of experienced PAs who can go on to precept, mentor, and shape the next generation of psychiatric PA clinicians.

- **Pairing Service Commitments & Financial Incentives to foster sustainability:** Consistent with a 2020 AAMC survey indicating that loan repayment significantly affects employment decisions,[2] an essential cornerstone of our strategy has been the use of financial incentives to stabilize and grow the behavioral health workforce. At the heart of these efforts is the BH4NYC Loan Repayment Program, which has awarded over $5M in student loan repayment to 200 clinicians in exchange for a three-year service commitment, boosting recruitment and retention of staff who collectively provide 110K+ inpatient and outpatient patient visits annually.

Retention and Wellbeing as a Driver of Stability

Retention efforts—ranging from fellowship opportunities to violence-prevention initiatives—are fostering a stronger culture of engagement, stability, and commitment across our system. These non-financial supports play a vital role in sustaining our workforce by strengthening job satisfaction,

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Supporting Supervisors and Mid-Level Leaders in Behavioral Health Organizations

By Marellyn Lajara-Ottley, LMHC and Tanya M. Sanchez, LMHC
New York Psychotherapy and Counseling Center (NYPCC)

More than five years after the COVID-19 pandemic disrupted the nation, the behavioral health field continues to undergo profound and lasting shifts. Early in the pandemic, the World Health Organization (2022) reported a global 25 percent increase in anxiety and depressive disorders, a surge that did not fade with time, as subsequent analyses continued to document widespread mental health burden (Kupcová et al., 2023; Kola et al., 2022). Instead, demand for behavioral health services has grown steadily, and clinicians now encounter increasingly complex and layered presentations requiring longer, more intensive episodes of care and thoughtful intervention (APA, 2022; SAMHSA, 2023; Savaglio et al., 2023).

As the complexity of client needs continues to rise, the behavioral health workforce is simultaneously experiencing significant strain, setting the stage for broader workforce pressures and the burden on leaders. Despite the growing demand for services, many organizations continue to struggle with staffing. The United States Bureau of Labor Statistics (2023) projects an 18 percent growth in employment for mental health counselors, behavioral disorder specialists, and substance use providers between 2022 and 2033, alongside similar increases for marriage and family therapists, social workers, and psychiatrists. In practice, however, many agencies face a shortage of qualified providers and ongoing difficulties with recruitment and retention. Burnout, chronic stress, and overwhelming workloads remain persistent themes across the field (Crocker et al., 2023).

As these pressures intensify, the impact is felt not only at the direct-care level but throughout the supervisory and administrative layers of an organization. Supervisors and Program Directors, even those without full caseloads, shoulder significant pressure as they work to stabilize teams, ensure compliance, manage operations, and navigate organizational demands. Under these conditions, emotional strain often begins to circulate through the system, revealing itself in the form of parallel process. Supervisors often experience bottom-up parallel processes, in which emotional dynamics from the therapy room emerge within the supervisory relationship. Zetzer and colleagues (2020) found that supervisors frequently internalize the emotional weight of clinicians' most challenging cases, leaving them vulnerable to compassion fatigue and role strain, especially when managing multiple layers of responsibility.

The same emotional patterns can move upward through an organization, impacting directors and senior leaders. Tracey, Bludworth, and Glidden-Tracey (2012) highlight that parallel process can flow in both directions, shaping not only supervisory relationships but the culture of the entire organization when cumulative pressures go unaddressed. As these pressures accumulate across organizational levels, the role of leadership becomes central to shaping workplace climate, staff stability, and overall system functioning, underscoring why supporting supervisors matters.

Organizational stability depends greatly on the quality of leadership. A recent study found that clinicians were more likely to remain in their roles when they experienced supportive administration, meaningful work, manageable work–life balance, fair compensation, and strong peer and supervisory support (Pathman et al., 2025). The widely recognized idea that "employees leave managers, not organizations" is deeply reflected in behavioral health research. When leaders model respect, empathy, accountability, and empowerment, they help retain staff and strengthen organizational morale.

Supporting supervisors, therefore, is not simply beneficial, it is essential to maintaining ethical practice, reducing burnout, and preserving the integrity of the system (Barnett et al., 2007; Edwards et al., 2023; Milne & Reiser, 2017).

One effective strategy for supporting leaders involves combining top-down and bottom-up approaches. In top-down models, senior leadership sets goals and guides the direction of the organization. In bottom-up approaches, staff on the ground identify needs and share insights that inform decision-making. When combined, these approaches create a more accurate picture of staff experiences and allow organizational leaders to respond with policies and structures that meaningfully support the workforce (Li, 2023). This responsiveness can interrupt negative parallel processes and improve client care by reinforcing a healthy organizational climate.

New York Psychotherapy and Counseling Center (NYPCC) applies this combined leadership philosophy to invest intentionally in its supervisory workforce and develop future leaders. As a growth-centered organization, NYPCC provides consistent support for Supervisors through collaborative forums, shared problem-solving, and structured opportunities for reflection. Because the quality of supervision depends on the support supervisors receive, the organization ensures that Supervisors participate in dedicated supervisory sessions that help them reflect on their work, refine their clinical and administrative skills, and address challenges such as countertransference. Directors conduct shadowing not only for evaluation but also to provide mentorship and space to explore the complexities inherent in leadership roles. Collaboration is further reinforced through NYPCC's supervisor line, a system that allows clinicians to reach a network of Supervisors during crises or complex situations. This model distributes responsibility, reduces pressure on individual leaders, and reinforces the organizational belief that no one should navigate difficult circumstances alone.

Taken together, these structures demonstrate NYPCC's commitment not only to strong supervision but to the overall well-being of its workforce. These practices naturally connect to the broader organizational priority of preventing burnout; a challenge that affects behavioral health systems at every level.

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Strengthening the Backbone: Supporting Mid-Level Managers in Nonprofit Organizations

By Nadjete Natchaba, EdD, LCSW, MPA
Chief Program Officer
Services for the UnderServed (S:US)

Nonprofit organizations operate in environments marked by complexity, rapid policy shifts, and ongoing community needs. Services for the UnderServed (S:US) is one of New York City's largest and most comprehensive human services agencies. S:US supports thousands of New Yorkers each year by providing housing and homeless services, behavioral health and treatment programs, developmental disabilities services, eviction prevention, and veteran services. With more than 2,000 dedicated employees and over 90 program sites across the boroughs and Long Island, S:US works to create opportunities for all by disrupting cycles of poverty, promoting wellness, and helping individuals and families stabilize and thrive.[1]

Within this landscape, mid-level managers play an essential role in shaping daily service delivery. They translate broad organizational strategy into clear expectations and operational practices. They serve as the primary support and accountability structure for frontline staff. They ensure regulatory compliance, facilitate performance management, coordinate with funders, navigate crises, and maintain a healthy overall climate within their teams. Despite the significance of their role, mid-level managers often receive inconsistent supervision or supervision that only focus on administrative tasks, without attending to the educational or supportive needs that sustain long-term leadership.

Strengthening the supervision of mid-level managers is essential for organizational sustainability, workforce retention, and the quality of services provided to vulnerable populations across New York City.

The Essential Role of Mid-Level Managers

Mid-level managers are the bridge between the frontline and senior leadership. They are responsible for ensuring that services are delivered with quality and consistency, that staff remain aligned with best practices, and that programs maintain fidelity to funder and regulatory requirements. They supervise multidisciplinary teams, address staff concerns, mediate conflicts, and create structures that support accountability and growth. They also provide coaching, maintain safety protocols, respond to crises, support documentation standards, and advance the organization's mission.

These responsibilities become even more demanding during times of workforce shortages. Behavioral health and human services agencies across the United States report high vacancy rates and persistent challenges in recruitment and retention. A national workforce analysis found that behavioral health organizations experience vacancy rates above thirty percent.[2] This places pressure on mid-level managers who must fill gaps, absorb additional responsibilities, and sustain team morale during periods of instability. Studies also show that leaders in human services settings are frequently exposed to vicarious trauma and chronic stress,[3] which impacts their own capacity to lead effectively and underscores the need for intentional supervisory support structures informed by workforce research.

The role requires emotional intelligence, flexibility, crisis management, administrative expertise, and the ability to guide staff through complex and often emotionally charged work. Without intense supervision, these challenges can become overwhelming.

Challenges Facing Mid-Level Managers

Role Ambiguity and Role Conflict: Many mid-level managers are promoted because they excelled in frontline roles. Although they may be skilled in direct service, they often receive limited preparation for supervisory responsibilities. Research demonstrates that role conflict and role overload significantly contribute to burnout and turnover in social service organizations.[4]

Limited Supervisory Training: Supervision training is not consistently offered in nonprofit agencies. Supervisors may default on administrative tasks required by auditors and funders, while the educational and supportive elements of supervision receive less attention.[5]

Emotional Labor and Vicarious Trauma: Mid-level managers carry the emotional weight of the work alongside frontline staff. They support employees who experience burnout, compassion fatigue, secondary traumatic stress, and frustration with systemic barriers. Compassion fatigue and vicarious trauma are widely documented among supervisors in human services settings.[6]

Workforce Shortages and Turnover: Persistent staffing shortages require mid-level managers to redistribute caseloads, adjust schedules, cover unfilled shifts, and respond to staff burnout. This significantly increases workload and reduces time available for high-quality supervision.

Pressure From Multiple Directions: Mid-level managers must satisfy the expectations of frontline staff, senior leadership, funders, auditors, community partners, and regulatory bodies, often simultaneously.

A Research-Based Framework for Strong Supervision

Three well-established domains of supervision offer a structure that supports mid-level leaders.[7]

1. **Normative or Administrative Supervision:** Normative supervision focuses on policies, documentation standards, ethical practice, accountability, and quality assurance.

2. **Formative or Educational Supervision**: Formative supervision focuses on skill building, professional development, and leadership growth.

3. **Restorative or Supportive Supervision:** Restorative supervision focuses on emotional wellness, morale, reflection, and resilience. Research indicates that supportive and reflective supervision reduces burnout and improves retention[8].

Why Restorative and Formative Supervision Must Be Prioritized

Organizations are more likely to retain staff when employees feel supported, valued, and invested in,[9] particularly when supervision includes both developmental and supportive components. Mid-level

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Investing in the Behavioral Health Workforce: Training, Professional Development, and Advancing Clinical Excellence

By Sarah Grey
Chief People Officer
Family Care Center

Behavioral health clinicians are seeing more patients with complex, co-occurring disorders and acute symptoms that require multidisciplinary care. At the same time, referrals and expectations for timely, high-quality care are rising.

These demands take a toll on care quality and clinician well-being. Emotional strain, high caseloads, and limited opportunities for skill development contribute to burnout, leaving even the most dedicated clinicians feeling underprepared.

Workforce development is key to addressing these challenges. By providing ongoing training and professional growth opportunities, organizations help clinicians feel supported, laying the foundation for compassionate, effective, and sustainable patient care.

Training That Meets Today's Clinical Realities

Today's behavioral landscape is increasingly complex. Clinicians are working with patients who present co-occurring conditions and rapidly shifting needs. To respond effectively, clinicians need more than foundational knowledge. They need evidence-based skills they can rely on in the moment when treating patients.

Organizations can help clinicians meet these evolving needs by offering targeted training in key areas, including:

- **Trauma-informed care** – understanding and responding to the impact of trauma on mental health
- **Acceptance and Commitment Therapy (ACT)** – helping patients align actions with values while managing difficult thoughts and emotions
- **Risk assessment and crisis intervention** – identifying and safely responding to acute clinical situations
- **Neuromodulation and interventional psychiatry, including transcranial magnetic stimulation (TMS)** – delivering advanced, evidence-based treatments with consistency and safety
- **Measurement-based care (MBC)** – using standardized tools to track outcomes and guide treatment

By equipping clinicians with these skills, organizations ensure care is not only evidence-based, but also tailored, responsive, and effective.

Using Miller's Pyramid to Strengthen Clinical Competence

Annual continuing education is helpful, but not enough. Most CEU programs emphasize theory, which supports knowledge but does not fully prepare clinicians for complex, real-time decisions. Clinicians need training that clarifies concepts, builds confidence, and strengthens skills on an ongoing basis.

Miller's Pyramid provides a framework for linking training to clinical competence. It shows how clinicians progress from foundational knowledge to independent application of clinical skills.

1. Knows – foundational knowledge
2. Knows How – understanding how to apply that knowledge
3. Shows How – demonstrating skills in a structured or supervised setting
4. Does – applying skills independently in real clinical practice

Consider how the levels of Miller's Pyramid correspond to behavioral health clinical development. Each step strengthens not only what clinicians know, but also how they perform and apply skills in daily care.

"Knows" and "Knows How" - Clinicians start by building a solid foundation through learning modules, readings, or self-paced materials on topics such as evidence-based practices, measurement-based care, trauma-informed approaches, or emerging treatments. These opportunities, and their knowledge assessments, can help demonstrate that the knowledge has been retained and that learners understand how and when to apply it.

"Shows How" - Next, clinicians practice their skills in safe, supportive environments. Case consultations, simulations, and structured supervision give clinicians a chance to demonstrate competence and receive constructive feedback. This step bridges the gap between knowledge and real-world applications.

"Does" - Finally, clinicians apply what they've learned in their daily work. Ongoing supervision, peer consultation, outcome review, and reflective learning help ensure that skills are applied consistently, confidently, and with fidelity to evidence-based care.

Real-World Application: Family Care Center's Workforce Model

Family Care Center, a national leader in outpatient behavioral health services, has built its training philosophy around a simple belief: Clinicians do their best work when they feel supported, prepared, and connected to a shared mission. The organization invests in both external and internal development, offering paid time and reimbursement for CME and CEU activities while also serving as an accredited sponsor of continuing education grounded in real clinical needs.

Across more than 45 clinics, internal programs focus on the challenges clinicians encounter every day, such as trauma, complex diagnoses, measurement-informed care, and team-based treatment. These shared learning experiences create a common language and a culture where clinical excellence is a reality, not a distant hope.

A meaningful example of this approach emerged during Suicide Awareness Month in September 2025. Rather than simply recognizing the occasion, Family Care Center used it as a chance to deepen practice and build confidence.

"We launched an accredited three-part suicide risk course series designed to equip clinicians for some of the most intense and emotionally charged moments in patient care," shared Heather Hallman, MSHA, MHA, CSSBB, the Director of Quality, Safety, and Training at Family Care Center.

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The People Behind Transcranial Magnetic Stimulation (TMS) Neuromodulation

Dr. TeeJay Tripp
Chief Medical Officer
Serenity Mental Health Centers

Protocol is important in Transcranial Magnetic Stimulation (TMS), but what makes the biggest difference is consistent care and support. A patient comes in every day depressed, exhausted, and not sure it will work. But there's a person who made it easier to show up anyway. In TMS care, that person is almost always the technician.

TMS technicians are an essential workforce innovation in behavioral health care and a day-to-day support system that directly shapes patient healing.

The Relationship Dimension

Behavioral health care workforce development often focuses on psychiatrists, psychologists, social workers, and nurses. But positive innovation outcomes can also come from building reliable, trained support roles for patients' daily healing.

TMS is a perfect example. The treatment is physician-ordered and clinically supervised, but it is carried out in practice by technicians. Over six to eight weeks, five days a week, 30 minutes a day, they become a consistent presence in a patient's journey.

The tech role expands the behavioral health workforce by focusing highly trained attention on adherence, comfort, and emotional safety.

Behind every TMS success story is a relationship: technicians provide the daily support that helps patients stay the course.

It's easy to forget, amid protocols and motor thresholds, that many patients begin TMS while still in severe distress. Some patients initially experience minor headaches, fatigue, or discouragement when they don't feel immediate change. Add transportation issues, schedule changes, childcare, and external daily life factors. The dropout risk could be high.

The tech is the person who notices the patient's subtle and gradual improvements each day, who hears the hesitation in "I don't know if this is doing anything," who can say, "Let's just get through today and we'll reassess together." This supportive structure changes everything.

TMS technicians aren't therapists, but the daily relationship they build creates micro-therapeutic moments: brief interactions that shape motivation, hope, and self-efficacy over time.

A patient might say to the technician, on day 12, "I don't think I can keep doing this." A tech who has been trained to respond calmly, validate feelings, and escalate concerns appropriately becomes critical. Their role isn't to directly treat the underlying disorder. Instead, it's to support the patient through the treatment with comfort.

Patients often come to trust technicians because they're the steady presence that shows up for them, session after session. The relationship is repetitive, comfortable, and grounded in a shared routine. For many patients, that consistency is stabilizing and strengthens their motivation to stay with the treatment.

Technicians' Actions Change Outcomes

The conversations that happen during treatment matter. Patients might joke, vent, cry, or shut down. Many say that practicing gratitude and goal setting while receiving treatment becomes a main part of their healing.

They are trained in supportive communication that is clinically aligned:

- **Normalization without minimization: "**A lot of people feel uncertain around week two. You're not doing anything wrong."
- **Providing reassurance: "**We'll keep tracking progress together, sometimes it's subtle before it's obvious."
- **Tackling patient goals: "**You said you want mornings to feel more manageable. Let's set a small goal that helps with that."
- **Motivational micro-skills:** Practicing reflective listening, providing reasons to continue, and affirming effort.

Over dozens of sessions, these small interactions help patients endure the "middle stretch" of treatment, where outcomes are being built.

In Serenity clinics, techs are quietly doing some of the highest-impact work:

- **They often notice the first shifts**: A patient laughs once, makes eye contact again, arrives on time without struggle.
- **They get to celebrate the small wins early:** Lighter conversations, a little more energy, or even said a "today felt easier than yesterday."
- **They reflect progress back in real time:** Helping patients see that change is happening even if it still feels slow.
- **They add encouragement to the routine:** Each visit feels less like a task and more like momentum.

In fact, Serenity is one of the only TMS clinics nationwide that can self-certify our own TMS technicians. Our TMS program has an **84% response rate and a 78% remission rate**, with results lasting 3 years+ for most patients.

What Workforce Innovation Requires

If we're serious about behavioral health workforce development, we must professionalize what technicians already do. That means standardized, clinic-supported training in protocol safety, communication, informed care, and more.

Techs hear people at their lowest. Without support, tech burnout can become the hidden bottleneck of TMS access. Workforce innovation isn't just hiring more techs; it's retaining them through supervision, career pathways, and recognition as a skilled behavioral health role.

This can be done through care planning, setting clear promotional paths, and highlighting their contributions in team culture. When techs believe what they do matters, they pay closer attention. When they feel supported, they stay longer. When they stay longer, patients get better care.

The Takeaway

Behavioral health care needs more roles that expand access, stabilize engagement, and humanize high-tech treatment. The future of workforce development is designing teams where every role is trained, valued, and aligned to healing.

So next time you think about TMS outcomes, don't only think about science. Think about:

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A Faltering Behavioral Health Workforce and a Prescription for Progress

By Ashley Brody, MPA, CPRP
Chief Executive Officer
Search for Change, Inc.

The behavioral healthcare workforce is under considerable duress and ill equipped to meet a moment marked by unprecedented rates of mental illness, substance dependence, and other indices of human distress. By some measures, approximately half of mental health professionals report burnout because of the emotional demands of their profession and systemic factors that undermine their efficacy (Ballout, 2025). Workforce pressures are intensified by a global shortage of professionals and structural impediments to the recruitment and retention of qualified personnel (World Health Organization, 2022). Service professionals also experience widespread moral injury due to their actual or perceived failure to meet needs beyond their conventional scope of practice (Rabin et al., 2023). For instance, service recipients' widespread exposure to such socioeconomic stressors as food insecurity and housing instability requires providers to pursue interventions largely beyond their control to alleviate the suffering of those entrusted to their care. For most professionals this has proven a Sisyphean task that compounds other stressors and exacerbates burnout. Moreover, these challenges are not evenly distributed across the behavioral health workforce. Members of historically marginalized populations including Black, Indigenous, and people of color (BIPOC) experience additional challenges in navigating bias and racism embedded in the structures of our healthcare and social welfare systems (Kyere & Fukui, 2023). Designated Peer Specialists enlisted to utilize their lived experience in recovery in service of others also encounter systemic bias and related obstacles to workforce integration.

Nearly half of the U.S. population resides in federally designated Mental Health Professional Shortage Areas (MHPAs), regions with moderate or severe shortages of mental health professionals available to meet their populations' needs (Ballout, 2025). This is tragic but unsurprising in consideration of innumerable impediments to the recruitment and retention of qualified personnel. Employment in behavioral healthcare and social welfare entails a specific type of labor that is unique among the professions and predisposes many to burnout and secondary trauma. Theoreticians have defined "Emotional Labor" as a process in which employees calibrate their emotional expressions in accordance with the needs of their clients and, in doing so, experience a dissonance that arises from discrepancies between their authentic emotional experiences and expressions of them (Zhao et al., 2025). Emotional Labor has been repeatedly linked to burnout, and its impact is presumed to be greater among employees who must manage large client caseloads due to the workforce shortage. Emotional Labor may be further compounded by the acuity of service recipients' needs amid widespread economic distress and related impediments to health and stability. Providers heretofore tasked to treat clients' behavioral health symptoms must now address their myriad Health Related Social Needs (HRSNs) without the resources needed for this task. Other factors implicated in this shortage include but are not limited to systemic dysfunction in the training, education, and professional development of behavioral healthcare professionals; regulatory and administrative barriers; and inadequate financial support for the behavioral health sector in general.

Aspiring behavioral healthcare practitioners incur exorbitant expenses in pursuit of their careers. Tuition for undergraduate and graduate education, supervisory fees, and other expenditures are prohibitive for most, and those who finance their education with loans often emerge with debts that eclipse their annual salaries. This is both a deterrent to entrance to this field and an additional source of stress for professionals who elected to enter it despite its inherent financial disadvantages (Georgetown University Center on Health Insurance Reforms, 2024). In addition, emerging professionals often encounter difficulties in locating eligible mentors or preceptors to ensure they fulfill licensure requirements. Senior professionals with the requisite experience to fulfill preceptor roles may command greater compensation in other settings. A consequent shortage of preceptors forestalls the development of aspiring professionals and exacerbates an existing workforce shortage. Opportunities for professional advancement are also notoriously scarce in the behavioral health and social welfare sectors, as advancement is highly dependent on education, credentialing, and licensure requirements. Providers with bachelor's or comparable (i.e., sub-graduate) degrees frequently attain the maximum, albeit meager, compensation available to them within their organizations and must assume additional responsibilities without commensurate opportunities for wage increases or professional growth. This trend may produce professional dissatisfaction and contribute to organizational turnover and attrition (Georgetown University Center on Health Insurance Reforms, 2024).

Regulatory schemes and administrative workloads characteristic of the behavioral health and social welfare sectors often undermine employee satisfaction and compound the foregoing challenges. Inasmuch as the sector is entrusted with the care of vulnerable individuals and depends largely on public funding for its operations, an extensive body of regulation has been enacted to ensure recipients' welfare and the appropriate use of available funding. These regulations, though necessary and justified, have had the unintended consequence of alienating professionals beholden to them. Professionals whose time is spent on adherence to complex (and ever changing) regulations and the preparation of clinical and administrative documentation have less time with which to meet recipients' needs (Frier Levitt, 2025). This trend is particularly acute within organizations that rely on private insurers, and Managed Care Organizations (MCOs) in particular, for reimbursement. MCOs are private (and frequently for-profit) organizations incentivized to maximize financial returns for their investors at the expense of their members (i.e., service recipients) and the behavioral healthcare providers on whom they depend. MCOs are notorious for their failures to process provider claims in a timely manner and their frequent rejection of claims on dubious grounds. These practices are particularly prevalent within the behavioral healthcare sector. MCOs have repeatedly engaged in disparate or outright discriminatory practices that favor primary care (i.e., medical and surgical care) over behavioral healthcare. These practices persist despite the passage of the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and similar legislation in New York State (NYS). As recently as 2022, NYS began to recoup monies MCOs improperly withheld and to reinvest them

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The NYSPA Report: Federal and State Coverage of Telehealth and Its Role in Expanding Access to Mental Health Care

By Rachel A. Fernbach, Esq.
and Jamie Papapetros
New York State Psychiatric Association (NYSPA)

Following the COVID-19 public health emergency, the federal Centers for Medicare and Medicaid Services (CMS) made permanent expansions to the coverage of telehealth under the Medicare program. CMS has greatly increased the number of services included on the permanent list of telehealth services and expanded the list of practitioners authorized to provide mental health telehealth to include physicians, nurse practitioners, LCSWs, clinical psychologists, marriage and family therapists and mental health counselors. These changes directly reflect the impact that the widespread availability of telehealth technology has had on the delivery of health care, particularly since the public health emergency. Considering widespread reports that the United States is amid a mental health crisis,[1] increased access to telehealth is a key component in ensuring that individuals receive necessary and life-saving mental health care and treatment. The following is a summary of Federal and state efforts in furtherance of this goal.

Medicare

The Medicare program will now permanently cover telehealth for mental health and substance use disorder (MH/SUD) services provided to patients at home. In other words, there are no longer any geographic restrictions on originating sites (patient location) for MH/SUD care. CMS has also expanded its definition of home, which now includes a patient's residence, homeless shelters, group homes, hotels and other settings that a patient may identify as home, whether temporary or permanent. In this context, home also includes circumstances where the patient, for private or other personal reasons, chooses to travel a short distance from their home for a telehealth service, perhaps to a car or other private space. In addition, the Medicare program now covers MH/SUD services delivered via audio-only communications (without a synchronous video component), if the patient does not have access to two-way, audio-video technology or does not consent to the use of two-way, audio-video technology.

At the same time, CMS has imposed some limitations on the coverage of telehealth in the mental health context, i.e., the 6-month rule and the 12-month rule. Under the 6-month rule, CMS has mandated that all new Medicare patients be seen at least once in person during the 6 months prior to initiating mental health telehealth services. For practical purposes, this means that the initial visit with a new Medicare patient must be in-person, with any telehealth follow-ups taking place within 6 months of the initial in-person visit. Please note that this rule applies only to new patients. CMS has clarified that if a patient has previously been seen via telehealth, that patient will be deemed an "established" patient and the 6-month rule will not apply. This rule was initially slated to go into effect on October 1, 2025, but implementation was extended to January 30, 2026, due to delays caused by the federal government shutdown.

Additionally, under the 12-month rule,

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From Collaboration to Impact: How a Foundation and CBO Are Strengthening the Behavioral Health Workforce for Older Adults

By Catherine Thurston, LCSW
Service Program for Older People (SPOP)
and Marc Damsky, MPH
Mother Cabrini Health Foundation (MCHF)

I am delighted that my colleague Marc Damsky, Senior Program Officer at the Mother Cabrini Health Foundation (MCHF), has joined me for a conversation about workforce innovation as it relates to mental health and aging. We are proud that MCHF is currently supporting two workforce projects at Service Program for Older People (SPOP), one focused on internships for social work students, and the other on providing training for those working in the aging or mental health sectors, particularly in rural areas of New York State.

As the only agency in New York City that is entirely dedicated to community-based behavioral healthcare for older adults, SPOP plays a vital role in the healthcare and aging sectors. We have assembled a staff with unrivalled expertise in aging and mental health, and we provide treatment to more than 1,000 clients annually. Marc, how does our work at SPOP fit within MCHF's mission?

Marc Damsky: Thanks, Catherine, and I'm really looking forward to this conversation. As you know, MCHF seeks to honor the legacy of our namesake by advancing the health and well-being of underserved and vulnerable populations across New York State. Our work is organized through five program areas: Basic Needs, Access to Healthcare, Mental and Behavioral Health, Healthcare Workforce, and a General Fund that supports our eight priority populations: immigrants, veterans, older adults, pregnant women/new parents/children, youth and young adults, and other low-income individuals.

I serve on the Mental and Behavioral Health Team. Our grants in this area focus on the full spectrum of issues: raising awareness and reducing stigma; advancing prevention; expanding access to services and treatment; and supporting individuals in their recovery. We recognize that mental and behavioral health is impacted by an individual's background, culture, community, and systems they may interact with. As a result, we strive to support work that is integrated, culturally responsive, and person-centered. We are grateful for our partnership with SPOP, which aligns with one of MCHF's areas of interest – addressing the mental health of rural older adults.

We also understand the critical role that the workforce plays in all of this. Can you talk about the specific workforce challenges SPOP faces?

Catherine Thurston: Staff recruitment and retention are high priorities for us. We monitor annual compensation trends to remain competitive, even as community-based agencies like ours face challenges in matching the resources of large hospital systems. The demand for specialized roles -- particularly bilingual prescribers and social workers -- underscores the complexity of our mission, and these positions require a rare combination of skills that are essential to serving our diverse community.

Marc Damsky, MPH, with a client on a visit to SPOP.
Photo Credit: Manny Amatrudo

At SPOP, we are committed to fostering a workplace culture where staff feel valued, supported, and inspired. Using the resources that we have at our disposal, we are always looking for ways to build a positive workplace culture. We encourage a healthy work-life balance, with little evening or weekend obligations and generous time off for vacation and wellness. We were fortunate to receive a NY State Office of Mental Health grant to support social work student loan repayment, which has been a great perk for our staff. We also offer generous staff training, continuing education, and advancement opportunities – all of which have resulted in an average annual retention rate of over 80-90%, reflecting the strength of our organizational culture.

For those entering the field, ageism is one of our greatest challenges. Negative, harmful stereotypes persist – such as the belief that "depression is a normal part of aging" or that "older people can't change." I see proof every single day that the opposite is true. Older adults demonstrate resilience, growth, and joy, and it is my personal mission to inspire every social work student to toss out these misconceptions and discover how profoundly gratifying it is to work with older adults.

Marc, how do you think about the behavioral health workforce challenges within New York State?

Marc: I'm impressed by your retention rate, Catherine. Our perspective on the challenges is very similar. We see how pipeline and retention issues contribute to large vacancy rates - reported to us as high as 40% - which inevitably affect service delivery. We have learned that barriers preventing more people from entering the field include the following: stigma, as you note; affordability of obtaining a master's degree, certification, or even the development of a new skill; insufficient wraparound supports such as childcare, tutoring, or mental health counseling, which are critical for successful completion of a program; and limited access to high quality internships. Ideally, we envision a workforce that reflects the communities it serves with opportunities for professional development in topics such as trauma, utilizing evidence-based practices, and specialized support for populations with unique needs such as veterans, survivors of domestic violence, or older adults.

In terms of retention issues, we understand compensation is a major factor, but so are effective supervision, opportunities for career growth, and strategies to reduce burnout. And as a funder supporting all of New York State, we are acutely aware of the shortage of mental health professionals in rural areas, which compounds these challenges.

But enough complaining about problems. I'd love to hear more about how SPOP is actively addressing these challenges.

Catherine: I'm so glad you asked! First, I can't tell you how tremendously proud we are of our student internship program for social workers. With support from the Mother Cabrini Health Foundation, we have built a nine-month internship program that fully integrates students into the agency. They receive excellent training and supervision and gain hands-on experience serving clients across all clinical programs. The students receive a stipend – which, unfortunately, is not the norm in

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Workforce Solutions in Behavioral Health: Insights from SMA Healthcare

Brooke Goodenow, MS
and Haley Pegram, MS
SMA Healthcare

The behavioral healthcare sector faces one of the most severe workforce shortages in decades. As of 2023, an estimated 169 million individuals in the U.S. live in Mental Health Professional Shortage Areas, which is projected to worsen by 2037 (National Center for Health Workforce Analysis, 2023). For organizations like SMA Healthcare, with more than 1,000 team members serving across crisis, residential, outpatient, and prevention programs in Florida, the workforce challenge is not simply a staffing issue. It is a matter of access to lifesaving services and care.

At SMA, we have made workforce development and innovation a top priority. By focusing on recruitment, retention, training, and sustainability, we are building strategies that are not only helping us stabilize our own workforce, but that can also be adapted by other behavioral healthcare providers.

Recruitment in a Competitive Labor Market

Recruiting behavioral healthcare team members has never been easy, but the post-pandemic labor market has added new challenges. Competition from hospitals, private practices, remote jobs, and other industries has drawn many qualified professionals away from community-based care.

SMA Healthcare team members at BHCon Florida, the annual Florida Behavioral Health Conference organized by Florida Behavioral Health Association

At SMA, recruitment innovation starts with three core strategies:

- **Pipeline Partnerships:** SMA partners with local universities, community colleges, and vocational programs to build clinical internship opportunities and pathways. Students are introduced to behavioral health careers early and receive mentorship that encourages long-term retention. In 2025, 8% of SMA interns transitioned into full-time positions after graduation, a direct return on investment in future talent.

- **Community-Based Recruitment:** Recognizing the importance of lived experience, SMA recruits directly from the communities it serves. Peer specialists, individuals with personal recovery experience, are integrated into clinical teams. SMA has 33 peer specialists embedded across programs, bringing both cultural competency and firsthand lived experience.

- **Meaningful Employer Branding:** Recruitment campaigns are designed to highlight SMA as a mission-driven organization where team members make a direct impact. Social media, job boards, and digital platforms are used to spotlight employee stories, day-in-the-life features, and testimonials about the rewards of working in behavioral health. SMA launched a digital campaign, "Why SMA?", which shares team member testimonials and highlights the impact of behavioral healthcare work. Why SMA? New Video Series Introduction This branding approach increased web traffic to the SMA Careers application portal by 34.6%, with video views totaling 20,171 across Facebook and Instagram.

Retention and Burnout Prevention

Recruitment is only half the battle. Nationally, behavioral healthcare turnover rates reach up to 40% annually (Pathman et al., 2025), driven by burnout, compassion fatigue, and lower compensation compared to other healthcare sectors. SMA has prioritized retention strategies that invest in team members' well-being and career growth.

- **Resilience and Wellness Programs**: SMA offers health and lifestyle campaigns through SMA Wellness education. Additionally, to encourage preventive health, team members who complete a qualifying preventive care visit (physical, screening, etc.) are entered into prize drawings for Apple Watches, Fitbits, AirPods, gift cards, and other prizes. To further promote health, a Wellness Rewards program is offered that rewards enrollees for completing preventive care visits, getting recommended hours of sleep, completing a certain number of steps in a day, getting a flu shot, etc. Currently, 38% of employees are enrolled and participate in the program.

- **Career Ladders and Growth Opportunities**: SMA has developed clear progression frameworks, such as for client support specialists and clinicians. Team members can see the steps needed to advance, receive training aligned with those steps, and are supported by leadership in their professional development. In 2025, 203 employees were promoted, transferred, or moved up on the career ladder. 102 of these team members advanced via career ladder to the next position in their respective areas, providing opportunities for growth and decreasing turnover.

- **Leadership Development and Continued Education:** Annually, SMA offers multiple opportunities for leadership development and expansion of skills through hosting continuing medical education (CME) sessions and offering an ADEPT Leadership Accelerating Leadership Impact program. The ADEPT System is a 3-month course designed to grow leadership skills and support interaction with team members from various programs across the 6-county agency. To date, 84 employees have completed the ADEPT program, advancing their leadership skills and professional development.

Training for Emerging Care Models

The behavioral health landscape is shifting rapidly. The rollout of the 988 Suicide & Crisis Lifeline, the expansion of integrated care, and the growth of mobile response teams are reshaping how care is delivered. Preparing the workforce for these emerging models requires proactive adaptable training.

At SMA, innovation in training includes:

- **Clinical Training & Skill Expansion**: Clinicians receive training across multiple program types and clinician specialties, tailoring skill development to

see Workforce Solutions on page 41

Innovative Training Through Personal Connections: How a Behavioral Health Podcast Is Transforming Staff Development

By Lori Ashcraft, MSW, MPA, PhD, ITE
Resilience, Inc.
and Patty Blum, PhD, CPRP, ITE
Crestwood Behavioral Health, Inc.

In today's rapidly changing behavioral health landscape, frontline staff often face complex challenges that require continuous learning, updating skills, and meaningful guidance from those with deep expertise. Traditional training formats, while valuable, can be difficult to attend due to time constraints, shift work, and the emotional demands of clinical environments. Recognizing these realities, a new and increasingly popular approach to staff development has emerged: a podcast designed specifically for behavioral health professionals.

This unique podcast model begins with simple but powerful practice—listening. By regularly checking in with staff across behavioral health facilities, the podcast creator identifies pressing needs, recurring concerns, and emerging topics essential to daily work. Whether staff are asking for support with trauma-informed care, burnout prevention, recovery-oriented practice, or evolving clinical trends, their voices directly shape each episode.

Once a training need is identified, the podcast brings in expert guests from across the behavioral health field. These leaders, clinicians, researchers, and peer specialists share practical insights and real-world experience that staff might otherwise never have access to. What results is a learning experience that feels personal, energizing, and deeply relevant.

The podcast format itself is part of the innovation. Staff can listen during commutes, breaks, or quieter moments on the job—turning training into something flexible, accessible, and even enjoyable. Rather than sitting through long lectures or navigating dense materials, they can engage in meaningful conversations that speak directly to their professional lives.

Beyond the convenience and quality of content, the podcast includes an important feature that elevates its impact: each episode provides continuing education (CE) certification. This allows employees to meet their training requirements while learning in a way that truly resonates with them. By blending expert knowledge with easy access to CE credits, the podcast bridges the gap between professional development and everyday realities of behavioral health work. Accompanying each podcast is a resume of each guest, giving viewers a chance to get to know the presenters on a deeper level. It also includes a narrative about the implications of the content and followed by three peer-reviewed references that give the viewers a way to easily find other peer-reviewed material that can expand their exposure to the topic.

In an environment where staff support, education, and retention are critical, this podcast stands out as a model of creative and practical innovation. It honors the expertise of those in the field, gives them direct access to leaders they may never meet in person, and turns learning into a dynamic, ongoing conversation.

Want to Try This at Home? Here's the Formula.

First, know that this is not an expensive process. It's conveyed through Zoom links with easy access for viewers. It can

see Podcast on page 43

Investing from page 13

The training focused on routine risk screening, structured assessment, and clear response workflows.

"Clinicians had a roadmap when a patient was struggling," Hallman said. "They had shared tools and clear expectations that reduced uncertainty and improved safety. These courses boosted provider competency, strengthened documentation, and aligned roles, protocols, and responses across the system."

This same commitment to preparation and excellence guides Family Care Center's work in emerging treatment modalities. As interventional psychiatry grows, Family Care Center has invested in a rigorous TMS training program that blends clinical precision with compassionate delivery, helping patients achieve outcomes that are higher than national averages. The goal is to ensure that every person receives consistent, high-quality care, no matter which clinic they walk into.

How to Build a Culture of Continuous Learning and Support

Workforce development should be more than a checkbox; it must be embedded in an organization's culture. By fostering an environment that prioritizes ongoing learning, mentorship, and clinical excellence, organizations support both clinician well-being and patient outcomes.

Key elements of a supportive, continuous-learning culture include:

- **Protected time for learning and skill development** for clinicians at all career stages
- **Supervision, mentorship, and consultation groups** that offer guidance and reflective space
- **Clear pathways for advancement and specialization** to encourage professional growth
- **Peer collaboration across clinics and disciplines** to share knowledge and best practices
- **Integration of measurement-informed care** across the system
- **Recognition and celebration of clinical excellence** to reinforce high standards and motivate teams

When organizations intentionally design training and support structures in this way, clinicians feel more confident, capable, and engaged. For providers managing increasingly complex cases, acute symptoms, and rising expectations for timely care, this support is critical. Continuous learning transforms what can feel like an unsustainable workload into a more manageable, collaborative practice. The result is reduced burnout, stronger job satisfaction, and the sustained capacity to deliver high-quality, compassionate care at scale.

Sarah Grey is Chief People Officer at Family Care Center. For more information, visit fccwellbeing.com.

Strengthening the Behavioral Health Workforce Through Upstream Overdose Prevention

By Stephanie Simons
MSW Intern, Zero Overdose
MSW Candidate, Saint Mary's University of Minnesota

I came to this work with a personal understanding of how overdose affects families and communities. I lost my brother to an unintentional fentanyl overdose two years ago after he took a pill that he believed was oxycodone, given by someone he trusted. The loss reshaped how I understood vulnerability and the urgency of prevention. My experience ties directly to the needs of the behavioral health workforce. Providers are navigating an overdose landscape where risk is no longer confined to long-term substance use. Many overdoses occur in moments of pain, instability, or emotional overwhelm, and the workforce is expected to address these shifting risks while balancing compassion, clarity, and clinical responsibilities.

The drug supply has changed in ways that make prevention even more critical. Counterfeit pills are often manufactured to look identical to legitimate prescriptions yet contain fentanyl in unpredictable concentrations. Many individuals who overdose are unaware they have taken fentanyl. This reality means risk extends to anyone who takes a non-prescribed pill during a stressful or vulnerable moment. Behavioral health providers play an important role in addressing this risk through education, conversation, and proactive safety planning.

Through my MSW training and clinical exposure, I have seen how often people do not view themselves as being at risk for overdose. Some are managing emotional distress or physical pain. Others are navigating instability at home, school, or work. At the same time, many providers are unsure how to talk about overdose unless someone openly identifies with substance use. Hesitation makes sense. Providers want to avoid causing shame or fear. Silence becomes common, and silence often signals that overdose is off-limits as a topic. When overdose is avoided, prevention gets missed.

Upstream overdose prevention brings these conversations into routine care. At Zero Overdose, I support a model that blends Motivational Interviewing with Overdose Safety Planning. This approach helps individuals identify warning signs, high-risk situations, coping strategies, and concrete steps to stay safe. The goal is not to assume someone will use substances. The goal is to recognize moments when pressure, pain, or emotional overwhelm might create risk and to offer a grounded plan that protects health and dignity.

A simple example of how this sounds in practice is: "I want to make sure you feel supported in staying safe, especially during times when pain increases or life feels overwhelming. Many medications that circulate outside of pharmacies are contaminated with fentanyl without people knowing. If there were ever a moment when you felt tempted or pressured to take something not prescribed to you, I would want you to have a plan that keeps you protected. Would you be open to talking through a few strategies together?"

The tone remains calm, respectful, and partnership oriented. The person keeps control of every decision. The provider offers information without judgment.

Strengthening the behavioral health

see Overdose Prevention on page 45

Addiction, Treatment and the Evolution of Therapeutic Communities: The Legacy of Dr. David A. Deitch

By Liliane Drago, MA, Master CASAC, MAC, Vice President of Training Outreach Development Corporation

David A. Deitch, PhD, is one of the most influential figures in the modern history of addiction treatment. A clinical and social psychologist, he currently holds the title of Emeritus Professor of Clinical Psychiatry at the University of California, San Diego, where he founded the Center for Criminality & Addiction Research, Training, and Application (CCARTA). Through a career span of more than 45 years, Dr. Deitch has helped shape both policy and practice, working across academic, governmental, and nonprofit sectors to build systems of care for people with substance use disorders.

A co-founder of Daytop Village and former Senior Vice President and Chief Clinical Officer of Phoenix House, Dr. Deitch played a key role in developing the therapeutic community (TC) model, one of the most influential and controversial approaches to addiction treatment in the 20th century. He has consulted for the United Nations, chaired national commissions under two U.S. Presidents, and authored foundational training materials still used across the field today.

Liliane Drago with Dr. David Deitch

I worked with David at Phoenix House, when he was its Chief Clinical Officer and I was the National Training Director. Together we worked on both preserving and updating the therapeutic community model.

This article brings together two in-depth explorations of therapeutic communities and addiction recovery, grounded in an extended conversation with Dr. Deitch. The first section delves into the nature of addiction and the second traces the origins, evolution, and philosophical tensions of the TC model through the lens of his lived and professional experience.

Together, these reflections offer insight into treatment practices that have shaped the lives of countless individuals. They also raise critical questions about what we preserve, what we revise, and how we ensure that healing remains at the center of all our efforts.

The Enduring Puzzle of Addiction: Genetics, Trauma, and the Human Condition

As we continue to grapple with addiction in the U.S., it's easy to assume that advances in science and psychology have brought us closer to a solution. But for Dr. David Deitch, a lifelong observer and practitioner in the field, the hard truth remains, we may not be much closer than we were a century ago.

"I don't think there's any place in the world where we've reached a truly rational, problem-solving approach to addiction," Dr. Deitch reflects. "We still don't have a widely accepted or conclusive understanding of the roots of substance overuse. The same themes, circumstance, chemistry, and plain accident, have been with us for hundreds of years."

While today's practitioners may be more attuned to the nuances of substance use than in decades past, Dr. Deitch points to one enduring truth: the role of genetics. "There's a vulnerability that runs through

see Dr. David Deitch on page 45

Westchester County Develops "Lives Forward" Program - Providing Mental Health and Addiction Peer Training for Justice-Involved Individuals

By Joseph A. Glazer, Esq.
Deputy Commissioner
Westchester County Department of Community Mental Health

The philosopher Søren Kierkegaard said, "Life can only be understood backwards, but it must be lived forwards." Few things illustrate this better than using one's lived experience to support another person seeking recovery from co-occurring disorders. Now formally recognized as "peer" support, this approach allows individuals who are successfully navigating their own recovery to share their insights and achievements to guide others on their journey.

The Federal Substance Abuse and Mental Health Services Administration (SAMHSA) highlights the value of peer support in recovery: "Peer support workers are people who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse. Peer support services can effectively extend the reach of treatment beyond the clinical setting into the everyday environment of those seeking a successful, sustained recovery process."

Lives Forward graduation for the fifth cohort of students, held in early December in the Westchester County jail.

Co-occurring disorders (the simultaneous presence of mental health and substance use disorders) can be complex and challenging to treat. Treatment systems are often misaligned, requiring individuals to navigate a range of service providers and treatment approaches. Individuals with lived experience can play a vital role in supporting others on their recovery journey. Both the New York State Office of Mental Health (OMH) and the Office of Addiction Services and Supports (OASAS) have established certification protocols to ensure that well-trained paraprofessionals serve as Peer Specialists (mental health) and Recovery Coaches (addiction).

The value of peers with lived experience is recognized throughout the treatment world. Hospitals, residential providers, outpatient clinics, mobile crisis teams and more are all seeking trained, certified peers to incorporate into their systems of care. The NYS Offices of Mental Health and Addiction Services and Supports are incorporating peer services into their licensed programs.

Lived experience can, and frequently does, include contact with the criminal justice system, often intertwined with co-occurring disorders. Research shows that 30-50% of incarcerated people have, or had, significant co-occurring disorders, with an additional percentage being diagnosable with one or the other. According to SAMHSA (2020), there are lower rates of mental health disorders and SUDs within the community than compared to rates within incarcerated people. Another statistic reported from the National Survey on Drug Use and Health (NSDUH) found more than 9 million adults meet criteria for a mental illness and substance use disorder simultaneously. Another report from the Bureau of Justice Statistics (BJS) (2017) reported that 42% of state prison inmates along with 37% of federal inmates meet criteria for a co-occurring disorder.

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Turning Data Inward: Predictive Analytics for Early Burnout Prevention in the Behavioral Health Workforce

By Curtis Forbes
CEO and Founder
MustardHub

Burnout doesn't announce itself. It shows up discreetly in copy-paste patient notes, rushed treatment plans, and quiet complaints to colleagues on a longer-than-it-should-be lunch break. Team morale starts to slump even before they quit, and it gets worse when remaining clinicians inherit their workload. By the time leaders see the physical signs of exhaustion, the clinician is already out the door.

Leaders feel blindsided, but the signs were always there. In a recent study from the American Psychological Association (APA), 52% of surveyed psychologists say their patients have more severe symptoms now than they did a year ago, and 26% say they see more work now than 12 months prior. The heavy case load and emotional toll inevitably wreak havoc on their mental health.

But the signs are also in the minutiae of employee data — calendars, payroll, HR systems. With the right tools, healthcare leaders can analyze employee data from inputs across the business and use the insights to detect burnout before it becomes turnover.

The Cost of the Burnout Crisis

Burnout isn't something to grin and bear. It has massive repercussions on the efficiency of your health system, the quality of patient care, and your bottom line.

A single exit can add up to thousands of dollars when you calculate the time and money it takes to recruit, hire, train, and certify new talent. Data from a Next Gen Healthcare and Behavioral Health Business white paper highlights that staff turnover costs about $7,600 per physician, estimating a $270,800 a year bill for the average hospital that experiences a 1% increase in registered nurse turnover costs.

And then there's the indirect costs, like lapses in patient care. Disconnected employees take weeks to do tasks that used to take minutes. Their favorite patients become just another responsibility, and they're less engaged in session. What's worse, patients feel this disconnect. The more mental health providers become checked out, the more they risk compromising the quality of patient care.

Costs start racking up at the first sign of overwhelm. That's why it's essential to get ahead of it. To detect burnout and signs of disengagement before they even happen.

Turning Analytics Inward to Spot the Signs

Healthcare providers use data from multiple systems to monitor patient progress and improve health outcomes. When a patient's anxiety scores spike, providers intervene. When sessions are consistently missed, they reach out. When symptoms plateau, they change approaches.

This data-driven vigilance has become standard practice for patient care — tracking subtle indicators, spotting warning signs early, acting before crisis hits. Yet organizations rarely turn this same analytical lens inward to support their own clinicians. With the right analytics, leaders will be able to tell if the psychologist who seems dedicated on the outside is just going through the motions.

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Strengthening the Behavioral Health Workforce: Leadership Strategies for a System in Transition

By Sarvesh Mohan, CPHQ, CPPS, CHFP, PMP
Healthcare Leader

Across North America, healthcare executives are facing a reality that can no longer be ignored: the behavioral health care workforce is stretched thin, unevenly distributed, and increasingly overwhelmed by the growing complexity of patient needs. The demands of mental health and addictions care have surged, while traditional models of training, staffing, and service delivery have struggled to keep pace. What emerges is a clear message to system leaders: strengthening the behavioral health workforce is no longer a project; it is a strategic imperative that requires innovation, coordinated action, and courageous leadership.

Workforce Under Pressure

The past decade has revealed deep cracks in the behavioral health workforce pipeline. Recruitment has failed to meet service demand, especially in rural and northern regions. Burnout among clinicians, from psychiatrists to social workers to addiction counsellors has become commonplace. Many teams work under chronic staffing gaps that compromise continuity of care and create a cycle of turnover.

At the same time, the needs of patients are becoming more complex. Comorbidities, trauma histories, substance use, social isolation, and homelessness often intersect. Traditional one-to-one models of care are no longer sufficient, and providers need new competencies in trauma-informed care, cultural safety, crisis de-escalation, digital technologies, and interprofessional collaboration.

For healthcare leaders, this moment calls for more than incremental improvements. It requires system-level strategies that reshape how we attract, retain, train, and support the behavioral health workforce.

1. Transforming the Talent Pipeline

The first priority for leaders is rebuilding the workforce pipeline in a way that acknowledges modern realities. For years, behavioral health careers have been positioned as emotionally demanding with limited growth opportunities. A stronger value proposition is needed.

Reframing Behavioral Health Careers - Executives can reposition behavioral health roles by emphasizing advanced practice opportunities, leadership pathways, and exposure to innovative care models. Recruitment messaging should highlight professional autonomy, the meaningful nature of the work, and opportunities to lead transformation efforts.

Reducing Barriers to Entry - Strategic partnerships with universities and colleges can expand enrollment in social work, counseling, nursing, and psychology programs. Hospitals and health authorities can also advocate for accelerated bridging programs, micro-credentialing, and competency-based training that fast-tracks qualified candidates into the workforce without compromising quality or safety.

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Using Trauma-Informed Supervision and Reflective Practice to Navigate Countertransference and Vicarious Trauma

By Marc Liff, LCSW ACSW
Senior Clinical Social Worker
SUNY Downstate Health Sciences University Special Treatment and Research Program (STAR)

Most mental health professionals currently engage or have engaged in supervision during their careers. Some view this as a chore to be completed as soon as possible during the week. Some view supervision as an opportunity to learn and grow professionally. Some see this as only an administrative task where the “numbers” are examined. Unfortunately, many supervisees do not view supervision as a venue to raise countertransference or vicarious trauma issues that they may be experiencing for fear of being judged, ridiculed, deemed incompetent, shamed, or other reasons. Often, this is the result of a supervision environment that feels unsafe or untrustworthy to the supervisee. Implementation of trauma-informed principles into supervision can provide a remedy for this as well as allow for reflective practice to effectively occur between the supervisor and supervisee within the context of countertransference and vicarious trauma.

Trauma-Informed Supervision

In regard to trauma-informed supervision, Knight (2018) states “The basic requisites of trauma-informed supervision include knowledge of trauma and its effects on clients, indirect trauma, core skills of clinical supervision, and core precepts of trauma-informed practice and care” (P.18). Safety, trust, choice, collaboration, and empowerment make up the five main principles of trauma-informed supervision (Knight, 2018; Knight, 2018; Narouze, et al. 2023; Berger and Quiros, 2014; Varghese et al. 2018). “Mirroring principles of trauma-informed direct practice, central to supervision for such practice is creating a supervisory environment that promotes emotional and physical safety, trustworthiness, choice, collaboration, and empowerment” (Varghese et al. 2018, P. 4). Hurless (2024) indicates that a supervisor who practices trauma-informed principles as well as supervision through the perspective of trauma may provide benefits for the supervisee especially those experiencing countertransference or other issues.

Trauma-informed supervision is supported by the principles of safety, trust, choice, collaboration, and empowerment. In terms of safety, the supervisee should feel safe enough to openly share the experiences, thoughts, and feelings that are present and the supervisor should be cognizant of the factors needed to make the environment feel safe (Narouze et al, 2023). Trust builds and grows when the supervisor ensures that professional boundaries are maintained in the supervision session, expectations are clear, and the supervisor has been consistent in professional behavior, reactions, and feedback (Narouze, et al. 2023). Choice is formed when supervisees have an active part to play in identifying options, alternatives, and choices in which to apply in their work with clients (Berger and Quiros, 2014; Narouze, et al. 2023). Collaboration occurs when the supervisor works with the supervisee in identifying the options and choices which appear to be the most effective. This helps to build an

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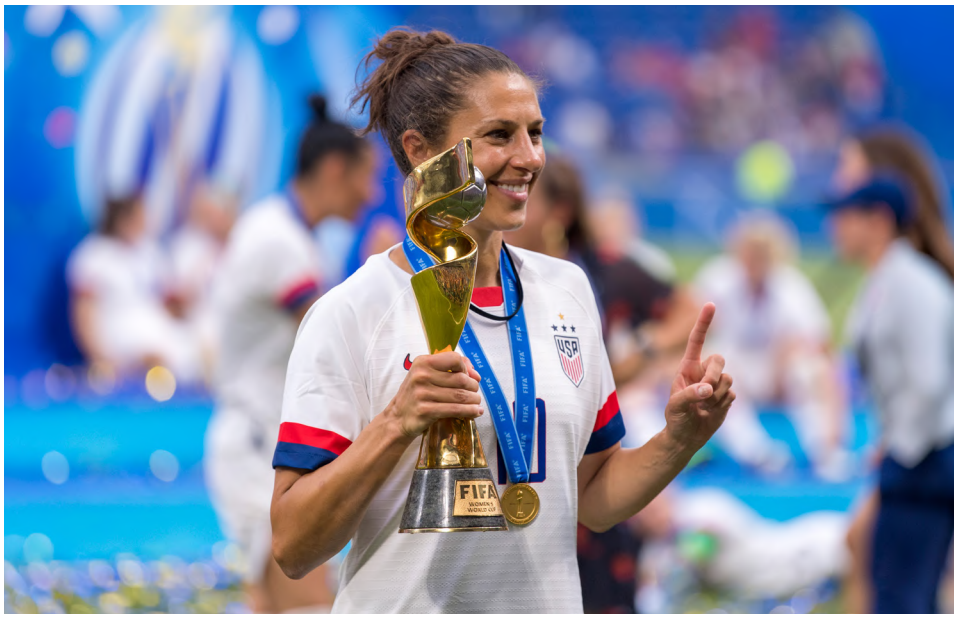
An Exclusive Interview with U.S. Soccer Legend Carli Lloyd: Advice for High School Athletes on Mental Health and Thriving Under Pressure

By Chandler Stone
Mira Costa High School, CA

Few athletes know pressure like Carli Lloyd. Across two decades on the world's biggest stages, she not only met it, but she also thrived in it. I wanted to know her secret. With two Olympic gold medals, two FIFA World Cup championships, she's a National Soccer Hall of Fame member, and two-time FIFA World Player of the Year. She has challenged gender stereotypes, and inspired millions of young athletes globally. Most known for her career with the U.S. Lloyd has made history earning 316 National Team Appearances, 134 goals, and 64 assists. Today she brings that same drive and insight in front of the camera, working as a TV analyst for FOX Sports, covering men's and women's soccer for millions of viewers.

I had the opportunity to sit down with Carli to talk about the toll pressure can take, how conversations around mental health have evolved, and what advice she has for high school athletes, like me, who are navigating their own challenges.



Carli Lloyd on the U.S. Women's National Team
c/o ISI Photos and U.S. Soccer

Chandler: There's often pressure to 'tough it out' in sports. Was there ever a moment where you realized strength also meant allowing yourself to feel and reflect?

Carli: I pushed myself a good portion of my career. I felt like the space I was in for several years didn't really give me the grace of not putting as much pressure on myself. That was the environment created within our team was that we had to push, we had to be strong, and you couldn't show any sign of weakness. I feel like it wasn't until I got near the end of my career where I kind of let my guard down a little bit and became more vulnerable. I think there's a fine balance of pushing yourself and knowing the situation you're in, but also giving yourself that grace to know that it's ok to show some signs of weakness, but I felt like during my time, there was not a space for me to be able to do that, because I felt like my spot would've been taken.

Chandler: Were there any specific moments in your career where you felt that your mental health was being overlooked?

Carli: I think what's hard is when you get to the top of somewhere, the expectation and the pressures that come with it are really, great. My generation of players, I would say, you had to get through a lot of those moments. There were teammates that doubted me, there were coaches that doubted me, there were media and fans that doubted me, all these things throughout my career, and I just said you know, I'm going to roll my sleeves up. I'm going to work even harder. I'm going to prove the doubters wrong. I think it's just a different space now, where people are focusing a little more on the mental health side, but I wouldn't do anything necessarily different because I think that it hardened me, made me stronger, made me into the player and person that I am today. But I don't think people really made an effort to hone in on people's mental health. It was just a different time, a different era, but I embraced that and fought back even harder.

see Carli Lloyd on page 46

Addressing Nonparticipation in Treatment Courts: The 5 As Framework

By Michael McGee, MD, DLFAPA
President
WellMind Inc.

Treatment courts face persistent challenges with participants failing to fully engage in treatment or dropping out altogether. Because engagement and retention are critical to public safety and outcomes, treatment courts must understand why nonparticipation occurs and how to respond when it does. This paper summarizes major predictors of nonparticipation and dropout and outlines practical principles and processes—especially the 5 As framework—for cultivating engagement and collaboration in treatment court settings.

Nonparticipation is common across healthcare and behavioral health. Roughly half of patients prescribed psychiatric medications do not adhere as recommended, psychotherapy dropout rates hover around 20%, and treatment court dropout rates are frequently about 40% (Laranjeira, 2023) (de Las Cuevas, 2023) (Linardon, 2018) (Coy & Estrellado, 2024). Nonparticipation is consistently associated with poorer long-term outcomes, higher relapses and recidivism, and greater costs for individuals and communities (Evans E, 2009) (Shannon LM, 2018). These realities underscore the need for treatment courts to identify participants at greatest risk of dropout and to use strategies that promote engagement from the outset.

Participant Contributors to
Nonparticipation and Dropout

Several individual factors reliably predict nonadherence or premature termination from treatment programs.

Unemployment and socioeconomic stress: Unemployment and unstable work histories predict lower treatment adherence. Individuals without steady income often face housing instability, transportation barriers, and competing demands that interfere with regular attendance (Åhs A, 2012).

Lower education: Lower educational attainment is associated with fewer coping resources, less familiarity with formal systems, and a more limited understanding of treatment concepts, all of which may contribute to confusion or disengagement (Silva M, 2022).

Severity of addiction and co-occurring mental illness: Greater addiction severity and co-occurring psychiatric disorders increase the risk of nonparticipation (Daigre C, 2021). Severe symptoms, chaotic lifestyles, and hopelessness can make consistent engagement in structured services feel overwhelming.

Structural barriers and stigma: Nonparticipation is also shaped by structural factors: limited treatment capacity, unstable program funding, fragmented services, and stigma—particularly around medications for opioid use disorder (Dickson-Gomez J, 2022).

Criminal justice history, motivation, and perceived program difficulty: Participants with more extensive criminal justice involvement may experience greater distrust in systems and anticipate failure. Low intrinsic motivation for treatment and perceptions that the program is too difficult, punitive, or irrelevant further increase dropout risk (Evans E, 2009) (Shannon LM, 2018).

Clinical Factors Affecting
Dropout and Nonparticipation

Many influences on participation lie within the control of clinicians and treatment teams.

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Re-imagining Conservatorship: Recovery and Career Planning Through Peer Support

By James A. Ritchie, PhD, CMPSS
Director of Operations
Crestwood Behavioral Health, Inc
Recovery Resilience Solutions

For most young people, career guidance centers on traditional roles—doctor, teacher, engineer, builder. Rarely does anyone tell a child struggling with a mental health condition that their experiences might one day qualify them for a career rooted in healing, empathy, and shared understanding. Instead, early diagnoses often bring limitations: internalized stigma, discrimination in schools and workplaces, and, in some cases, legal intervention in the form of conservatorship. Under conservatorship, individuals may be deemed unable to manage their own physical, financial, or routine decision-making needs. While conservatorship is justified as a tool to ensure safety and care, few would argue that the current system represents the most effective model for supporting long-term recovery—particularly amid a national landscape where community-based mental health services remain severely under-resourced.

The true value of a Peer Support Specialist (PSS) is rooted not only in formal training but in the depth of lived experience each practitioner brings to the work. While the 80-hour certification training defines our scope of practice, the real preparation begins years—sometimes decades—before a PSS ever steps into a classroom. It is shaped by personal encounters with mental health challenges, the long trajectory toward recovery, and the resilience forged along the way. For many, these experiences give rise to the essential question: *Why is this happening to me?* Peer Support reframes that question by offering a profound answer—our lived experiences can become the foundation for meaningful, purpose-driven work that supports the recovery of others.

The emerging professionalization of Peer Support offers a critical inflection point. Since becoming a formally recognized Medi-Cal certifiable discipline in California on July 1, 2022, Peer Support has brought a transformative lens to longstanding challenges in behavioral health. As highlighted by the President's New Freedom Commission Report of 2002, integrating lived experience into care models improves recovery outcomes and strengthens the entire system (Mills et al., 2006).

One of the most innovative applications of this approach is the Peer Employment Learning Center (PELC), developed within California, and based on the new certification standards for the discipline of a Peer Support Specialist. Founded on the belief that *all people can recover*, PELC was created specifically for individuals placed on conservatorship. The model embraces an essential truth: people do not need to wait until after conservatorship to begin building a future. They can start that journey while still in care, using their lived experience to actively train as Peer Support Specialists.

A Statewide Investment in Recovery

PELC operates across five geographically diverse psychiatric facility settings in California—San Diego, Bakersfield, Eureka, Pleasant Hill, and Fresno/Kingsburg. The program identifies potential participants

see Peer Support on page 47

Integrated Psycho-Oncology: A Mandate for Behavioral Health Leaders

By Dr. Josh Myers, PhD, LPC-S
Co-Founder & CEO
Adjuvant Behavioral Health

For decades, the standard of care in oncology has prioritized the defeat of the disease. While medical advancements have transformed cancer into a complex, chronic illness for many, they have left a significant gap in clinical responsibility. The reality is that cancer is a profound psychological and systemic crisis, demanding an integrated response.

This demands an intentional shift in focus from behavioral health leaders: treating the patient's physical body without intentionally treating the person, their family, and their emotional landscape is incomplete medicine. The integration of behavioral health into oncology, known as psycho-oncology, is not an optional add-on; it's a clinical and systemic necessity for achieving true whole-person cancer care. This transition requires crucial leadership and a commitment to operationalizing evidence-based models.

The Crisis of Care: The Unmet Need

The data paints a stark picture of the immense and often unmet psychological need in oncology: While many patients experience distress that warrants clinical intervention, studies show that an estimated 70 percent of cancer patients experiencing psychological distress do not receive appropriate behavioral health care (Sharpe et al., 2014).

Ignoring this distress has critical consequences beyond emotional suffering, impacting quality of life and survivorship outcomes. Behavioral health leaders must understand the full scope of the clinical imperative, which includes addressing four major areas of distress:

- **Clinical Disorders:** The high prevalence of diagnosable conditions, with up to 40% of patients meeting criteria for mood or anxiety disorder during treatment (Shalata et al., 2024). This often includes depression, generalized anxiety, and cancer-related Post-Traumatic Stress Disorder (PTSD).

- **Existential and Identity Distress:** Cancer disrupts identity, sense of purpose, and life plans. Fear of recurrence (known as "scanxiety"), grief, and demoralization are pervasive issues that require specialized psychosocial support.

- **Financial Toxicity:** The immense cost of cancer care is a recognized stressor that contributes to psychological distress, treatment non-adherence, and diminished quality of life.

- **Caregiver Burden:** The crisis extends to the family unit. Caregivers often experience significant rates of depression, anxiety, and physical exhaustion; their untreated distress can compromise the patient's ability to adhere to treatment. Our model must inherently treat the whole family system.

For behavioral health leaders, this pervasive unmet need translates to a clear mandate: we must close this 70% gap by moving from reactive, disjointed referrals to proactive, embedded, and technology-enabled support.

Actionable Strategies for Behavioral Health Leaders

To move beyond fragmented care and champion the whole-person model, leaders must focus on three core areas:

see Psycho-Oncology on page 41

Relationships are Defined by How They End: The Importance of Acknowledging Loss at Work

By Elaine Edelman, PhD, LCSW, CASAC-Adv., Professor of Practice – Social Work and Addiction Counseling Kansas State University

Death, as well as other major losses, is dealt with differently by different agencies and at different times in the life of an agency. Our "work family" is often an important part of our lives, so it is important to realize that dealing with loss at work sets the tone for how these relationships are experienced. Major losses at work can also include an important team member leaving or even losing a valued program. In my observation, relationships are often defined by how they end. Not acknowledging a death, or a team member's departure, leaves people without a collective space to mourn. It begs the question as to whether we matter to the people we work with or the agency as a whole. It's all well and good to have a "staff appreciation day" or a glowing evaluation, but if the most consequential thing that can happen to us, besides being born, is ignored or minimized, no expression of appreciation can truly be felt to be valid.

My family recently suffered a sudden and devastating loss. A beloved cousin, who had been dealing with renal disease for years, took a sudden turn for the worse. My daughter hopped on a plane from Washington State to New Jersey to see her, knowing that the end was near. Sadly, she did not arrive in time. She took some comfort in knowing that at least she would be there for the funeral. Unfortunately, this was during a period when temperatures were in the teens. Since many of my cousin's friends and relatives were in their seventies, it was decided by her immediate family to forgo a funeral and have a memorial service in a few weeks, when the weather was more conducive to gathering. While this was clearly in the best interest of all involved, my family felt a collective emptiness. What do we do with all these feelings of loss? Where were the rituals that gave us guidance and comfort during the worst of times? The circumstances dictated how we would collectively mourn but did not change the hollow feeling. This event gave me pause to appreciate the importance of collective mourning, of having a structure to connect, as well as a time and place to experience grief. It also brought back memories of experiences I've had at workplaces where grief and mourning were ignored.

During the pandemic, agencies were scrambling to do everything they could to keep everyone safe. I became aware of the death of a young case manager at my agency. Little was said about the cause of death. Given the chaos of those early days of the shutdown, no memorial service was scheduled (although a virtual gathering could have been arranged). I remember the first Zoom meeting after we learned of their passing. There was no mention of the death or moment of silence. The feeling after that first staff meeting included a lack of closure and a painful existential question. *If this person's death would go unacknowledged, would it matter if I disappeared? Do any of us matter to this organization?*

A more egregious example of minimizing the death of someone occurred at an agency that employs many peer workers. One of the peers, who was known to his co-workers for years, began to deteriorate

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Connecting Workplaces to Wellness: Structural Solutions to Burnout

By Kara Cloud, BA
Team Awareness Workplace Wellness Project Coordinator
National Council on Alcoholism and Drug Dependence – Rochester Area

What percentage of your time at work is spent connecting with others? A central tenet of behavioral and mental health care is how we show up matters. Yet, a desire to care for the wellbeing of others does not directly translate to wellness among our workforces. The National Council for Mental Wellbeing's 2023 survey found 62% were experiencing moderate or severe levels of burnout. This trend is not isolated to behavioral healthcare, with a 2021 survey of 238 businesses across various industries in New York State finding that half were experiencing financial loss due to workforce wellness concerns, and leaders were spending approximately 39% of their time responding to these issues, often reactively addressing crises after they have taken a toll.

These widespread concerns prompted the U.S. Department of Health and Human Services to release the 2022 Surgeon General's Framework for Workplace Mental Health and Wellbeing, which identifies Connection and Community as essential ingredients for workplace wellness. To understand why connection is key to workplace wellness, it helps to consider what burnout entails. The Maslach Burnout Inventory describes three components of burnout: exhaustion, depersonalization, and reduced personal achievement. Each component can be considered an arena of disconnection: first from one's role, then from others, and finally from one's sense of self. Recognizing burnout as disconnection reveals the path forward: to prevent and remediate burnout, organizations must adapt and develop strategies to strengthen connections in the workplace.

What is Connection

Connection is defined as a verb "to bring together or into contact so that a real or notional link is established," or a noun "a relationship in which a person, thing, or idea is linked or associated with something else." While connection in the workplace can begin with the employment contract, it reaches far beyond this initial link and continuously shifts due to the bidirectional nature of connection. Examples include how often employees meet with supervisors and what is typically discussed, the social norms established in a case conference, or the expected responsiveness and degree of helpfulness of care management team members. The complexity of these examples demonstrates why workplace connections are often implicitly understood, rather than explicitly addressed. SAMHSA's Toolkit for Addressing Burnout in the Behavioral Health Workforce, released in 2022, highlights two often overlooked examples of connection in the workplace: organizational culture – the way work is completed based on shared norms, and organizational climate – the way employees perceive the overall work environment. Organizational culture describes how things are done, while climate reflects how it feels to work within the organization. Connections play a vital role in shaping culture and climate, showing up as shared norms, group perceptions, and overall environment.

Connection as a Structural Intervention

Commonly, workplace health promotion programs aim to address individual employees by offering support in making

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Healing at the Source: How Tribal Nations Are Redefining Substance Use Disorder Treatment

By Douglas M. Leech
CEO
Ascension Recovery Services

Substance use disorder (SUD) has taken a devastating toll on the Nation's Tribal Lands, yet Tribal Nations are confronting the crisis with courage, creativity, and cultural wisdom. Native communities carry a disproportionate burden of addiction and mental health challenges while facing some of the most limited access to care, particularly culturally relevant care that honors the spiritual dimensions of recovery.

To bridge this gap, Tribes are forging their own pathways to healing. At Ascension Recovery Services (ARS), we have the privilege of partnering with the Pawnee Nation of Oklahoma on one such effort: a landmark behavioral health and SUD treatment center. The Pawnee Nation Behavioral Health Facility represents more than a building; it's a declaration that lasting recovery is grounded in community.

The Pawnee Nation Behavioral Health Facility

A National Crisis that's Close to Home

SUD touches nearly every family in America, but for Native peoples the impact is especially profound. Youth in Tribal communities often begin substance use earlier and experience more co-occurring conditions. National surveys show that roughly 41% of American Indian and Alaska Native adults report either a SUD or mental illness diagnosis within the past year, far above the national average. CDC data show that overdose mortality among American Indian and Alaska Native people is now the highest of any racial or ethnic group at 65 deaths per 100,000 in recent years.

Too often, treatment options are hours away, under-resourced, and culturally disconnected. Traditional Western programs rarely integrate ceremony, language, or community healing practices essential to Native identity. This leads to lower engagement, shorter retention, and missed opportunities to change lives.

Why Tribal-Led Solutions Matter

Successful healing solutions must be shaped by those who understand the root causes of pain; addiction is no exception. When Tribes design and operate their own behavioral health systems, they define what true wellness means. Locally led programs repair trust and allow traditional and evidence-based methods to coexist.

Additionally, tribally owned health centers keep economic resources where they are needed most: within the community. Every counselor hired, meal served, and support contract awarded strengthens the local workforce and reinforces Tribal sovereignty.

The Pawnee Nation's Blueprint for Healing Sovereignty

The newly completed Pawnee Nation Behavioral Health Facility is a $22 million initiative that includes a 26-bed detoxification and residential unit, outpatient services, and wraparound care for individuals and families navigating addiction. What makes the project extraordinary is not only its cultural design but its financing: the facility was built at no direct cost to the Tribe.

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Amplifying Peer Specialists in the Behavioral Health Continuum of Care

By Jantra Coll, PhD
and Johnell Lawrence, MSW
Vibrant Emotional Health

We have witnessed the ongoing strain on our traditional mental health care system over the past five years. There is a growing need for help across communities, where help seekers are experiencing nuanced mental health challenges. From suicidality, stress, bullying, substance misuse, to family planning, systems navigation, and relationship woes, getting access to a mental health service and making that first appointment can feel insurmountable.

For many, the process of accessing a mental health service is even more challenging during their time of need, due to lengthy intake processes and changes in providers. Recent data indicate that our current national network of healthcare providers is only meeting 26% of the actual need, and an additional 6,200 providers would need to be hired to help alleviate this shortage.

The pathway to expanding the vital workforce needed is quite challenging and might take too long to provide sustainable relief to the system. Obstacles like a lack of funding and low reimbursement rates for services continue to dissuade some providers from specializing in mental health.

Even earlier in the process, obtaining clinical degrees or licensure is not always possible. Salary disparities across systems cause many qualified providers to seek out administrative roles or private sector positions that may be more flexible and better for their well-being but are inaccessible for many of our help seekers.

What remains is an ongoing need for affirming and accessible services for communities. This is an opportunity to truly highlight the value and therapeutic benefits of lived experience to carry us through this gap.

Why Peer Support Is Essential to Modern Mental Health Care

Peer support bridges the clinical with the essential by bringing lived experience, pairing individuals seeking care with trained advocates who have navigated similar challenges and can offer guidance grounded in empathy, trust, and real-world understanding. At Vibrant Emotional Health (Vibrant), we have prioritized peer roles across all service lines: crisis hotlines, youth education, and family and youth wellness programming. As an organization with both deep crisis-focused expertise and a breadth of preventive programming, we know how essential it is for every individual to receive thoughtful and compassionate care, no matter the trauma or complexity. To us, this means paving a pathway via a supportive framework that centers the individual's expressed needs rather than prescribing treatment at the outset.

Building trust is vital to retention in care. Therefore, co-creation and collaboration are vital for the desired outcomes and impact of services. Task-sharing is a viable option to meet the needs of our communities and uplift essential and valued health workers to bridge the visible treatment gaps.

Peer specialists are globally recognized as qualified non-specialists or paraprofessionals who can offer low-intensity mental health support. Instead of relying on traditional mental health specialists to provide support, much of the care can happen within communities, led by those who have successfully navigated these systems and thrived.

In the United States, the peer support role continues to be underutilized due to the lack of understanding regarding what

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Meeting the Moment: Addressing the Challenges to Advance Solutions for Mental Health Clinical Trial Recruitment

By Suzanne Harris
Senior Vice President
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SubjectWell

Mental health has become one of the most urgent and complex public health challenges of our era. Today, more than 1 billion people globally live with some form of a mental health disorder.[1] Among young people, the situation is equally concerning: 1 in 7 adolescents experience a mental health condition during the critical period of emotional, cognitive, and social development.[2] Alcohol and substance use disorders affect an additional 400 million individuals worldwide,[3] with prevalence projected to rise in the coming years as economic instability, social isolation, and chronic stress continue to heighten vulnerability.

Stigma is often a large part of why individuals don't seek diagnosis. Globally, 75% of those with mental, neurological, or substance use disorders receive no treatment at all.[4] Access disparities are compounded by gender differences: women are significantly more likely to experience depression and anxiety, while men face higher rates of early-onset schizophrenia and substance use disorders. Yet despite the breadth and depth of the crisis, mental health accounts for only 2% of domestic government healthcare spending worldwide.[5] This global deprioritization creates a disconnect that leaves millions without support.

The consequences reverberate far beyond emotional well-being. Mental health conditions now account for more years lived in poor health than cardiovascular disease, respiratory disease, diabetes, kidney disease, and cancer combined.[5] They also intensify the difficulty of treating nearly every chronic illness, compounding healthcare needs, complicating clinical decision-making, and driving higher utilization of healthcare resources. Because mental health influences the trajectory of so many other conditions, improving mental health outcomes is not only a clinical imperative but a foundational step in reducing the global burden of disease.

Against this backdrop, clinical research holds immense promise. New treatment modalities—including digital therapeutics, precision psychiatry approaches, neuromodulation tools, and next-generation psychopharmacology—offer opportunities to transform care. But these innovations cannot move forward without successful clinical trials, and mental health trials face some of the steepest recruitment and retention challenges in medicine. Understanding and addressing these obstacles is critical to developing more effective therapies and improving the lives of those living with mental health conditions.

Why It's So Hard to Recruit for Mental Health Trials

Recruitment and retention for mental health studies present distinct complexities shaped by human experience, clinical variability, and operational realities. Unlike in other therapeutic areas—where symptoms often follow clearer biological pathways or where patients are already embedded in structured care systems, mental health trials must navigate layered barriers that influence willingness, eligibility, and ability to participate.

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The Impact of Peer-Based Storytelling on Workplace Mental Health

By Maggie G. Mortali, MPH
and Jennifer Da Silva, MPA
NAMI-NYC

Peer-based storytelling is critical to individual recovery and creating healthier workplace environments. Centering lived experience, NAMI-NYC community member Sabrina shares about her mental health challenges as well as the loss of her son to suicide at NAMIWalks NYC + Mental Health Street Fest 2025. Credit: By Veronica Photography

NAMI-NYC participant reflections illustrate why a peer-based approach matters. One participant shared that they did not know anyone in their life who had experience depression and that hearing a peer speak made them feel less isolated, saying, "I don't have anyone who has depression around me, so hearing from you makes me feel like I'm not alone." Another participant said that the presentation gave them new language to use with family members, stating "Very powerful and brave. This presentation has given me more dialogue on how to approach mental health with family." These reactions are common across workplaces and demonstrate why storytelling can reach employees who may not engage in traditional training.

Workforce wellbeing is a proven contributor to productivity and retention. National estimates suggest that disengagement and unaddressed mental health concerns result in substantial losses each year (Gallup). Individual skill building is important, but individual level strategies work best when managers and senior leaders reinforce healthy expectations and model open communication. For this reason, NAMI-NYC applies to a public health approach that addresses the individual, interpersonal, and organizational levels of a workplace. Peer-based presentations and storytelling are part of this framework.

Peer support refers to a range of activities and interactions among people with shared experiences of living with a mental health condition, substance use disorders, or both (SAMHSA). This shared experience increases trust and helps normalize conversations about mental health. NAMI-NYC's peer-based programs, including In Our Own Voice, Ending the Silence, and Family & Friends, often serve as a starting point for employers seeking to invest in their workforce. Each of these presentations can be customized to specific workplaces from hospitals and universities to community organizations and Fortune 500 companies. Many employers incorporate peer-based elements into larger training series, including sharing stories of lived experience or intentionally offering time for meaningful discussion among attendees during sessions.

These presentations help shift workplace culture by creating space for vulnerability and shared understanding. At a multinational beauty company, NAMI-NYC delivered a five-part workplace resilience training series. Senior leaders began each session with their own stories about burnout and recovery. Employees reported that hearing these personal experiences increased their trust and their willingness to discuss mental health more openly. As a result, the company expanded both individual level wellbeing programs and broader organizational initiatives.

Peer-based presentations and storytelling also increase help-seeking and help-supporting behaviors. This recognition reduces hesitation to speak up or access support. After a NAMI-NYC presentation,

see Peer Storytelling on page 52

Keeping Clinicians in Private Practice: AI's Role in Sustaining the Behavioral Health Workforce

By Jonathan Seltzer
CEO
SimplePractice

The behavioral health workforce is under strain as demand for mental healthcare continues to accelerate. Over one third of the U.S. population lives in a Mental Health Professional Shortage Area as of 2024. Private practice clinicians are central to serving these communities, offering a low-cost model for inpatient behavioral health care by avoiding the corporate overhead that inflates costs in larger health organizations. Yet rising administrative demands threaten their sustainability.

Recruiting new clinicians won't solve this. Retention depends on ensuring existing practitioners have the autonomy and support they need to remain in practice, deliver high-quality care, and manage the administrative tasks that increasingly consume their time. As these pressures grow, supporting the day-to-day realities of practice has become just as critical as supporting clinical decision-making.

In addition to enabling several useful tools in the provision of care, thoughtful use of AI and technology can preserve what makes private practice work by reducing the administrative load, maintaining clinician autonomy, and creating more time for deep client relationships this model is defined by. These tools create the stability clinicians need to remain in practice, protecting access to care, and supporting the long-term strength of the behavioral health workforce.

The Private Practice Trade-Off

Most behavioral health professionals operate solo or small group practices. Unlike practitioners in large systems, they handle every business task themselves. Working independently allows them to control their schedule, make their own clinical decisions, and build long-standing therapeutic relationships within their communities. These relationships often deepen over years, giving clients consistency and trust that can be harder to achieve within more consolidated care environments. This model is powerful, but it comes with a trade-off.

Administrative responsibilities required to maintain a private practice continue to grow verifying insurance eligibility, following up on claim denials, completing credentialing requirements, managing scheduling and cancellations, and keeping up with documentation. These non-clinical burdens chip away at the advantages of private practice and create tension between spending time with clients and running a practice. This in turn drives burnout and can push clinicians to leave private practice entirely.

The Cost of Attrition

When a private practice clinician closes their practice or is less available, the impact is immediate. Clients wait months for new care. Therapeutic relationships built over years vanish overnight. Communities lose trusted providers they can't replace. This is particularly true in private practice, where sustained therapeutic connection is often central to a client's progress. Losing that connection can set clients back, derail momentum, and make care reengagement more challenging.

Keeping private practice clinicians in practice is not only a staffing concern, but a core access-to-care issue. Retaining

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Telehealth and Its Role in Expanding Workforce Capacity

By Temitope Fabayo, BA, MBA-HR
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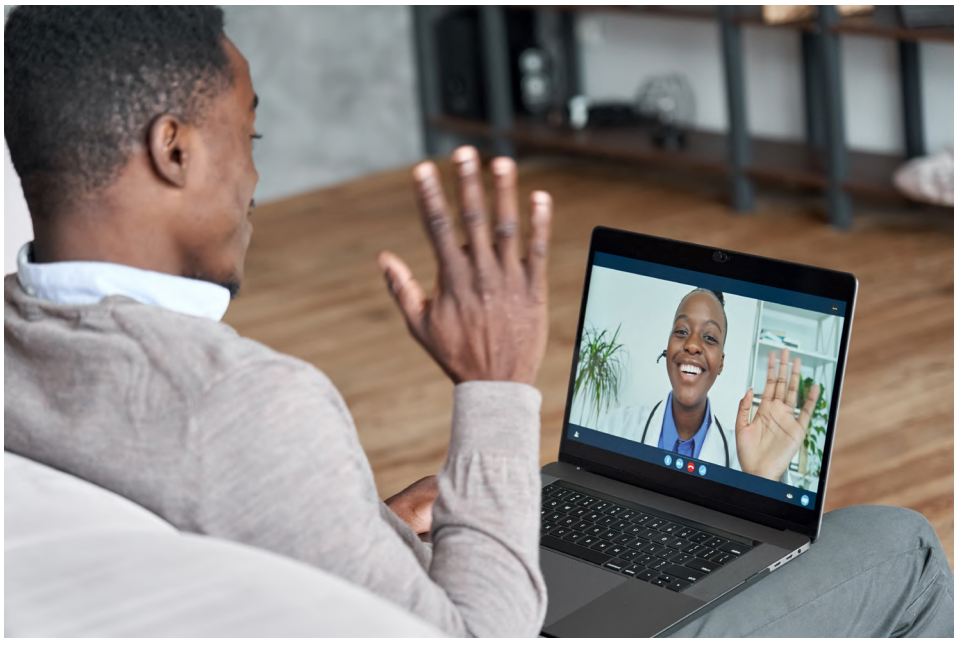

The truth is that accessing healthcare is a part-time activity. There is the morning travel, the hour (or three) you spend waiting in line at the doctor's office, the panic call to your boss about a late report, again. It is not only a nuisance, but it is a colossal waste of the most precious commodity of our time and our working capacity. But what should happen is that a large portion of this friction simply disappears? Hello Telehealth, the mute revolution that is doing much more than just providing screen-based care. It essentially adds to our workforce, puts idle time back to work, and makes people healthier and more productive at work. This is not merely one of the tech upgrades but a release of human potential.

Waiting Room versus Living Room

Consider your last visit to the half-day check-up of an employee or yourself. The math is sobering. A 20-minute follow-up to a stable condition may easily take 2-3 hours of travelling and waiting. Now multiply it by millions of appointments per year. With Telehealth, the timeline collapses to just 20 minutes in your office, your home, or your car during a lunch break. The saving of time is instant and dramatic.

However, the effect is more than a few hours saved. It's about continuity. A parent does not need to quit work early to pick up a sick child, take them to a clinic, and lose another half day. During a break, they can consult a pediatrician. An employee with a chronic illness such as diabetes or hypertension can undergo fast, frequent check-ins and not always have to vanish behind the desk, which will enable them to better manage their health conditions that can lead to larger, more damaging crises later. Telehealth transforms healthcare into an aspect of life without interrupting the working day.

The Facts Behind the Disruption

It is not a feel-good theory. The data is accumulating, with actual returns of workforce participation and productivity.

The Mental Health Lifeline Study: A 2018 study, involving a seminal study, concluded that patients in telehealth who underwent psychotherapy had significantly lower levels of absenteeism and presenteeism (being at work but not fully functioning) than those in only in-person care. With mental health support being more accessible and less stigmatized, as it is available at the convenience of their homes, telehealth has directly ensured that people remain more engaged and productive at their workplaces. It addressed the burnout until it resulted in a resignation.

The Chronic Condition Management Proof Point: A study in the American Journal of Managed Care highlighted a program for patients with complex chronic conditions. With remote monitoring equipment and frequent virtual visits, the program achieved a 63 percent reduction in hospital admissions. To the workforce, this is a massive development. Reduced hospitalization results in fewer catastrophic and long-term absences. The employees remain steady, regarding their treatment schemes, and more importantly, within the workplace.

The Integrity Multiplier: A report by the CDC itself highlighted a significant increase in telehealth use during the pandemic, particularly among populations with a history of transportation barriers or those

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Relapse is Part of Recovery, Shame Shouldn't Be: What I Wish More Families Understood

Chris Cummins
Chief Operating Officer
Laguna Treatment Center

When someone returns to treatment after a relapse, it's often with a heavy heart. They walk through our doors carrying the weight of shame, disappointment, and fear of judgment, not just from others, but from themselves. Families often ask, "what went wrong," and wonder why their loved one couldn't "get it right" the first time. But what I wish more people understood is that addiction is a chronic relapsing disease.

According to the National Institute on Drug Abuse, between 40% and 60% of people with substance use disorders relapse at least once. Relapses aren't a sign of failure; it's a sign that someone is still fighting. Every return to treatment represents courage, not defeat. I know firsthand that no matter how long it takes, recovery is always possible. I've seen it happen time and time again. The truth is that relapse happens. It's how we move forward that makes all the difference.

The "Pink Cloud" of Recovery

Individuals in early recovery often feel on top of the world. They feel confident they'll never drink or use again. They're in what we call the "pink cloud," or the honeymoon phase, of recovery. But eventually that wears off and old feelings and triggers return.

Consider this: someone who once drank to cope with loneliness in school may no longer face that exact trigger as an adult, but workplace conflict or relationship strain can reignite the same emotional need. The brain, conditioned over time, still recognizes alcohol as a source of relief. Without the right support and lacking the tools to cope in a healthy manner, that person is likely to reach for a drink to alleviate their distress.

As the COO of an addiction treatment provider, I know very well that sustained recovery requires more than just abstinence. It means addressing the biological, social, psychological, and systemic factors that contribute to relapse, and it requires ongoing care, support, and understanding.

Because eventually the pink cloud will fade and the enthusiasm for recovery may begin to wear down as challenges arise. Instead of ignoring it or shaming ourselves or our loved ones for these feelings, we must watch for the red flags and have a plan for what to do next.

When the Warning Bells Ring, Be a Lifeline, Not a Judge

Since relapse is a common part of recovery, we need to learn to recognize the warning signs so we can intervene early. Relapses rarely appear out of nowhere; it builds slowly, through familiar patterns and behaviors we can learn to spot.

Take, for instance, someone who starts dismissing their therapist's advice because they "know better," or refuses aftercare support because they believe they can do it alone. That's not independence; that's a sign of denial creeping in.

Isolation is another major red flag. The "I got this" mindset might sound strong, but it's a huge flashing sign of impending relapse. Recovery doesn't happen in solitude; it happens in community.

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What It's Really Like Living with Bipolar Disorder

By Hannah Soukup
Graduate
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Hannah Soukup

As of 2019, 0.53% of people in the world are bipolar, according to a study from the World Health Organization. I am one of them. Living with bipolar disorder isn't easy. Scholarly journals document the symptoms and struggles that come with this disorder, but they're far from accurate. Common systems include hypomanic and manic episodes, depressive swings, anxiety, psychosis and the rapid cycling of emotions. These symptoms often make it unclear what somebody with bipolar disorder is actually feeling on a day-to-day basis.

Diagnosis and Early Struggles

I was diagnosed with bipolar disorder II when I was 17 years old. Doctors aren't typically supposed to diagnose you until you're 18, but with the persistence of my condition, they had no choice.

It often doesn't come out of nowhere. Many cases are linked to genetics, according to a study from the National Institute of Mental Health. A close loved one of mine struggles with bipolar I, further proving bipolar disorder is hereditary. I didn't seem different than other kids until I was about 15. I began engaging in unsafe behaviors and dealt with a severe eating disorder all by the time I was 16.

What scholars seem to forget is that with bipolar disorder comes increased urges of substance abuse, unsafe behaviors, economic struggles and addiction, in any form. Furthermore, students with bipolar disorder are 70% more likely to drop out of college compared to students with no psychiatric problems, according to the National Alliance on Mental Health.

Impact on Relationships and Daily Life

I have firsthand seen rapid changes happen in one's life due to bipolar disorder. One of my loved ones has gone unmedicated with bipolar disorder for about 10 years now. He has learned to cope with his disorder, but not without prevalent issues. He dealt with extreme alcohol abuse, troubled relationships and more just in his adolescence. Medical journals seem to forget how difficult it is to maintain relationships when you're bipolar, specifically romantic relationships.

With my own personal relationships, I've struggled with maintaining a balance between being codependent on my friends and loved ones or completely going off the grid. There's a constant voice in my head telling me my friends and/or loved ones are angry at me among other things, which makes it difficult to be stable in relationships.

This wasn't mentioned in the textbook definition of bipolar disorder, was it?

Finding Balance and Treatment

Although it may sound hopeless, there are ways to live a fulfilling life with bipolar disorder. The most common ways to combat it are medication treatments, often using mood stabilizers or antipsychotics, such as Carbatrol, Lithium and Lamictal, as well as psychotherapy and lifestyle changes, according to MyDepressionTeam.

I went to therapy on and off for about five years. I stopped last year as I felt confident in my ability to cope, and since then, I've learned what triggers hyperactivity and irrational thoughts. Therapy has helped me tremendously, and although it's often looked down upon, once the right therapist is found, it can make a huge difference. If therapy is not for you, or you simply don't have access to it, there are resources out there to help you get better. For me personally, journaling and animal therapy have been lifesavers, but there are lots of healthy coping mechanisms to try. One is bound to be right for you.

Living with bipolar disorder is not a straight line. Some days I wake up feeling unstoppable, and other days, it feels impossible to get out of bed. What I've learned over the years is that neither extreme defines me. They're both part of who I am, but they don't control the entirety of my story. Finding balance is an ongoing process, not a destination.

Breaking Stigma and Building Support

I've also realized how important community is. When you're living with a mood disorder, isolation can become your worst enemy. Reaching out to people, even when it feels uncomfortable, is one of the most powerful tools you have. Whether it's a

see Bipolar Disorder on page 55

Reaching the Unreachable: Why Human-Centered Engagement is the Missing Link in Behavioral Health

By Lauren Barca, MHA, RN, BSN
VP of Quality
86Borders

Behavioral health needs are a major driver of overall healthcare use and yet they are still often overlooked across the care continuum. The total health care costs of undertreated behavioral health disorders are more than $290 billion each year in the U.S. alone. When behavioral health issues go unmet or undiagnosed, members tend to experience more medical complications, and their care becomes harder to coordinate. This makes it difficult for care teams to move the needle on engagement or stability when the behavioral health issues influencing a member's day-to-day life are not being addressed.

When behavioral health needs are not addressed, the entire care ecosystem, including plans and providers, often invests time and resources in ways that miss the real drivers of instability and rising costs. Traditional outreach like postcards, automated calls, and scripted reminders were never built for members with significant behavioral health challenges. A reminder to schedule a mammogram or colonoscopy does not land when someone is managing severe depression, anxiety, trauma, or the daily effort required just to function. If a member cannot reliably get out of bed, secure transportation, or keep track of appointments, informational outreach does not register. The issue is not awareness. It is whether the member has the capacity, the readiness, and the trust needed to engage.

The Role of Trust in Behavioral Health Engagement

Trust is often the starting point for meaningful engagement. Members are more likely to respond when the interaction feels personal and grounded in real listening. Human-centered engagement focuses on real conversations and thoughtful questions that help reveal what is happening in a member's life. Teams that use relational approaches pay attention to barriers the member may not say outright, such as untreated anxiety that keeps them home, fear or confusion about the healthcare process, or the emotional strain of recent events. These interactions bring forward the reasons behind missed appointments and gaps in care. When the connection feels genuine, members are more willing to take steps toward care. Trust creates conditions for engagement and stability, and without it, progress is difficult.

Social Barriers That Derail Care

Behavioral health challenges often appear alongside social needs that make it difficult for members to stay connected to care. Members who are navigating unstable housing, limited transportation, food insecurity, or unsafe environments often struggle to participate in care even when they want to. Many of these social challenges commonly co-occur with behavioral health conditions, creating even more complexity in how members navigate care. A care plan cannot move forward if it depends on stability the member does not have. Daily crises and unmet basic needs make participation nearly impossible. Identifying these barriers early through open, human-centered conversation helps care teams and community partners understand what support is needed. Addressing behavioral health and social needs together is essential because they often influence each other.

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Using NIATx Process Improvement to Enhance Workforce Recruitment, Hiring, Retention & Promotion

By Mathew R. Roosa, LCSW-R
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University of Wisconsin–Madison

Much of the focus on quality improvement in behavioral health is dedicated to "the what", as it focuses on enhancing the quality of services through the implementation and sustainment of high-fidelity evidence-based practices. But without also focusing on the process, "the how", the capacity for lasting improvement is limited.

The NIATx model for improvement, developed in 2003 at the Center for Health Enhancement Systems Studies (CHESS) at the University of Wisconsin–Madison, builds on a foundation created by process improvement pioneers from the 1950s. W. Edwards Deming and others enhanced manufacturing processes across a range of industries by understanding that everything that we do is a sequence of steps: a process. Deming helped us to see that process is the primary driver of the customer's experience of quality. While the quality of the product (the "what") is important, the process (the "how") has the biggest impact on the customer's experience. As we applied these concepts to health care, we came to understand that the patient's experience of care was more influenced by factors such as on-time service delivery and a provider who engages with and listens to them, than the actual quality of the clinical services delivered.

Over two decades, NIATx has advanced this earlier thinking into a model designed for substance use services. NIATx has subsequently expanded its footprint across a wide array of human service settings, assisting thousands of provider systems in improving their processes using a simple set of accessible tools.

The four core NIATx tools for improvement:

1. **Walk-Through**: A role play of the customer experience conducted by the change team.

2. **Flowchart:** A process map of the process experienced during the walk-through that builds consensus among team members regarding the current process and potential areas for improvement.

3. **Nominal Group Technique:** A structured brainstorming method designed to select a strategy to address the needs revealed by the walk-through and flow chart.

4. **PDSA Plan-Do-Study-Act:** rapid cycle testing of the strategy selected in the Nominal Group Technique.

The NIATx model was developed through research about the traits of organizations that succeed when implementing change. An analysis of data from 640 organizations in 13 industries covering 80 potential contributing factors revealed five that consistently drive successful change. These five factors became the five NIATx principles:

1. Know and understand the customer

2. Fix key problems of leadership

see NIATx Process on page 54

Maternal Mental Health in CUNY/SUNY Public Universities as a Workforce Development Strategy

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Maternal mental health conditions are the most common complication associated with childbirth[1] and the leading cause of maternal mortality in New York.[2] Perinatal Mood and Anxiety Disorders (PMADs) include depression, anxiety, OCD, PTSD, and psychosis during pregnancy and up to one year postpartum. Overall, at least one in five pregnant and postpartum people[3] struggle with a PMAD - while up to 40% of Black and Brown birthing people[4][5] experience these conditions due to structural inequities and racism. An estimated 75% of all cases remain undiagnosed and untreated.[6] Untreated illness contributes to preterm birth, low birth weight, impaired bonding, long-term cognitive and developmental challenges for children, and in severe cases, suicide and infanticide.[7] These consequences cost the U.S. an estimated $14 billion annually.[8]

A core driver of this PMAD crisis is the shortage of culturally responsive, perinatally trained mental health providers. Expanding access to perinatal mental health education within New York's public university system offers an achievable strategy to reduce this gap. Encouraging all CUNY and SUNY Master of Social Work (MSW) programs to offer a maternal mental health elective would significantly increase the state's workforce, improve access to specialized care in under-resourced communities, and help reduce New York's persistent maternal mental health crisis.

New York's Perinatal Mental Health Workforce Gap

National workforce data reveal a widening crisis. HRSA's National Center for Health Workforce Analysis has projected growing shortages in mental health providers through 2037. Within this broader workforce shortage, gaps between the number of adequately trained mental health providers and the need for such providers are likely to similarly widen.

A 2025 report from the Policy Center for Maternal Mental Health found that **84%** of birthing-age women in the United States live in areas with a shortage of perinatal mental health professionals. Nearly **700 counties** face high PMAD risk with insufficient resources, and more than **150 counties** are considered *perinatal mental health dark zones*. Kings County and Queens County—two of the most populous counties in New York—rank among the top 15 counties nationwide with the greatest perinatal mental health resource needs and the highest provider shortages. Many low-income rural New York counties have **only one or no** maternal mental health specialist serving an entire region.

The Policy Center's 2025 New York State Report Card further reflects a failing grade for the ratio of non-prescribing maternal mental health providers to births (5 per 1,000). At the same time, increasing rates of mothers report their mental health as "fair" or "poor."[9] These findings underscore the urgent need to expand a workforce trained to identify, treat, and support individuals experiencing PMADs.

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Addressing the Needs of the Perinatal Behavioral Health Workforce

By Damali Wilson, PhD,
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The behavioral health care workforce, including mental health and substance use, is facing mounting uncertainty at a critical moment. Under the recently passed, One Big Beautiful Bill, new limits on federal loans will place strict limits on caps on the borrowing of future medical students. A proposal has been put forth to impose stricter limits on graduate degrees including nursing, public health and social work. This has the potential to deepen long standing shortages in the workforce, which disproportionately impact vulnerable populations, including women and birthing people.

Perinatal mood and anxiety disorders (PMADs) remain the most common complication of childbirth. During pregnancy through the first year postpartum, PMADs impact quality of life such as adherence to medical care and loss of interpersonal and financial resources and are associated with increased medical risk for conditions like preeclampsia, gestational diabetes, and preterm birth [Weingarten]. PMADs can also contribute to substance use disorders [Weingarten]. Mental health conditions are a major driver of maternal mortality across the U.S., including New York City, where according to the Maternal Mortality Review Committee, mental health conditions are one of the leading causes of maternal mortality across all racial/ethnic groups. [Litvak] Nationally, mental health conditions while prevalent, are most often undiagnosed and undertreated [Sangtiani]. Pregnant individuals and those of childbearing potential make up a large percentage of the population [Strid] and addressing their mental health needs is critical from improving maternal health outcomes.

Given these challenges and burden, bold and sustainable solutions are needed.

Workforce Solutions

One promising approach is expanding access to education and workforce development. In New York State, residents now have access to the Excelsior Scholarship for the city and state public colleges and universities, City University of New York (CUNY) and State University of New York (SUNY). CUNY is the largest urban university system in the United States; over 75% students of color; over one-third of students are born outside of the U.S. mainland and speak a native language other than English [Office of the New York City Comptroller]. SUNY is the largest comprehensive system of higher education in the US; 56% female and non-binary; 45% students of color, multi-racial, or international [The State University of New York]. Full-time students meeting eligibility requirements are provided free tuition for Associate's and bachelor's programs, allowing New Yorkers to earn a degree in mental health and human services career pathways. This initiative has the potential to strengthen, expand and diversify the behavioral health workforce while improving the lives of thousands of mothers and families.

Another workforce challenge is inadequate wages or student debt related to training costs. Federal loan repayment programs (LRPs) are an incentive strategy to support the recruitment and retention of behavioral health providers in high-needs facilities or areas, or with underserved populations. This includes psychiatrists, psychologists, psychiatric nurse practitioners, clinical social workers, and primary care

see Perinatal Workforce on page 38

Leveraging Behavioral Health Consultants in Integrated Care to Detect and Triage Menopause in Midlife Women

By Kim Hunter-Bryant, MA, LCSW, PMH-C
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Covenant House Health Services

The United States is facing an urgent crisis: a significant shortage of behavioral health professionals that leaves countless individuals without the care they desperately need (Bishop et al., 2024). In this landscape, optimizing the existing workforce is not merely a tactical choice; it is a strategic necessity. One promising avenue for this optimization lies within primary care settings, where the unique needs of midlife women navigating the tumultuous menopausal transition are often overlooked.

Midlife women often navigate a challenging landscape of mental health symptoms, including anxiety, mood swings, cognitive changes, and elevated stress levels. The complexities of these issues are frequently overlooked or misattributed to other medical conditions. This is where the role of the Behavioral Health Consultant (BHC) becomes indispensable. Within the framework of the Primary Care Behavioral Health (PCBH) integrated care model, BHCs serve as essential liaisons between mental health and primary care services.

Assessment	Intervention Decision	Triage and Follow-Up
INTAKE & SCREENING	PATH A: MENOPAUSE SUSPICION	TRIAGE A: MEDICAL REFERRAL
1. Review PHQ-9, GAD-7	BHC Action: Provide psychoeducation, CBT, and Sleep Hygiene.	Warm Handoff to PCP/OBGYN for medical workup.
2. Hormonal Screening (VMS/Menses Changes)	Goal: Normalize symptoms.	FOLLOW-UP: Document/Communicate plan to team.
3. Life Context Review ("Love, Work, Play, Health")	PATH B: PRIMARY MH DISORDER	TRIAGE B: SPECIALTY BH
DIFFERENTIAL ANALYSIS (Acute vs. Chronic)	BHC Action: Skills-based intervention (Emotional Regulation).	Referral to Specialty Behavioral Health for longer-term therapy.

The Problem: A Menopause Misdiagnosis Epidemic

The symptoms of the perimenopausal and menopausal transition, which can span a decade, are notoriously broad and often mimic primary psychiatric disorders. Leading clinical bodies note that women with no history of mental illness may experience new-onset depression and anxiety during this time due to fluctuating estrogen levels (Massachusetts General Hospital Center for Women's Mental Health [MGH], n.d.). These symptoms include intense mood swings, irritability, sleep disturbance, and concentration difficulties often described as "brain fog" (Dementia UK, n.d.; Greene, 1998).

In the traditional, time-crunched primary care visit, these complaints are often addressed by focusing solely on the mental health component (Cleveland Clinic, n.d.). A woman reports low mood and poor sleep, and the busy Primary Care Provider (PCP) or OB/GYN may initiate a script for an antidepressant without taking the detailed psychosocial and hormonal history needed for an accurate differential diagnosis. This practice leads to delayed detection and inadequate treatment.

BHCs: The Workforce Innovation in Triage

The BHC's expertise in brief, focused assessment and differentiation is the perfect solution to this clinical challenge. Operating under a consultation model, the BHC is tasked not with traditional long-term therapy, but with rapid assessment, behavioral intervention, and effective triage (Robinson & Reiter, 2016).

Targeted Assessment and Differentiation

When a midlife woman presents to the integrated care clinic with symptoms like anxiety or insomnia, the BHC's workflow is designed to quickly differentiate the likely cause. In addition to standard screening tools (PHQ-9 and GAD-7), the BHC can incorporate simple, validated screeners like the Greene Climacteric Scale or targeted questions regarding vasomotor symptoms (hot flashes, night sweats) and menstrual history.

Psychoeducation and Immediate Intervention

Once a hormonal component is suspected, the BHC immediately provides psychoeducation, normalizing the experience and reframing the symptoms from a mental health deficit to a hormonal transition. Furthermore, the BHC can implement

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When Workforce Strategy Becomes a Finance Problem

By Carter Freeman
Vice President
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Every behavioral-health CEO I work with is watching the same crisis unfold. They need more clinicians than the market can supply, and even when they succeed in hiring, keeping those clinicians becomes a significant challenge. More than 122 million Americans live in areas where they might struggle to access mental health resources if they were to need support.[1]

State agencies agree: 43 out of 44 states responding to a national survey reported workforce shortages across therapy, psychiatry, nursing, and crisis services.[2]

The default response is often to ramp up recruiting or enhance HR programs. Helpful steps, but not sufficient. The deeper work lies within the financial model: how organizations pay for the workforce they need, how long they can sustain that workforce, and what the numbers reveal about retention and attrition.

In vcfo's work with both community mental health centers and private clinics, the same patterns emerge—vacancies lead to lost revenue and higher costs. This is not just a "recruitment problem." It is a financial design issue. HR plays a crucial role, but so does the CFO.

When Workforce Strategy Shows Up on the Income Statement

In many behavioral health settings, reimbursement rates fall short of what the labor market demands. Leading behavioral-health associations cite low pay and high cost-of-living mismatches as key drivers of the workforce gap.[4]

Most organizations budget their service offering first and then attach staffing. Today's environment requires flipping that thinking to either start with the wage floor required to attract and retain clinicians in your market, then build the funding strategy around that number or at least consider realistic staffing as a limiting factor.

Several states have begun to deploy Medicaid-based enhancements, loan-repayment programs, and rate increases aimed specifically at workforce stabilization.[5] When you build budgets starting with staff compensation and retention risk, the hiring plan, reimbursement strategy, and operational plan become one integrated model.

Building Workforce Plans Around Funding Reality

Too many workforce initiatives are bolted on outside the budgeting cycle. When finance and HR don't operate in lockstep, it puts workforce plans at much greater risk.

Real retention depends on items that show up on a budget: protected supervision time, ongoing professional development, schedule flexibility, and manageable documentation burdens. The Kaiser Family Foundation guidance on behavioral health burnout specifically notes supervision, workload, and support as key retention levers.[6]

When staffing plans include those costs early rather than retrofitting after problems emerge, they become sustainable instead of temporary.

Grants, Waivers, and the "Free Money" That Isn't

Grants and Medicaid waivers frequently appear as ideal solutions to workforce shortfalls. But many fail because the overhead isn't fully accounted for, such as billing systems, onboarding, IT, supervision, and compliance.

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amount of compensation.

On the other hand, pay that is too low and the sense that one is not being valued can lead to financial stress and prompt workers to look for better-paying jobs. Although increasing wages is necessary, it is not sufficient. Compensation must be part of a larger strategy that tackles a variety of workplace requirements.

How Benefits Support the Whole Employee

Salary is not the sole reason why people work; their wellbeing is also at stake. And the wellbeing of workers is achieved, for the most part, through benefits that go far beyond the paycheck (Hallett et al., 2023). A comprehensive benefits package, including health insurance, retirement plans, training and skill development opportunities, and adequate mental health support, sends a powerful message: This organization cares about more than just your working hours. It cares about your life.

Behavioral healthcare workers face emotional exhaustion and need access to mental health resources and flexible scheduling. The best organizations tend to give their staff decent access to that kind of support. They offer effective Employee Assistance Programs (EAPs). They provide the type of well-carved-out, family-friendly policies that help staff balance work and home. They are the kind of organizations you want to work for.

According to a 2023 survey by the National Council for Mental Wellbeing, **nearly half** (48%) of behavioral health workers say the impacts of workforce shortages have caused them to consider other employment options. Thus, to ease the burden, they proposed an introduction of more telehealth options, student loan forgiveness, and apprenticeship programs. (National Council for Mental Wellbeing, 2023).

Career Development and Pathways to Growth and Fulfillment

Career development opportunities are strong retention factors. Behavioral healthcare professionals are typically motivated by a desire to make a difference and grow their expertise. When organizations offer structured training, mentorship, and advancement opportunities, employees feel valued and see a future with the organization.

Professional identity and professional belonging foster a perception of the job that is not just a temporary stop on the way to something else. This perception is influenced in part by the fact that some companies have clear career ladders. Some companies also offer a variety of development programs for their employees. If your company has both of those things, it is a relative haven in which to work.

Pipeline Development and Securing the Future Workforce

To ensure a constant inflow of qualified professionals, it is not enough to work on retention. It is equally important to put in place strong pipeline development

Isaac Mawuko Adusu, DHA, MSNPM

strategies. Pipeline development means attracting, training, and supporting new behavioral healthcare workforce members. Effective pipeline strategies include partnerships with educational institutions, internships, scholarships, and community outreach programs. These initiatives can directly support the recruitment of underrepresented populations and communities that typically lack access to behavioral health careers. Also, it's great that these communities aren't just being recruited; they're also being retained. And finally, these communities are adding to the diversity and cultural competence of the behavioral health workforce (Hubbard et al., 2022).

Organizations can work with universities to set up practicum placements that afford authentic experience and mentorship. They may also offer tuition assistance or program particulars (e.g., loan forgiveness) to reduce the financial barriers that prevent students from pursuing degrees in behavioral health. A resilient pipeline not only renews staff but also reduces burnout among current employees by eliminating understaffing.

Integrating Retention and Pipeline Strategies

Retention and pipeline development are inextricably linked. High turnover can dishearten new entrants, while a strong pipeline can bolster a staffing shortage and reduce overworked, burned-out staff. Organizations that align retention with pipeline development create a sustainable ecosystem with a steady state of new entrants and a state of grace for the career-long staff (Galbreath, 2025).

How Managers Should Address Retention Issues

1. **Perform Routine Assessments of Employee Compensation:** Benchmark salaries with regional and sector standards to ensure you're in the competitive ballpark. Account for cost-of-living differences and make good use of clear, trust-building communication around the rationale for your pay structure.

2. **Improve Benefits to Align with Employee Feedback:** Identify the benefits that employees value most by using surveys and focus groups. Ensure that your benefit offerings include not only mental health support but also flexible work arrangements, childcare assistance, and wellness programs that are relevant to behavioral health professionals. These are the kinds of benefits most shown to be directly correlated with workplace satisfaction and, thus, retention (National Council for Mental Wellbeing, 2023).

3. **Build Well-Defined Progression Paths:** Create clear progression paths within your organization, with explicit nuclei of defined competencies, training prerequisites, and criteria for promotions.

4. **Invest in Your People:** Put money and resources into developing your employees. Use well-thought-out programs with good content and good delivery. Consider investing in the very leadership programs that are often found to be lacking in many organizations if you want to retain internal candidates.

5. **Create a More Diverse Talent Pool:** Stop trying to hire just people who already have had the experience of working in your kind of organization. Use strategies and tactics that have been shown to work for building more diverse talent pools (Galbreath, 2025).

6. **Create a Supportive Work Environment:** Administer routine oversight, support staff in the formation of peer support groups, and create opportunities for debriefing sessions to reduce the likelihood of experiencing burnout. Recognize and celebrate their contributions to the workplace to bolster morale and promote a culture of belonging.

7. **Invest in Pipeline Partnerships:** Work with academic institutions, community organizations, and professional associations to establish internship, scholarship, and recruitment initiatives aimed at attracting diverse candidates (Galbreath, 2025).

8. **Use Technology for Training and Support:** E-learning platforms and virtual mentoring provide accessible and ongoing professional development for all our teachers.

9. **Exit and Stay Interviews:** Implement exit surveys along with the others. According to (Fukui et al., 2025), exit surveys can effectively reveal why employees leave, helping organizations design targeted interventions.

10. **Advance a Work-Life Balance:** Support good employee health by managing reasonable caseloads, flexible scheduling, and time-off policies that respect the personal lives of employees (National Council for Mental Wellbeing, 2023).

Conclusion

The societal wellbeing of the United States is directly linked to the work of the behavioral healthcare workforce, which has an astonishing 40% turnover rate, according to National Council for Mental Wellbeing. Retention and turnover have two primary drivers: satisfaction and commitment. To increase both, we must improve the pay, the benefits, and the career development that we offer our staff. These activities are a list of very good things that cover the basis for what we need to do to retain and keep people. However, failing to do these things will lead to a violation of the commitment part and increase the turnover part. So far, most readers are thinking to themselves, "Yeah, that's all well and good! But what about my facility's budget?" These challenge our organizational culture in a way that makes us vulnerable to turnover.

For leadership, ensuring a bright future requires investments in pay and perks, developing in-house talent, acknowledging efforts large and small, and forging collaborations that nurture the next generation of behavioral health practitioners. Such steps seem elementary. Yet the not-so-obvious truth is that they aren't being carried out with even a minimal sense of urgency in most cases.

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and retention, especially in underfunded systems

- **Alternative licensure pathways / reciprocity** to reduce barriers for providers moving across states
- **Data & workforce analytics systems** that monitor vacancy rates, turnover drivers, workforce demographics, and link them to outcomes

Some of these funding needs and policy changes are already being piloted or implemented in some states in response to behavioral health workforce crises (Hallett et al., 2023).

Vision Forward and Recommendations

A sustainable and effective behavioral health workforce for DD populations would encompass:

- Clear, competency-based career paths from DSP to behavioral specialist to clinical roles
- Integrated telehealth-enabled teams to extend reach without sacrificing quality
- Ongoing mentoring, supervision, and reflective support built into roles
- Staff empowered by decision support tools to reduce administrative burden
- Engagement of people with DD in workforce roles and system design
- Policy and funding mechanisms that sustain workforce investment

To realize this vision, leaders in agencies, academia, and government must collaborate. Pilots and demonstration projects can test hybrid models, apprenticeship systems, telehealth innovations, and co-design training. Simultaneously, data systems must track workforce metrics and their re-

Mark Schwartz

Richard Anemone, MPS, LMHC

Conclusion

The behavioral health workforce supporting individuals with developmental disabilities is at a pivotal moment. States across the country are facing deep shortages but also possess robust infrastructure and the opportunity to implement forward-looking strategies that strengthen training, improve retention, modernize care models, and prioritize lived experience. With alignment across policy, funding, and practice, states can build a workforce that is resilient, skilled, and capable of delivering equitable, person-centered care for decades to come.

Mark Schwartz is a veteran workforce development and IDD programs leader with more than 30 years of experience advancing training excellence, staff development, and clinical practice standards and quality of care across behavioral health, intellectual and developmental disabilities (IDD), and human services organizations. He started his career working with teenagers with developmental disabilities 32 years ago and these early experiences shaped his career trajectory.

As VP of Workforce Development at ICL, Mark oversees a comprehensive training infrastructure that supports more than 1,500 employees across clinical and non-clinical roles. He leads a dedicated team responsible for designing and delivering evidence-based, trauma-informed, and person-centered training programs. Mark brings a deep commitment to ethical practice, human rights, and ensuring staff are equipped to provide safe, compassionate, person-centered care.

Prior to his current role, Mark provided training that supported adults and children with developmental disabilities. In these roles, he worked to strengthen agency-wide training systems, advanced best-practice implementation, and supported staff across behavioral health and IDD programs.

Mark holds a master's degree in Disability Studies from the CUNY School of Professional Studies, where he also served as an adjunct professor, and a bachelor's degree in English from the University of Connecticut.

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Such investments in higher education are crucial to building pathways into the public mental health system. In 2001, OMH partnered with multiple New York Schools of Social Work to create a program to teach master level students evidence-based mental health practices. Students in the program receive training and education in recovery-oriented, evidence-based practices through approved internships, coursework, and colloquia. More than 5,000 social work students have completed the coursework for this program. In 2023, this program was adapted for Mental Health Counseling master level students. Both programs add new schools every year.

In the last year, OMH partnered with New York City Health and Hospitals to create a fellowship program for physician assistants (PA). While New York has nearly 20,000 licensed PAs, only about 2 percent specialize in psychiatry. That's even though more than 60 percent of PAs report evaluating mental health conditions in their patients on a weekly basis. The Psychiatric Physician Assistant Career Pathways Program will provide physician assistants with the training and experience necessary to work in the public mental health system. The first cohort of physician assistant fellows began in September.

Strengthening and growing the peer and unlicensed support staff is part of the OMH workforce strategy to address the impact of population changes in the state. OMH is creating a credential for mental health paraprofessionals. The Credentialed Mental Health Support Specialist (CMHSS) will provide identity, standardization, and specialized training for support staff who work in the system. The CMHSS will have multiple levels, creating a career ladder for unlicensed staff. Peers are a critical piece of the mental health workforce. OMH recently awarded 10 grants for $275,000 each to community-based organizations. These organizations are tasked with partnering with grassroots organizations to recruit youth and family peers to work in their own communities. The goal is to recruit and train 150 diverse youth and family peers across the state.

New York has also become one of seven additional states joining the youth Mental Health Corps, which is a collaborative program in schools and communities that offers young adults a pathway into behavioral health careers. This initiative is designed to build a service-to-career pathway for 18-to-29-year-old peers, who gain experience toward a Youth Peer Advocate credential and earn AmeriCorps member benefits.

Strategies to support staff retainment are as important as initiatives aimed at recruiting individuals to the public mental health system. One of the most effective retainment strategies is offering free training opportunities for the workforce. OMH funds more than two dozen training platforms and technical assistance centers. These platforms provide quality training on various topics including clinical services, trauma-informed care, suicide prevention, cultural awareness, and implementation of evidence-based practices.

Another imperative part of the OMH workforce strategy is educating the public about mental health careers and connecting career seekers to open positions. To meet this need, OMH is creating a new workforce website. The website will allow individuals to research mental health career pathways, mental health program settings, workforce initiatives, and connect to open mental health positions.

Wages are another important part of growing the workforce. Governor Kathy Hochul has shepherded through targeted inflationary wage increases for community mental health providers in each of the last three years, along with salary enhancements for direct care staff at state-operated facilities. OMH is also using the flexibility provided by the state Department of Civil Service's Hiring for Emergency Limited Placement Statewide, or "HELPS" program, to streamline hiring.

There is no question that building and maintaining a strong, dexterous mental healthcare workforce will take ongoing commitment and creativity in the years to come. OMH is committed to supporting individuals who choose to work in the public mental health system.

Dr. Ann M. Sullivan is Commissioner of the New York State Office of Mental Health.

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reinforcing supervisory infrastructure, and ensuring continuity of care. Together, they form the backbone of a supportive environment that encourages staff to thrive within NYC Health + Hospitals and provide a foundation on which to expand career pathways, deepen clinical expertise, and promote safety and trust across behavioral health settings:

- **Career Ladders:** The system launched the first cohort of our Social Work Clinical Licensure Program, offering up to 82 Licensed Master Social Workers free test prep and exam fee coverage in exchange for a two-year service commitment. At the same time, the Behavioral Health Nursing Career Ladder has created new pathways for up to 24 entry-level nursing support staff to become registered nurses, including tuition support, academic preparation, and a three-year post-graduation service commitment; since program launch 6 months ago, 50% have already completed prerequisites and applied to nursing school.

- **Strengthening Psychiatric Mental Health Nurse Practitioner Training:** Launching in January 2026, we will introduce a new program to strengthen the behavioral health practice of PMHNPs hired within the past three years. For the past several years, NYC Health + Hospitals has partnered with Community Healthcare Network (CHN) to place and develop PMHNPs within their advanced training program. Building on that experience, we are now establishing our own internal program. While the rapid expansion of PMHNP programs has helped increase system capacity nationwide, there remains opportunities to deepen clinical training and standardize practice expectations for new graduates.[3] To support this workforce, a new program uses an 18-week cohort model integrating

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lectures, interactive workshops, and real-time coaching. By equipping our newest PMHNPs with enhanced skills and structured guidance, we are strengthening their practice and advancing a broader culture shift that affirms and elevates the role of PMHNPs across NYC Health + Hospitals.

- **Workplace Safety & Violence Prevention:** Violence-prevention initiatives continue to support both staff safety and overall morale by enhancing psychological safety, strengthening team cohesion, and increasing the visibility of organizational support.[4] Through our Violence Prevention Academy, approximately 1,500 staff have received *advanced-level training*—including specialized crisis communication, de-escalation skills, and train-the-trainer preparation that enables them to return to their units and support broader learning. Preliminary pre-post data show statistically significant increases in confidence related to de-escalation skills.

These workforce investments have sparked a renewed sense of pride and motivation among behavioral health staff. Clinicians report feeling seen, valued, and better supported.

Changing the Narrative:
From Shortage to Strength

The gains that NYC Health + Hospitals has made in behavioral health workforce development offer a model for strengthening public service careers more broadly, and our progress is measurable:

- **The behavioral health turnover rate** has dropped significantly, now at 8.47% compared to nearly 18% in 2022, reflecting improved job satisfaction and organizational stability

- **Vacancies across disciplines have declined sharply**, most notably in social work, where the vacancy rate has fallen to 4.3%, from 12% in 2024, ensuring continuity of care and reducing gaps

- Our 2024 social worker recruitment campaign, ***Social Workers Needed Here***, has won a Silver Award for Purpose-Led Campaign of the Year from Modern Healthcare and Ad Age

NYC Health + Hospitals is demonstrating what is possible within civil service systems by centering investment in people, aligning workforce strategy with operational needs, and advancing inclusive hiring and retention practice. Workforce development is no longer a background function: it is a central driver of health system performance, equity, and reputation.

Sophie Pauze, MPA, is Senior Director of Strategic and Impact, and Omar Fattal, MD, MPH, is System Chief of Behavioral Health Services at NYC Health + Hospitals. For more information, contact Sophie Pauze at pauzes@nychhc.org or (347) 675-8928, or visit the NYC Health + Hospitals website at www.nychealthandhospitals.org.

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Predictive Analytics from page 22

Using Predictive Analytics
for Burnout Prevention

The good news is, you already collect the data you need for burnout prevention — scheduling patterns, supervision attendance, documentation quality, and even PTO usage. By connecting employee data across the organization, behavioral health leaders can expose invisible burnout triggers they often miss and provide the support their employees need.

Data and predictive analytics allow leaders to move quickly, saving thousands on rehiring costs and preventing potential patient neglect. Here's how.

Build human risk profiles to predict departures - Synchronized employee data paints a truer picture of the workforce. Consecutive on-call shifts, a consistent pattern of Monday/Friday absences, and a mildly negative sentiment towards the job can seem negligible at first glance. But predictive analytics allows leaders to aggregate that data into a profile that highlights hidden patterns and identifies who is at risk of leaving.

Curtis Forbes

Provide benefits that keep them engaged - Armed with all this data, leaders get a clearer picture of their employee as a whole person, not just a worker. Once they uncover the patterns in employee need — noticing, for example, how many arrive late because of unreliable transportation, or how many caregivers in the home — leaders can offer personalized benefits that fit their lifestyle. These meaningful benefits remove sources of tension in their personal lives and allow them to be more present at work.

Develop targeted burnout intervention programs - According to a 2025 MustardHub survey, 46% of workers have already quit jobs due to feeling disconnected or unsupported. But 59% are open to their supervisor intervening if they're at risk for burnout. This indicates that employees are more inclined to see intervention as care, not surveillance. Early, targeted intervention can stop burnout in its tracks and re-engage employees on the brink of quitting.

Moving From Insight to Action

Mental health organizations have spent years perfecting how they track patient progress while relying on intuition to understand staff well-being. The result is a disjointed employee experience where people who would otherwise love their jobs are searching for the nearest exit.

The data exists in all your systems. By turning predictive analytics inward, leaders can close mental health care gaps and gain visibility into burnout patterns that would otherwise stay hidden until someone resigns.

Curtis Forbes is the founder and CEO of MustardHub, a workforce engagement platform that helps companies reduce turnover, build stronger cultures, and unlock predictive insights into employee well-being. A serial entrepreneur with a background in both technology startups and education, Curtis previously built and scaled Forbes Music Company and later expanded into a roll-up portfolio of education businesses before exiting in 2025.

With more than two decades of experience leading distributed teams, he has seen firsthand how trust, recognition, and flexible support systems shape whether people stay and thrive, or burn out and leave. At MustardHub, he is pioneering approaches to employee engagement, predictive workforce insights, and portable benefits that align with the realities of modern work. Outside of work, Curtis stays active in music, enjoys traveling, and advocates for social causes, particularly initiatives supporting foster youth in Central Texas.

To learn more about MustardHub or get in contact with someone, please visit www.mustardhub.com.

Supporting Leaders from page 11

Burnout in behavioral health involves emotional exhaustion, depersonalization, and reduced sense of accomplishment, symptoms that are difficult to reverse once they emerge. As Posluns and Gall (2019) emphasize, prevention is essential. NYPCC treats self-care as an organizational responsibility rather than an individual burden. In addition to traditional paid time off, clinical staff receive quarterly Mental Health Days, access to Health and Wellness fairs, and opportunities to connect with colleagues through monthly social events. These initiatives help sustain morale, promote connection and strengthen the sense of belonging that makes day-to-day work more manageable.

Recognizing the demands placed on leaders, NYPCC also offers robust Clinical Supervisor Training to clarify expectations and equip Supervisors with the tools needed to guide their teams. The annual leadership retreat provides additional time for connection, reflection, and strategic planning, with follow-up meetings ensuring that leadership practices continue to evolve alongside program needs. Thematic Clinical Supervisor Consultation Groups deepen this learning by supporting Supervisors in training their teams on essential tasks such as documentation, workflow management, and quality assurance.

A strength-based approach is woven into all aspects of the organization. Leadership development is matched by strong recognition practices, including a structured rewards system and the Circle of Champions program. Through peer nominations and executive acknowledgment, staff are celebrated for their skills, commitment, and alignment with organizational values.

Together, NYPCC's focus on burnout prevention, supervisor development, and leadership support reflects a broader commitment to creating conditions in which staff can thrive. After more than fifty years as a behavioral health organization, NYPCC demonstrates that prioritizing staff well-being and cultivating strong leaders are essential to sustained effectiveness. Its recognition by Mental Health America with the Platinum Bell Seal for Workplace Mental Health and by City and State as a top place to work in New York in 2025 illustrates how these efforts contribute to a workplace culture that supports employees at all levels and the communities they serve.

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Perinatal Workforce from page 32

providers that address behavioral health. All of whom could specialize in or service the perinatal population. Though varying in their benefits, requirements, and implementation, LRPs in general have been shown to lead to an increase in behavioral health providers, increased capacity to deliver substance use treatment, greater provider presence in rural areas, and increased staffing being linked to increased patient visits [Last].

Models of Care

In our own work focused on training community health workers (CHWs), who have a proven track record of delivering effective care and addressing health related social needs of mothers, which includes mental health support. With appropriate tools and protocols, CHWs can provide critical mental health support for mothers and serve as a bridge to specialized care when needed, especially ensuring no individual falls through the cracks. This also ensures culturally relevant workforce development.

Additionally, newer technologies such as artificial intelligence (AI) are being developed to support behavioral health care. Large language models and AI-powered tools like virtual assistants may offer innovative ways to enhance maternal mental health care and have already shown promise in delivering personalized support [Vaidyam]. While the field should approach this cautiously, the behavioral workforce should actively engage with these advancements to ensure they meet the needs of mothers and divers communities. Inadequate information about these tools may also limit our ability to contribute to their deployment. Targeted awareness among the field will be needed to ensure that the needs of mothers are central to these discussions.

New York State (NYS) has made significant advancements in telehealth workforce development, implementing initiatives to train clinicians and providing incentives to expand their adoption of telehealth [Marks Smit]. However, challenges remain particularly in building a robust telehealth infrastructure and ensuring that providers receive sustainable, long-term support. Moreover, while Medicaid reimbursement rate increases have contributed to service improvements and systemic reform, further enhancements are needed to address access to care, lengthy appointment wait times and the overall inefficiencies in the behavioral health system.

Collaborations between policymakers, community partners and educational institutions are key to addressing maternal mental health and building a sustainable behavioral health workforce. By prioritizing investments in workforce training and

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Supporting Managers from page 12

managers need supervision that extends beyond administrative oversight. Prioritizing restorative and formative supervision strengthen leadership confidence, team cohesion, and overall program stability.

At Services for the UnderServed, these principles are central to how senior leadership supports mid-level managers and managers of managers and reflect organizational learning grounded in practice experience. S:US uses a structured supervision model grounded in the normative, formative, and restorative framework. [7] At the C-suite level, particular emphasis is placed on restorative supervision, which provides protected space for leaders to process emotional labor, navigate organizational pressures, and strengthen reflective decision-making. This intentional approach models healthy supervision practices, fosters psychological safety, and ensures that managers can confidently support their teams.

Recommendations for Strengthening Supervision of Mid-Level Managers

The following recommendations reflect practices implemented at Services for the UnderServed (S:US) as part of senior leadership's commitment to developing strong managers and building a resilient workforce.

Implement a structured supervisory model grounded in evidence and practice: At S:US, supervision is anchored in the normative, formative, and restorative framework.[7] Supervisory meetings consistently address administrative expectations, professional development, and reflective space.

Nadjete Natchaba, EdD, LCSW, MPA

Provide leadership development through ongoing coaching and formative supervision: S:US integrates coaching and modeling into supervision to strengthen communication, problem-solving, and leadership confidence.[5]

Prioritize restorative supervision to support emotional labor: Senior leadership and directors at S:US receive restorative supervision that addresses stressors, emotional fatigue, and the complex decisions required in human services.[8]

Normalize reflective dialogue and transparent communication: S:US promotes open conversations that allow leaders to examine dilemmas, team dynamics, and systemic barriers in a supportive environment.

Support wellness and sustainable workloads for supervisors: S:US advocates for manageable workloads, protected supervision time, and shared problem-solving across program leadership.

Alignment with Human Resources, Quality Assurance, and senior leadership to reinforce supervisory expectations: S:US ensures consistent supervision expectations across programs through collaboration between executive leadership, human resources, and quality assurance teams.

Mid-level managers are essential to nonprofit human services organizations and are supported through supervision approaches that reflect emerging practice-based evidence and leadership scholarship.[10] Strengthening formative and restorative supervision while maintaining administrative oversight helps build confident, resilient, and effective leaders. The supervision model implemented at Services for the UnderServed demonstrates how intentional investment in leadership development enhances organizational culture, improves service delivery, and supports the well-being of supervisors at every level.

Dr. Nadjete Natchaba is a senior nonprofit executive and licensed clinical social worker with extensive experience overseeing large-scale human services programs across New York City. Her work centers on leadership development, program quality, organizational culture, and advancing equitable, trauma-informed service delivery. She is the Chief Program Officer at Services for the UnderServed (S:US), where she provides executive leadership for the organization's Homeless Services, Behavioral Health Recovery and Treatment programs, Eviction Prevention Services, and Veteran Services portfolio.

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into the behavioral healthcare provider community. Such egregious payor practices are both injurious to service recipients and demoralizing to provider organizations, behavioral healthcare professionals, and administrative personnel whose precious time is spent in pursuit of financial reimbursement essential to their operations.

The crisis that plagues the behavioral health workforce has become undeniable to key stakeholders, and measures to repair it are underway. For instance, the New York State (NYS) Office of Mental Health (OMH) is among several state agencies that have established career development pathways to incentivize aspiring professionals to enter the workforce. Emerging partnerships with institutions of higher education, the development of credentialing programs for existing and incoming paraprofessional personnel, and loan forgiveness programs promise to bolster a flagging workforce in coming years. The OMH has also established an Office of Diversity and Inclusion to promote diversity within the behavioral health workforce and to maximize recipients' access to culturally competent care. In a similar vein, NYS has promoted the development and professionalization of Peer Specialists through the New York Peer Specialist Certification Board and corresponding credentialing and career pathways.

Additional opportunities to reinvigorate the behavioral health workforce hold considerable promise but have yet to materialize. An ambitious initiative undertaken in partnership between the state and federal governments is poised to deliver an enhanced array of support services to vulnerable Medicaid recipients heretofore unavailable to them. Eligible recipients may receive limited assistance in meeting select housing, transportation, and nutrition needs through Social Care Networks (SCNs) comprised of healthcare providers, community-based organizations, and other entities serving our state's most vulnerable residents. To the extent these and similar initiatives are successful, they will address unmet needs and complement the actions of healthcare professionals, thereby easing the burden on them. Technological innovations, most notably those within the Artificial Intelligence (AI) realm, have enormous potential to support both clinical and administrative workloads and to enhance the efficiency and efficacy with which (human) providers approach their work. These technologies also entail innumerable risks that must be fully understood given the potential repercussions of their misuse. It is nevertheless incumbent on all stakeholders to the behavioral health and social welfare systems to explore increasingly innovative approaches if these systems are to finally meet a critical moment in public health.

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which will also go into effect on January 30, 2026, all established Medicare patients must be seen in person every 12 months. However, to take individual circumstances into account, there are a variety of exceptions built into this rule. Here, an in-person visit will not be required if the benefits of a non-telehealth service are outweighed by the risks and burdens associated with an in-person service, for example:

1. An in-person service is likely to cause disruption in service delivery.

2. An in-person service has the potential to worsen the patient's condition.

3. If patient is in partial or full remission and only requires maintenance level of care.

4. Patients are clinically stable and in-person visit has risk of worsening patient's condition, creating undue hardship on self or family; or

5. Patients are at risk of disengagement with previously effective care.

The basis for any exception must be noted in the patient record. The follow-up in-person visit may be furnished by a different psychiatrist in the same group or practice if the original psychiatrist is unavailable. Please note that the 6-month and 12-month requirements apply solely to mental health treatment and not to substance use disorder (SUD) treatment. Now, there is no Medicare requirement for in-person visits for SUD treatment. Of course, it must be noted that in-person visits may occur more than once a year, with frequency dictated by clinical judgment and medical necessity.

The new framework for telehealth coverage of MH/SUD treatment under the Medicare program is a significant step forward in ensuring access to services for those who face challenges in accessing in-person treatment. In this case, CMS has made a clear distinction between MH/SUD telehealth treatment and non-MH/SUD telehealth treatment. Now, only *telehealth for MH/SUD* has been identified as a *permanent* change within the Medicare program.

Another recent change is the ability of providers rendering non-patient facing or telehealth services from a home office to keep their home address private. Providers

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Jamie Papapetros

may now request that their home address be listed in Medicare records solely as a "Home office for administrative/telehealth use only." This will suppress the street address and phone number in Medicare records. This approach is also helpful for circumstances where there is a safety concern related to a provider's practice information being made publicly available.

New York Coverage of Telehealth

New York has already implemented a similar framework that is even more robust, mandating across-the-board coverage of all telehealth treatment by commercial plans and carriers, Medicaid Fee-for-Service and Medicaid Managed Care plans. Audio-only telehealth is also covered to the extent the patient is unable or declines to participate in audio/video telehealth. In addition, New York has enacted a law mandating reimbursement parity between in-person care and telehealth "on the same basis, at the same rate, and to the same extent the equivalent services, … are reimbursed when delivered in person." This reimbursement parity law will be sunset on April 1, 2026. The New York State Psychiatric Association and other stakeholders strongly advocate that these provisions not be permitted to expire and be made permanent as part of the FY 2026-27 state budget.

In addition to statutory changes regarding coverage of telehealth, New York is also looking closely at workforce shortages and its role in inhibiting access to care. The NYS Assembly Standing Committee on Mental Health and Standing Committee on Alcoholism and Drug Abuse recently announced, as of this writing, a public hearing scheduled for December 10, 2025, to examine the status of the behavioral health workforce. As stated, "The purpose of this hearing is to provide the Committees with an opportunity to examine the status of the behavioral health workforce, including attrition and vacancy rates, and its impact on a person's ability to access behavioral health services." The hearing notice cites "a lack of access to services, long waiting lists, and an increase in complications associated with unmet treatment needs for individuals at risk of, or diagnosed with, mental health, substance use or other medical conditions." It is essential that government leaders and legislative bodies gather information about the current workforce crisis and identify possible remedies and next steps that may be reflected in further legislative action.

In conclusion, telehealth has played a critical role in extending the reach of the workforce to enhance access to care for those in need of mental health and substance use disorder services. Surveys have consistently found an increase in Americans willing to use telehealth for mental health care. Telehealth also helps overcome other persistent barriers to care including transportation challenges and the stigma associated with walking into an office. As we consider ways to enhance the workforce, it is important we maintain access to telehealth as part of that plan for the short and long term. Along with the rise of telehealth is the rapid proliferation of artificial intelligence in all spaces, including mental health. As it stands, New York State and other states are taking or contemplating action regarding the use of AI in mental health care. The New York State Senate Committee on Internet and Technology has scheduled a public hearing on January 15, 2026 to solicit testimony on "… risks, solutions, and best practices with respect to the use of artificial intelligence in consequential or high-risk contexts, and related issues, such as classification of the types and risk levels of AI uses, frameworks for auditing AI tools for bias, and transparency improvements."

The good news is New York State recently ranked #1 for mental health in Mental Health America's 2025 The State of Mental Health in America based on a set of measures including prevalence and access to care. This acknowledgement truly reflects the collective work of policymakers, regulators, advocates, and patients, while recognizing the challenges that remain to achieve the right care at the right time in the right place.

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technology, NYS can improve behavioral health outcomes for mothers, children and communities, ultimately serving as a model for other regions.

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industry and community demands. With a shortage of clinicians and qualified supervisors to mentor future providers in the field, SMA began offering an annual Qualified Supervisor course, providing staff with the educational requirements necessary to become a Qualified Supervisor in Florida. This not only expands Qualified Supervisors for interns at partnering universities but also addresses the behavioral health workforce shortage by supporting new talent and pre-licensed professionals new to the field.

- **Annual Conference Training & Collaboration**: Every year, SMA sends team members to participate in the Florida Behavioral Health Association's annual conference to learn and collaborate with other behavioral health providers. SMA also participates through presentation sessions at the conference to share programmatic success or innovative practices. In 2025, SMA's Jeremiah Alberico, Terence Thomas, and Robin Lanier, along with Deborah Velez with the Marion County Hospital District presented, "Pathways to Healing: Navigating a One-Stop Shop for Substance Use and Mental Health Treatment" at the conference, sharing collaborative strategies to improve treatment access with other professionals.

- **Mental Health Symposium**: The SMA Foundation hosts an annual Mental Health Symposium, "Who is Jay?" providing team members and the community with speakers and training sessions tailored to current and emerging needs in behavioral healthcare. Team members can earn continued education units (CEUs) for their licensure and educational requirements, while learning about relevant trends and best practices in behavioral healthcare.

Brooke Goodenow, MS

Haley Pegram, MS

Compensation and
Financial Sustainability

For behavioral health providers, the conversation about workforce sustainability should not begin and end with wages. SMA has adopted a broader definition of compensation as one that values purpose, professional identity, and overall employment experience alongside pay.

- **Tuition Reimbursement:** SMA is committed to supporting the growth and advancement of its team. From 2023-2025, SMA helped 70 employees with tuition reimbursement, reducing their financial burden and strengthening retention. For team members continuing education or maintaining licensure, credential reimbursement is also provided. From 2023-2025, 266 employees were reimbursed for credentialing efforts, providing another benefit for professional development.

- **Tenure Bonuses and Recognition:** SMA offers a tenure bonus program tied to work anniversaries, offering milestone incentives at 3, 5, and 10 years of service. Team members are also invited to a celebratory luncheon, honoring their professional accomplishments and commitment to SMA. In 2025, 182 employees were recognized for their years of service, totaling 1,233 years.

SMA Healthcare's workforce development strategies demonstrate a comprehensive approach to strengthening the behavioral health workforce. By prioritizing recruitment, retention, training, and sustainability with evolving community needs, SMA illustrates how organizational innovation can drive systematic impact. These efforts not only address current workforce shortages but also build long-term sustainability through professional pathways, continuous learning, and a culture of equity and excellence. As behavioral health challenges continue to expand nationwide, SMA's model offers a replicable framework for developing resilient and mission-driven teams that advance quality and access to care delivery.

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Psycho-Oncology from page 25

1. Implement Technology-Integrated Screening and Triage - The greatest barrier to psycho-oncology care is often the lack of identification and seamless referral at the point of care. Leaders must prioritize partnerships that integrate behavioral health directly into the oncology treatment workflow via technology platforms.

- **The Technology Integration Model**: This system involves embedding behavioral health assessments and clinical guidelines directly into the oncology electronic health record (EHR) or clinical decision support system. This technology-enabled approach ensures that distress is treated as the "sixth vital sign," making screening mandatory and consistent.

- **Real-Time Intervention**: The integration allows the system to utilize patient-reported distress scores and clinical data to trigger flags. It can automatically generate suggested behavioral health actions for oncologists and facilitate direct, closed-loop referral and monitoring without relying on external faxes or fragmented communication.

2. Operationalize the Collaborative Care Model (CoCM) - For scalable and efficient support within large oncology centers and community practices, the Collaborative Care Model (CoCM) provides the necessary structure. This goes beyond simple co-location; it requires true operational integration in two phases:

Dr. Josh Myers, PhD, LPC-S

- **Implementing the CoCM Blueprint:** establishing a structured care management system with specialized roles: the primary cancer care team, the behavioral health care manager, the consulting psychiatrist, and the patient.

- **Scope, Value, and Monitoring:** ensures the support goes beyond simple talk therapy to include proactive, stepped-care monitoring, evidence-based interventions for sub-threshold symptoms, and psychiatric consultation for medication management. This is the gold standard for delivering effective psychosocial care in chronic illness settings and is incentivized under value-based care programs like the Enhancing Oncology Model.

3. Prioritize Specialized Training and Policy Advocacy - Effective psycho-oncology requires a specialized skillset that extends beyond generalist behavioral health practice.

- **Training Imperative:** Leaders must invest in training for their behavioral health staff in psycho-oncology principles, including the management of treatment side effects (e.g., steroid-induced mania), end-of-life concerns, and navigating oncological prognosis and language. This is vital to ensure that embedded providers are truly integrated and effective partners.

- **Policy Advocacy:** Behavioral health executives must advocate for pay policies that adequately reimburse the integrated, time-intensive services required by CoCM. Systemic adoption requires payer policies that fully align reimbursement with the immense value of coordinated care.

A Shared Vision for Leadership

The whole-person imperative is the next frontier in quality cancer care. Our role as behavioral health leaders is to make sure that emotional and mental support is seamless, efficient, and evidence based. By championing technology integration, implementing the Collaborative Care Model, and investing in specialized training, we can treat the whole person, close the 70% gap in care, and ensure that every patient feels seen, heard, and cared for in every part of their cancer journey.

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Relationships from page 26

after his housing became unstable. He relapsed after a long period of sobriety and started to spend the money he had saved on drugs. His stable housing was lost, and he ended up in a shelter. However, his health issues, which had been kept at bay, began to exacerbate and after a year of being in and out of hospitals, with his former colleagues trying to help him manage his affairs, he passed away. This friendly face that was a part of the fabric of the program, where we all worked, was suddenly gone. The manager of the program planned a memorial service for the same day that the peer workers were scheduled for their on-site group supervision, a few days after learning of his death. The manager was concerned about how the loss would affect the peer workers because, in this particular program, all the peers had lived experience with substances. Their risk of relapse over this loss was substantially increased. (The agency had announced, vaguely, that they would do a memorial "some time" the following month; again, what do we do with our feelings in the meantime?). The manager received an email from her supervisor just prior to the start of the memorial, chastising her for scheduling a service when there was a monthly management meeting on the calendar at the same time as the memorial. When the manager responded to the email noting the importance of giving the peers a place to grieve, she was told, in a stunning lack of empathy, "The staff can deal with that next week." The manager was then left with the task of telling the other supervisors that they had to choose

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between the memorial and the meeting (which was routinely recorded on zoom). The interpersonal damage had been done. The idea that people will deal with their grief when management has time to facilitate it is a textbook example of insensitivity as to how human beings actually work. It is an abandonment of leadership when it is needed most.

Several years ago, shortly after my brother passed away, I was telling my colleagues about "sitting Shiva." I was surprised to find out that they were completely unaware of this Jewish custom. (Shiva – which literally means "seven" - is the Jewish ritual of staying home for seven days following the funeral of an immediate family member, and receiving guests, who traditionally bring food as a community effort to care for the family). Shortly after that conversation, my agency was doing their annual Quality Improvement Project (QI) with the theme of "Improving Cultural Competence." My team chose to have an "Understanding Mourning Rituals" workshop. This included people bringing in dishes reflecting their culture and talking about the mourning rituals that they were brought up with. This took place in a residence for people with homelessness, substance use disorder, and psychiatric illness. The staff and the residents both participated in the meal and discussion. We talked about Shiva (over noodle kugel), what goes on at a wake, at a Christian funeral service (in both the North and the South, as African American churches have unique customs). Most importantly, we talked about how to support each other during times of loss and began to normalize talking about the pain of grief.

Regarding my own family situation, as my daughter was preparing to fly back to Washington where she works for a large, multinational corporation, she received a gift from her manager; a Door Dash card, to provide a meal for her and the family. It felt like a "virtual Shiva meal." This small and unexpected act of kindness left us feeling that the people she works for really care about her and her colleagues.

I would like to offer the following suggestions to support staff during times of loss:

- When a staff member passes away, a meeting should be held as soon as possible with the staff and clients involved. YouTube.

- (Remember, if *the person we lost doesn't matter, do any of us matter?*) This initial meeting should not be in lieu of a memorial or some type of service.

- Identify staff and/or peer workers who might be most at risk.

- Have HR or senior staff check in within a few weeks to see how people are doing.

- Have a "cultural exchange project," (such as the "Understanding Mourning Rituals" meal cited above) either in individual programs or across the agency, for people to learn about the customs of each other's cultures. This can include mourning rituals, responding to illness, or (more happily) how to support people with births or marriages. This is a way to learn how to best support our colleagues.

- Have HR protocols to reach out to people when they have had a significant loss. Some cultures highly value flowers, some food (as a care taking effort), some baskets, and some donations. What is most important is that the loss be acknowledged.

Sadly, loss and grief will always be a part of life. But if we can talk about it, and create healthy connections to cope with it, we can create a stronger and more supportive work community.

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our field – as well as mentorship opportunities and invitations to participate in clinical training sessions. Although it's too soon to measure the internship program's long-term impact on students' career plans, last year's participants expressed a strong interest in pursuing work in the aging sector, which is encouraging.

Looking beyond our own staff, we have also expanded our workforce training offerings in aging and mental health. For more than 25 years, SPOP has provided training designed to expand the knowledge, skills, and confidence of those who work with an older population. Thanks to grant funding from the MCHF, in 2025 we expanded that program statewide.

Using targeted outreach and marketing, we have provided no-cost training webinars to over 400 individuals throughout New York State this year, including about 150 participants from rural communities. We also partnered with the Dutchess County Department of Mental Health and Dutchess County Office for the Aging to offer two full days of customized workshops on aging and mental health, developed specifically to fill knowledge and skills gaps that they had identified. This collaboration – remarkably, the first of its kind between these two agencies – brought together 27 staff members for shared learning and skills building.

I can't overemphasize how valuable this kind of experience can be for mental health and aging services professionals who are burned out or feel alone in their work. We look forward to doing more on-site consulting and learning with providers throughout the state.

How does MCHF address workforce issues?

Marc: Yes, we are proud of our partnership with SPOP to address stigma surrounding mental health and ageism, and the internship program to help strengthen the pipeline. Other projects we're supporting to expand and diversify the workforce include educational scholarship programs, wraparound supports for graduate students to improve graduation rates and help them pass required certification/licensing exams, and programs that introduce high school students to rewarding careers in mental health through classes that can be applied toward college credit in a concentration for future work in mental health. Other grants invest in helping bilingual college graduates living in workforce shortage areas to obtain a master's degree, enabling them to practice in communities where they already happily reside.

Retention initiatives focus on employee recognition, supporting fair-market salaries, professional development, including supervision required for social workers to become LCSWs, and training to obtain skills to treat trauma or use evidence-based practices for SUDs or other complex conditions. We have also supported a social work residency program and a career ladder initiative to provide opportunities for lower-level workers to become mid-level managers.

MCHF recognizes the unique role foundations can play in supporting these initiatives that are essential and not reimbursable. At the same time, we are mindful that any project in mental and behavioral health we seek to fund needs to include staff, and should not be individuals pulled from other existing, core services. This is where providers and foundations can effectively collaborate.

How do you see direct service providers and funders working more closely together to address these issues?

Catherine: One of the important lessons we have learned is the power of collaboration. By working with staff from the Mother Cabrini Health Foundation, mental healthcare and aging services providers in the field, local and regional agencies, and schools of social work, we have expanded the conversation about aging and mental health throughout the state of New York. Together, we strengthened the workforce by providing skills-based training to more than 400 individuals and welcomed social work interns into the broader community of mental healthcare providers.

At SPOP we envision a world that values older adults and ensures age-affirming behavioral healthcare for all. But we know we cannot achieve this vision alone. Strategic alliances are the most effective way I know to overcome ageism and stigma related to mental health, raise awareness of the benefits of mental healthcare at every stage of life, and build a workforce equipped to support the health and independence of older adults.

Marc: I couldn't agree more – partnerships and collaboration are critical in any work in mental and behavioral health. These problems are too large and complex to go at them alone. That is why we value our partnership with SPOP. Your perspective has helped shape how we view opportunities to improve mental and behavioral health outcomes for rural older adults, and your partnerships with adjacent sectors and organizations have advanced our shared mission. In turn, I know the connections we have facilitated have helped expand your work throughout New York State.

We must remain open to having an ongoing dialogue -- identifying the problems and collectively brainstorming solutions that work.

Thank you, Catherine, for your partnership and for this meaningful conversation.

Catherine Thurston, LCSW, has served as Chief Executive Officer of Service Program for Older People (SPOP) since 2024, having previously served as Chief Program Officer. She has over 35 years of experience in gerontological social work. She has been a member of the Adjunct Faculty at the Silberman School of Social Work at Hunter College since 2016. She received her Masters of Social Work from Hunter College School of Social Work.

Marc Damsky, MPH, is a Senior Program Officer at the Mother Cabrini Health Foundation, supporting its grantmaking focused on Mental and Behavioral Health and responding to needs in the Long Island region. He received his BS from Brandeis University and Masters in Public Health from The Mailman School of Public Health. Before coming to MCHF, he spent his career in the service delivery system focused on older adults across different long term care settings and those with serious mental illness throughout New York City.

Leadership Strategies from page 23

Growing the Workforce Locally - For northern, Indigenous, and rural communities, local recruitment is essential. Leaders can invest in "grow-your-own" strategies, sponsoring students, funding local scholarships, and providing clinical placements within the community. Retention rates are significantly higher when learners train where they eventually practice.

2. Retention Through Supportive and Sustainable Work Environments

Recruitment means little if organizations cannot retain the professionals they hire. Behavioral health care is emotionally demanding, and teams often work with limited resources. Leaders need to design workplaces where people feel supported, valued, and able to grow.

Psychological Health and Safety as a Leadership Priority - Executives play a critical role in shaping organizational culture. Implementing psychological health and safety standards, not as a document on the shelf, but as a lived practice, can reduce burnout and turnover. Leaders should ensure manageable caseloads, access to debriefing, and routine supervision structures. Investing in wellness is not a cost; it is a retention strategy.

Cultivating Leadership Within the Workforce - Too often, behavioral health clinicians feel disconnected from decision-making processes. Emerging leaders, particularly new graduates, need mentorship, coaching, and clear pathways for advancement. Programs that pair early-career professionals with seasoned leaders help create a sense of belonging and purpose, and they build a strong leadership bench for the future.

Embedding Flexibility and Innovation in Work Design - Flexibility is now a key driver of workforce satisfaction. Blended schedules, hybrid roles, and opportunities for portfolio diversification allow clinicians to balance direct patient care with re-

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search, quality improvement, or education. Leaders who embrace flexible models are better able to retain experienced professionals who might otherwise leave.

3. Leveraging Technology to Expand Capacity

Technology is often discussed as a replacement for in-person care, but its real value lies in extending the reach and impact of the workforce.

Digital Tools as Workforce Extenders - Virtual mental health services, AI-supported clinical decision tools, and digital therapeutics can relieve pressure on clinicians by streamlining assessments, enhancing patient monitoring, and reducing administrative burden. When implemented thoughtfully, technology helps clinicians focus on high-complexity tasks while automating routine processes.

Training the Workforce for a Digital Future - Executives must ensure staff have the confidence and skills to use digital tools effectively. Ongoing training, peer support groups, and "digital champions" embedded in clinical teams help bridge the gap between innovation and practice. Technology must feel like an enabler, not an added stressor.

4. Strengthening Interprofessional and Community Partnerships

Behavioral health care does not operate in isolation. Effective workforce strategies require collaboration across sectors, disciplines, and community systems.

Building Interprofessional Teams - Teams that include nurses, social workers, peer support workers, addiction specialists, and community health navigators can distribute workload more effectively. Interdisciplinary collaboration ensures patients receive timely, comprehensive care and reduces the pressure on any single provider group.

Partnering With Community and Indigenous Organizations - Community partners offer cultural knowledge, trusted relationships, and resources that the traditional health system cannot provide alone. Co-developed programs with Indigenous leaders, social service agencies, and nonprofit organizations enhance cultural safety, support local hiring, and strengthen continuity of care.

5. A New Model of Leadership for Behavioral Health

Perhaps the most important element of workforce transformation is leadership itself. Executives must shift from crisis-driven management to courageous, strategic, and relational leadership that puts the workforce at the center of system redesign.

Leading With Purpose and Transparency - Honest communication about workload pressures, recruitment challenges, and organizational priorities builds trust even in difficult circumstances. Transparency allows clinicians to feel included rather than blindsided by change.

Driving Innovation Through Co-Design - Frontline providers have deep insights into what works, and what doesn't. Leaders who invite clinicians, patients, Elders, and community partners into co-design processes create solutions that are grounded in lived experience, not assumptions. Co-design also increases buy-in and reduces resistance to change.

Data-Driven, People-Centered Decision Making - Executives must use data to guide workforce planning, but numbers alone cannot shape strategy. Metrics should be paired with real narratives from the workforce: stories of burnout, success, and innovation. Combining quantitative and qualitative insights leads to more responsive policies and resource allocation.

Conclusion: The Future of Behavioral Health Depends on the Workforce We Build Today

The behavioral health care landscape is at a defining moment. System pressures are real, but so are the opportunities for meaningful change. If healthcare executives can lead with vision, investing in workforce development, supporting innovation, and centering staff wellbeing, the system can emerge stronger, more resilient, and better able to meet the needs of communities.

Behavioral health care transformation is not just about adding staff or introducing new technologies. It is about reshaping how the system values and supports the people who deliver care every day. The choices leaders make today will define the quality, accessibility, and humanity of behavioral health care for decades to come.

Sarvesh Mohan is a healthcare leader with expertise in clinical excellence, quality improvement, and hospital leadership. He has contributed to national publications on patient safety, strategic planning, and healthcare leadership, shaping best practices across the sector. Sarvesh is pursuing an MBA and holds a Bachelor of Dental Surgery (BDS), and a Post-Graduation in Healthcare Administration and Service Management. He is certified as a CPPS, CPHQ, CHFP, and PMP, demonstrating his dedication to driving innovation and excellence in healthcare.

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be set up much like a Zoom conversation between the host and the guest. Some questions are known before the podcast begins, and some are impromptu, leaving room for spontaneous ideas to QA.

The guiding content principles we use to keep us on track are:

- The podcast must present new and innovative ideas that will inspire the listener to try new approaches to their work.
- There must be a degree of intimacy on both the part of the host and the guest. This can include questions or stories that bring forth deep feelings of joy and sadness, disappointment and satisfaction. We bring the conversation around to beliefs and doubts that leave room for a robust discussion that provide a safe setting for staff to explore new ways of doing the work that is sustainable.
- Most accrediting bodies require a written description of the content, at least five learning objectives, an agenda that reveals how much time is spent on each objective, and a 10-question test.

As behavioral health continues to evolve, so must the ways we support the workforce. This process not only delivers knowledge, but it also builds connection, relevance, and a sense of shared purpose. And in behavioral health, that can make all the difference.

To view podcasts that we have created, visit the Crestwood Recovery Resilience Solutions website and click on Viva La Evolution. There you will find more than 64 podcasts that feature interviews with leaders in the recovery and behavioral health field, as well as people who are in recovery and how they got there.

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Additionally, according to one researcher, even before the pandemic, formerly incarcerated people had an unemployment rate of around 27%. That is higher than at any point since the Great Depression. People who have been incarcerated lose up to $500,000 in earnings over their lifetimes.

Those released from incarceration often owe upwards of about $13,000, on average, in court fees and fines (publicintegrity.org/inequality-poverty-opportunity/how-financial-barriers-stifle-formerly-incarcerated-people).

It is through a confluence of all these points that the "*Lives Forward*" program was created. Seeking to create a pool of dually certified peers with lived criminal justice experience, Westchester County developed a model for currently incarcerated individuals to potentially fill a need in the service system, as well as foster deeper insight into one's own on-going recovery.

Lives Forward is a collaborative model developed by the Westchester Department of Community Mental Health (DCMH) that works directly with the Westchester County Department of Corrections (WCDOC) and community-based service providers, as well as accredited peer program trainers for both the OMH and OASAS systems. Like prospective peers, the *Lives Forward* trainers have concomitant lived

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experience with mental health and/or addiction diagnoses, as well as criminal justice system contact.

With broad-based agreement across the community that peers with lived experience can make a great impact on those with co-occurring disorders and those who are entering either the mental health or criminal justice system, it has been found that meeting the need and finding peer counselors has been difficult. *Lives Forward* is a program that serves to help us "grow our own staff."

Funding from the Opioid Lawsuit Settlements is used to contract with the peer certification training providers. Currently, the Mental Health Empowerment Project (MHEP) provides the Peer Specialist Program, and the National Council on Alcoholism and Drug Dependency, Westchester, Inc. (NCADD) provides the Recovery Coach training.

Since early 2024, the program has been serving individuals who reside in the Westchester County Jail. Facility and program staff inform current residents about the opportunity to become dually certified as peers. Those who are interested and self-identify are then screened for their potential to successfully participate. The trainers work collaboratively with WCDOC staff to fill each class with 8–12 participants. The program uses a small-group format and recognizes that participants may return to the community before completing it. Upon return to the community, individuals will be able to continue the program until completion and certification.

Working with DCMH, the community providers will serve as a "clearinghouse" to connect now-dually certified peers with potential employers, with the goal of facilitating timely employment as paraprofessionals. This creates a potential win-win: strengthening recovery for successful *Lives Forward* participants while also benefiting the individuals they ultimately support and guide.

The creation of this expanded workforce offers numerous lasting benefits. Community-based providers frequently seek peers and recovery coaches, and Lives Forward ensures the development of a trained workforce to meet this demand. Returning citizens gain real opportunities for meaningful work and career growth—opportunities they may not have imagined—while participating in a program that supports their own recovery. This collaboration not only helps build a sustainable workforce but also provides essential peer support that can reduce recidivism and keep people out of the criminal justice system.

To date, *Lives Forward* has completed five cohorts in the jail, with more than 40 students successfully completing both programs. Because residents in the jail do not have internet access, accreditation requires intensive support in the community after release. Several students have gone on to become certified Peer Specialists and/or Recovery Coaches, with some securing employment in the treatment field.

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personal healthy choices, such as company-sponsored 5k runs, personal finance education, and vaccine clinics. In contrast, workplace wellness programs targeting organization-level factors aim to create a supportive environment that reinforces the benefits of making healthy choices. Research suggests interventions promoting workplace wellness are more effective when they include structural strategies and organization-directed approaches (Olsen et al., 2019).

A further study compares a health promotion program targeting the workplace's social climate to a program targeting employees' personal health choices, and measures effects on wellbeing outcomes. The study also compares each program's mediating effects (if any) on wellbeing climate, defined as perceptions of coworker relationships, policies, and supervisor behavior that support optimizing physical and mental health. The findings indicate workplace health promotion programs targeting social climates positively correlate with positive wellbeing outcomes (perceived wellbeing, positive unwinding, help-seeking attitudes), negatively correlate with negative wellbeing outcomes (health symptoms, work-family conflict, stress, substance use), and have a significant mediating effect on the organization's wellness climate. In contrast, the program targeting individual health choices had no effect on workplace wellbeing climate, a result likely attributable to the mediating effect of the workplace's wellness climate (Reynold & Bennett, 2023).

How Organizations Can Build Connection

Connection is a key element distinguishing organizational strategies for workplace health promotion from interventions targeting individual behavior change. Connection is the driving force in wellness interventions such as communication skill development workshops, leadership development programs, role-playing activities for peer support, and facilitated discussions on topics such as workplace norms and policies, organizational values, and resources available to staff both inside and outside the workplace (Reynolds & Bennett, 2023; Olson et al., 2019).

Kara Cloud, BA

There are numerous creative ways to center connections in the workplace. Providing staff with guidelines for healthy communication and tools to improve communication and listening skills, such as journal prompts and reflection questions, can improve workplace conversations and culture. Similarly, offering leadership training can break down silos and increase positive behavior modeling, creating far-reaching effects. Providing education on the early warning signs of stress among coworkers and offering guidance on how to seek help can improve psychological safety and increase prosocial behavior. Normalizing feedback and assessing and responding to the workplace wellness climate demonstrates that the organization truly values employees' perspectives and presence.

Conclusion

Workplaces are a major point of connection in people's lives, and a focal point within communities. Connection is more than a soft skill, but a structural determinant of wellness. Organizations that intentionally cultivate connection not only support our workforce but also improve outcomes for the people we serve.

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Overdose Prevention from page 20

workforce requires more than training. It depends on leaders who model supportive communication, supervisors who create space for questions, and team cultures that normalize discussions about overdose risk. Providers build confidence through practice, reflection, and environments where uncertainty is expected rather than hidden. When staff feel grounded, connected, and supported by their organizations, prevention becomes a natural part of the workday instead of an additional burden.

My commitment to this field is shaped by personal loss and strengthened through my work in prevention. I believe in a behavioral health workforce that feels equipped and supported to recognize overdose risk early and integrate safety planning into routine care. When providers have clear frameworks and training pathways, prevention becomes manageable instead of overwhelming. This creates continuity across service settings, reduces crisis-driven responses, and strengthens recovery-oriented environments. A community that can talk openly about overdose is a community that protects life, and I'm committed to advancing an upstream model that helps providers make that possible.

Stephanie Simons is an MSW Intern at Zero Overdose and an MSW Candidate at Saint Mary's University of Minnesota.

Dr. David Deitch from page 21

families, not just to one specific drug, but to excess itself. To a biology that can get captured by it." That vulnerability, he says, is deeply ingrained and not easily resolved through social policy or intervention.

In that light, addiction becomes less of a social anomaly and more of a human constant. "It's something we'll always be living with," he says. "When we look at children of alcoholics, for example, that's one of the clearest tools we have for understanding this condition."

Trauma and the Gene Bank

But the picture isn't purely genetic. Psychological trauma, especially childhood trauma, is often present in the lives of people with substance use disorders. While Dr. Deitch acknowledges this connection, he cautions against viewing it as a complete explanation. "We shouldn't pretend it's an accident, but we also shouldn't ignore that once a genetic vulnerability shows up in the gene bank, it becomes a constant danger for generations."

This dual lens—genetics and trauma—shapes how we should view prevention and treatment. "The interplay is real," says Dr. Deitch, "Abuse, neglect, dysfunctional families—all of it contributes. But even without a clear family history, people can still develop addiction. And when that happens, we must ask what other traits, impulsivity, self-neglect, acting out, may point to underlying vulnerability."

The challenge is that these traits don't operate in isolation. "It's hard to tease apart what's most significant. Often, it's not just one thing. And when these behaviors are left unchecked, they can become antisocial, and that tends to go hand in hand with substance misuse."

Implications for Solutions

What does all of this mean for preventing and treating addiction? Dr. Deitch believes it starts with early awareness. "That doesn't mean banning alcohol from someone's life, but it does mean recognizing the signs early and acting accordingly. For some, information is enough. For others, we need an action plan, something reparative."

He emphasizes that culture and environment shape how this work unfolds, but the core idea remains: identify risk early, and respond with empathy, not just control.

Addiction isn't something we'll "solve," but with humility, compassion, and a deeper understanding of both biology and environment, we may be able to better support those who struggle with it and perhaps even change the course for the next generation.

Dr.Deitch's life spanned decades in and out of recovery spaces. He's witnessed the evolution of the therapeutic community model firsthand, from the raw, experimental days of Synanon to more professionalized iterations like Phoenix House. And he carries those stories not as a historian or academic, but as someone who lived them from the inside out.

"We were experimenting in real time," he told me. "No manuals, no metrics, no funding protocols, just human beings trying to figure out how to save each other."

But over time, the movement fractured. Some communities professionalized. Others veered into controlling, even cult-like behavior. And still others dissolved under the weight of financial or political pressures.

One of the most pressing questions today: *What parts of that original model are worth preserving? And what parts should we leave behind?*

The Early Days: Magic and Mayhem

Synanon, Daytop, and Phoenix House weren't just programs, they were countercultures. People came not only to get sober, but to remake their lives entirely.

"There was a specialness to it," Dr. Deitch said. "It felt magical. Painful, yes, but also transformative."

In those early years, everything was communal. Confrontation was the norm. You might be called out brutally in the morning but still have coffee with the same people that afternoon. Forgiveness came after penance. Suffering was a currency, and for many, the first sign that healing was even possible.

"We were turning the ugliness in our private lives into something communal. There was camaraderie. There was meaning."

But it didn't last. At least, not everywhere.

"I watched the Netflix documentary," he said. "And I was disgusted with how impressionable I was. What I thought was brilliance, I see now as narcissism. But at the time? We believed. Wholeheartedly."

When the Dream Curled Inward

Dr. Deitch's disillusionment began in San Francisco, during a leadership transition. He was asked to run a facility, a rarity at the time for someone so newly in recovery. And then, two moments changed everything.

First, when he brought up a book he admired, Synanon founder Chuck Dederich replied, *"I don't read other people's books. I write them."*

Second, he was told to hustle a Cadillac for Chuck. *Not a Chevy. A Cadillac.*

"That was it," he said. "I started to see him clearly—not as a wise leader, but as a man who had lost touch with what we were doing."

Shortly after, Synanon abolished the second and third phases of treatment. The message was clear: once in, always in. There was no graduation, no reentry into society. What started as temporary healing became a permanent lifestyle.

Radical Shifts and Growth

Some of the program's changes veered into the bizarre. Same-sex couples were split up. Clothing and presentation were strictly policed. New romantic partnerships were assigned by leadership. What had once been framed as recovery now resembled social engineering.

"There were elements of insanity," Dr. Deitch said. "But at the same time, it was an incredible social experiment. For the first time, people with addiction were living without using drugs, working together, and creating something new."

Even as Synanon's model frayed, its legacy spread. Other therapeutic communities across the U.S. adopted parts of the approach—some more grounded, others harsher still.

"New York's version was more aggressive. California's had softness by comparison," he reflected. "But New York was also more racially tolerant. There were contradictions everywhere."

What Do We Keep?

So where does that leave us now?

"Disclosure," Dr. Deitch. Said, "That's the piece I'd fight for. The power of personal truth-telling—not to shame, but to shed shame."

He explained how early marathon groups invited people to move step by step—from guardedness to vulnerability, from secrecy to relief.

"By the end, people weren't just crying—they were rejoicing. They had been seen. And still accepted."

But he's clear that this process takes time.

"You can't expect someone to tell you about their deepest trauma on day one. You start with what they *can* say. And you build from there."

What Must Change?

And what should be left behind?

"The aggression. The humiliation. The idea that you must be broken to be healed."

At Phoenix House, we began shifting the model with "Care and Concern" groups, structured forums for resolving conflicts and developing interpersonal insight. Borrowing from family therapy models, we taught clients constructive ways to voice struggles. We created a practitioner's manual and trained both staff and residents.

The results were mixed: many clients embraced the approach, while others clung to harshness as the only path to change. Perhaps, we concluded, this was more about familiarity than actual necessity.

As David often advised: "Admonish with love. Healing happens in safe communities, not punitive ones."

We trained staff in motivational interviewing, used positive reinforcement and incentives, and incorporated trauma-informed approaches. The storied 24-hour marathons, once the stage for processing trauma, were replaced with safer, more structured interventions.

The Evolution Ahead

Dr. Deitch sees ongoing value in therapeutic communities, if they continue to evolve, though shorter treatment stays threaten their efficacy. He questions the extent to which we can get good outcomes as the duration of treatment becomes shorter.

"The old model worked on multiple levels, emotional, cognitive, behavioral, and social. Most importantly, it gave people connection and community. We can still do that. But we need to bring back emotional depth. That's what's missing now."

He believes in integrating TC principles with contemporary approaches: blending CBT with small, emotionally focused process groups. "There's no real cognition without emotion, no transformation without vulnerability." Guided by that belief—and inspired by Kevin McEneaney, then COO of Phoenix House—we developed a manualized program called *Emotional Cartography*. Designed for both group facilitators and clients, the program applied principles of CBT to build emotional literacy, foster introspection, and encourage progressive self-disclosure and emotional processing. Through structured workbook exercises, clients labeled and mapped their emotions, identified personal triggers, and practiced strategies for managing their feelings, sharing insights and reflections with their peers in group sessions.

And the central lesson to this day, he says, remains clear: "People don't need to be hurt to grow. They need to be seen and valued. That's the heart of it."

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Supervision from page 23

aligned professional relationship in supervision where the input of the supervisor does not automatically supersede or overrule the input of the supervisee (Berger and Quiros, 2014; Narouze, et al. 2023). Finally, there is empowerment. This occurs when supervisees are given opportunities to learn and put what they have learned into practice as well as receiving validation and approval when appropriate (Berger and Quiros, 2014; Narouze, et al. 2023).

Another element of trauma-informed supervision is awareness of trauma and its effects on the supervisee. Berger and Quiros (2014) state that "Ongoing supervision has been recognized as a major protective factor because it can serve as a buffer against vicarious trauma, that is, trauma reactions triggered in clinicians because of working with traumatized clients (P.298). These trauma effects include over identification with the client, indirect trauma, vicarious traumatization, compassion fatigue, neglecting self-care, and burnout (Berger and Quiros, 2014, Berger and Quiros, 2016; Knight, 2013; Quinn, Ji, and Nackerud, 2019). Quinn et al. (2019) posit that a supervisor who provides "a genuine, open, understanding, and accepting environment for the supervisee" (P.521) may provide a protective environment for supervisees on reducing the effects of secondary trauma symptoms. Considering this, the supervisor must take care to maintain professional boundaries and not transform a supervision session into a therapy session (Knight, 2013). Conversely, the supervisor needs to balance this with what the supervisee may be experiencing. Knight (2013) indicates that a supervisor may concentrate too heavily on the clinical work with the client and not provide any or ample time for the supervisee to share feelings, etc. thus leading to resentment. Hurless (2024) states "A supervisor who is knowledgeable of trauma-informed practice and applies trauma-informed practices in their work may be able to supervise more effectively by offering supervisees a safe, trusting, transparent, and empowering relationship" (P.3).

Marc Liff, LCSW ACSW

Reflective practice

Reflective practice, also known as reflection, use of self, and/or critical reflection is a well-known method of looking into oneself to learn about oneself ultimately resulting in increased understanding of oneself (Asakura and Maurer, 2018). Reflection consists of stopping and truly thinking about what one heard from the client, supervisee, or supervisor as well as what ideas, preconceived notions, memories, etc.one may have inside that may skew or affect what is heard.

Related to this is inquiry. This occurs when one (supervisor) asks or respectfully probes for more information from the other (supervisee) so both can gain a deeper understanding (Varghese et al. 2018). Varghese et al. (2018) recommend two strategies to assist the supervisor in creating an environment conducive to reflective practice. One strategy includes engaging in dialogue with the supervisee. Engaging in dialogue entails listening, suspension of judgment, identifying biases, and reflection. It is actual engagement in a conversation and not listening to another with the goal to only respond. The second strategy is locating oneself. Locating oneself entails reflecting on one's personal identities and where one may fall at the intersection of many identities to better learn about oneself and be able to accept what the other person is presenting (Varghese et al. 2018). As countertransference and other forms of vicarious trauma affect a supervisee, they evoke emotions, feelings, memories, and other personal from a supervisee's life which not only influence the work in supervision but with clients as well. Reflection and the use of self is an effective tool to confront this when presented in a supervision atmosphere that makes one feel safe enough to be vulnerable and share their true feelings.

To improve the supervision experience so both the supervisor and supervisee can not only feel safe, trusted, validated, and valued, trauma-informed principles can be very effective when utilized in this setting. When this type of supervision environment is achieved, reflection can be utilized more effectively as well as the participants feel safer to probe deeper into themselves and be able to make themselves more vulnerable with their feelings, emotions, experiences, biases, and whatever else is found inside them.

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Carli Lloyd from page 24

Chandler: What advice would you give to a teenager now, who feels like they're struggling with a personal mental health crisis?

Carli: I think the biggest thing I would say is to remove what's not healthy in your life. I think you are all growing up in a generation different from the world I grew up in. You have social media, you have everything being plastered everywhere, what you should look like, what you should do, what you should buy, and I think it goes back to just trying to embrace who you are as a human being. If there are some things in your life that aren't healthy for you, if that's social media- get rid of it, if it's your friends- get rid of it. And I know that's hard because of the pressures, but I just go back to trying to be the best human being you can be. The pressures of growing up are difficult, but if you can surround yourself with the people that help you the most, that can offer you the best advice, I think that would be the best thing.

Chandler: How do you deal with social media hate?

Carli: I think there's a false reality of life of what's being put out there in social media. I've always tried to lead an authentic life. A lot of what you see isn't the real true reflection of people's lives. I don't get my validation from outside people or social media. I think the most important thing is you can't look at people who don't know who you are for feedback in your life. What makes me happy is just being real, being authentic, being with people that mean the most to me. That's my support system, husband, family, and friends.

Chandler: What tools or practices have helped you the most with your mental health, especially during moments of self-doubt or public criticism?

Carli: Relying on my support system, that is a big one. I think it's important to have people in your corner who are not going to kill you to death, but they are going to support you and give you tough love. Getting through challenging situations, like failing, struggling, injuries, if a coach benched me or if I got cut, being able to brush that off and fight back and build myself back up allowed me to become more mentally tough. Self-reflection also helped, reading books, self-help books, motivational books, and quotes.

Chandler: What lessons do you try to pass on to kids you coach?

Carli: I do some soccer clinics, and I always tell the parents, I'm not going to turn your son or daughter into a professional soccer player. The most important thing to me is to get across the messaging of just trying to be a good human being. Sports can bring that out in people. It can help in your social life, your athletic life and educational life. It's just honing those skills of being a good person, being a good teammate, being a good student, working hard, knowing that things aren't going to be handed to you. Be more in love with yourself. People put so much pressure on how they must be as a person, if you look a certain way, or grew up in a certain household it shouldn't matter. Everyone brings something unique to the table. I think the most important thing is to know you're unique and embrace who you are as a person. And every single day just try to do a little something to get better.

Carli Lloyd's story reminds us that greatness isn't just measured in medals or goals. It's also about real conversations, talking honestly about mental health and sharing wisdom to guide the next generation. As I left our conversation, what stayed with me most was how grounded Carli is and that vulnerability is not weakness, resilience doesn't mean going alone, and protecting your mental health is just as vital as chasing any dream. The biggest action I'm taking from our conversation is evaluating what's not healthy in my own life and removing it.

Chandler Stone is a high school student, athlete, and mental health advocate. She volunteers at a crisis center answering calls to support people in need and leads community programs that provide tutoring and resources for kids experiencing homelessness in Los Angeles. For more information, email ChandlerGStone@icloud.com.

Peer Support from page 25

from within these facilities through targeted outreach and engagement, introducing them to Peer Support as both a discipline and a viable career pathway. Because PSS professionals must have lived experience with recovery, PELC participants bring the ideal foundation to the work.

Importantly, PELC is designed not only for program participants but also for the systems and staff who support them. The model recognizes that *organizations themselves must also recover*—from the impacts of stigma, outdated policies, and the unintentional disempowerment often perpetuated within institutional settings. PELC therefore invests in whole-system development, ensuring that recovery values are embedded throughout each participating facility.

Peer Employment Learning Center (PELC) Program Components

The PELC project encompasses four major components:

- Planning, Infrastructure, and Organization
- Competency-Based Curricula
- Career Planning and Paid Internship
- Formal Celebration, Community Placement, and Outcomes Measurement

Planning, Infrastructure, and Organization - The process begins with collaboration. Leadership teams, program managers, conservators, vocational coordinators, and training facilitators meet to map out the schedule, allocate resources, and define expectations for each site. Monthly PELC Group Meetings continue throughout the program, ensuring alignment, accountability, and consistent support—extending even beyond the graduation celebration.

Competency-Based Curricula - PELC's training investment is significant, reflecting its goal of establishing a true Recovery Culture across each organization. Training includes leadership development, staff-wide education, participant-focused skill building, and mentor preparation, totaling

James A. Ritchie, PhD, CMPSS

hundreds of hours across roles. All leadership and mentors complete the same 80-hour Medi-Cal PSS Certification Training as participants—ensuring a shared understanding of scope, competencies, and recovery principles.

Key curricula include:

- **Recovery Practices for Leaders** – 16 hours (Martin, C.W., & Ashcraft, L. (2017). Recovery Practices for Leaders. Crestwood Behavioral Health, Inc.)
- **Recovery Practices of Organization (All Staff)** – 8 hours (Martin, C.W., & Ashcraft, L. (2018). Recovery practices for organizations. Crestwood Behavioral Health, Inc.)
- **Medi-Cal Peer Support Specialist Certification (Leadership & Supervisors)** – 80 hours (Martin, C.W., & Ashcraft, L. (2016). Peer support learning for the 21st century. Crestwood Behavioral Health, Inc.)
- **Resilient Culture Playbook** – 8 hours
- **How About a Vocation (Resident Candidates)** – 16 hours
- **Medi-Cal PSS Certification (PELC Participants & Mentors)** – 80 hours
- **Mentor Training** – 4 hours
- **Intern Orientation** – 4 hours

Through these efforts, the organization adopts a strengths-based approach that elevates hope, agency, and meaningful contribution for everyone involved.

Career Planning and Paid Internship - After completing their 80-hour certification training, participants advance to a 10-week paid internship and become PSS Interns. Each intern works seven paid hours per week carrying out tasks aligned with the official California scope of practice:

1. Sharing their recovery story
2. Providing intentional one-on-one Peer Support
3. Planning and co-facilitating wellness and recovery groups
4. Supporting residents in completing recovery documentation

Each intern also receives one hour of weekly mentorship. To ensure financial stability, staff proactively coordinate with conservators and benefits systems to mitigate impacts on SSI or SSDI. Increased earnings often allow interns to save for future needs, softening any temporary adjustments to benefits.

Graduation, Community Placement, and Measured Outcomes - Upon completing the internship, participants graduate in a formal ceremony—caps, gowns, community partners, and family included. Even if individuals discharge before finishing the internship, they are invited to return and celebrate their achievements.

After graduation, vocational planning continues. For individuals still on conservatorship, employment opportunities may continue through the Dreamcatchers program, allowing ongoing paid work as a PSS within the facility. Graduates who are discharged from conservatorship receive support in applying for open positions across Crestwood or within community-based programs. PELC also provides resources to help graduates prepare for and complete the state certification exam to become Certified Medi-Cal Peer Support Specialists (CMPSS).

Expected outcomes include:

- Paid employment as Peer Support Specialists
- Dreamcatcher roles for conservatorship-maintained participants
- Volunteer opportunities to build additional work experience
- Part-time or full-time employment while maintaining benefits
- In rare but powerful cases, full-time employment that leads individuals to voluntarily exit disability status through Ticket to Work

A Model for Systems Change

PELC represents more than a workforce initiative—it is a system-level intervention that reimagines what is possible for individuals on conservatorship. By centering lived experience as a strength, PELC transforms recovery from a theoretical concept into a lived, shared practice. It reframes conservatorship not as an endpoint but as a place where hope and opportunity can take root.

As Peer Support continues to expand nationally, PELC stands as a model for what compassionate, recovery-oriented innovation can accomplish. It recognizes what the evidence has long shown: people recover, communities recover, and systems can recover too.

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Human-Centered from page 31

Measuring the Impact of Human-Centered Engagement

Human-centered and relationship-based engagement gives members the kind of steady support that helps them stay connected to care. When someone reaches out with consistency and genuine interest, members are likely to participate more fully in their treatment plans because the guidance they receive fits their day-to-day reality. Care teams gain a clearer picture of what members are dealing with, since real conversations surface stressors and barriers that standard outreach often misses. With this insight, providers and health plan teams can respond in ways that are more timely, appropriate, and effective. Meaningful changes like these come from trust, continuity, and a real relationship, not from increasing the number of calls or reminders.

Lauren Barca, MHA, RN, BSN

Why Engagement Models Need to Change

It's clear that behavioral health engagement requires more than transactional outreach or one-size-fits-all communication. Automated messages and rigid scripts move quickly, but they cannot capture the complexity of what many members are dealing with. Without rethinking how engagement works, organizations may continue to fund programs and interventions that never reach the members who need them most. Supporting behavioral health engagement is not just a clinical task, it is a shared responsibility across the system.

The Case for Partnering with Relationship-Based Engagement Teams

Behavioral health barriers often touch many parts of a member's life, which means effective engagement requires more than basic outreach skills. Teams trained in relationship building and motivational communication are better equipped to reach members who have stepped away from care. Their work gives providers and plans clearer visibility into what members are facing, which helps guide more effective support. With that foundation, relationship-based engagement reaches members traditional outreach cannot and helps them regain stability.

Human-centered engagement is not a nice-to-have, it's often the missing link in behavioral health because it gives members the steady support they need to return to care and move forward.

Lauren Barca, MHA, RN, BSN is VP of Quality of 86Borders, a human-first care coordination and member engagement company that helps health plan members overcome obstacles to care – especially among hard-to-reach populations.

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Tribal Nations from page 27

Together, the Pawnee Nation and ARS assembled a diverse capital stack that blended Tribal American Rescue Plan Act (ARPA) funds, federal and state grants, New Markets Tax Credits facilitated by Ryker Douglas, Baker Tilly, USDA-backed loans, and short-term, non-dilutive private investments.

From the intimacy of room designs to community-centered spiritual-care spaces that honor holistic health, and the art of storytelling, Elders, clinicians, and community members shaped the vision so that every element reflects the heart of Pawnee values.

Beyond Treatment: Rebuilding Economies and Culture

Investing in behavioral health is also economic development. The Pawnee Nation project supports dozens of skilled jobs and workforce development training. When recovery services operate within the community, transportation costs drop, family involvement rises, and the benefits ripple outward to schools, workplaces, and future generations.

For many Tribal leaders, this kind of project represents healing sovereignty: the ability to reclaim health, identity, and prosperity on their terms. Every dollar reinvested locally reduces dependency on culturally disconnected systems and reinforces a continuum of care that sustains long-term recovery.

A Model for the Nation

As CEO of Ascension Recovery Services, I've learned that the most powerful solutions are those built with communities, not for them. The Pawnee Nation Behavioral Health Facility proves that culturally grounded, financially strategic recovery centers can thrive and that Tribes need not shoulder the financial burden alone.

Across the country, other Native Nations are exploring similar initiatives using innovative funding mechanisms such as 638 compacts, 340B pharmacy programs, and USDA loans. The momentum is real, and the impact extends far beyond Tribal Lands. These projects demonstrate what's possible when we invest in wellness as a driver of both public health and economic vitality.

Investing in healing is investing in a future where recovery is not imported but homegrown.

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Triage Menopause from page 33

evidence-based behavioral strategies within the same visit:

- **Sleep Hygiene:** Targeting insomnia related to night sweats.
- **Cognitive Behavioral Therapy (CBT) for Hot Flashes:** A validated intervention to reduce the impact and severity of vasomotor symptoms (Hickey et al., 2022).

These interventions offer immediate relief while the patient awaits a specialized medical follow-up, thereby embodying whole-person care.

Upskilling for Emerging Roles

To maximize the BHC's effectiveness in this crucial area, there must be a deliberate effort to upskill the existing workforce. While many BHCs are skilled in depression and anxiety, training programs should embed competencies specific to women's health throughout the life cycle, including understanding neurobiological mechanisms and familiarity with menopausal treatments.

By investing in this specialized training, health systems transform their BHCs into clinical experts who not only screen for general mental health issues but also serve as the clinic's front-line specialists for midlife women's health. This strategic investment is a practical solution to the behavioral health workforce challenge, aligning with national efforts to expand access and quality of care (Bishop et al., 2024).

Essential Resources for BHCs and Patients

As BHCs often serve as educational resource brokers, having a curated list of reliable, evidence-based sources is vital for supporting patient self-management and facilitating informed dialogue with the medical team.

Conclusion

The integration of behavioral health consultants into the primary care system is not just beneficial; it is vital. The BHC in integrated care is more than just a therapist; they are sophisticated triage specialists and educators. Leveraging their role to "unmask" menopause from generalized mood disorder is a powerful example of workforce innovation that yields better diagnosis, targeted treatment, and ultimately, superior patient outcomes.

Kim Hunter-Bryant, MA, LCSW, PMH-C, serves as the Director of Women's Health & Wellness and a Behavioral Health Consultant at Covenant House Health Services. An advocate for workforce innovation in integrated care, she specializes in the intersection of behavioral health and women's midlife transitions. Her clinical work focuses on "unmasking" menopausal symptoms in primary care to ensure accurate diagnosis and holistic treatment. For more information, contact kbryant@covenanthousehealth.org or visit Kim's LinkedIn Profile.

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Peer Specialists from page 27

this role is, as well as the ongoing over-professionalization of mental health services. With greater adoption of the peer support model through increased funding, we have an opportunity to turn the tide on a widening gap in care.

Embedding Lived Experience Across Crisis, Youth, and Family Systems

Peer support strengthens mental health systems by embedding lived experience across prevention, crisis response, youth development, and family engagement, and offering scalable solutions.

At Vibrant, the peer support role is integrated throughout multiple areas – beginning with family advocacy. Vibrant pioneered New York City's first Family Support Program and Parent Resource Center, establishing a model that centers caregivers as informed partners and advocates for their children. In crisis services, there is dedicated peer support within NYC 988 and HOPEline to ensure that individuals in distress can connect with trained peers whose lived experience helps reduce stigma, encourage hope, and foster continued engagement.

Youth peer advocacy is integrated into community-based programs such as the Adolescent Skills Centers and the Queens Affirming Youth and Family Alliance, where peer advocates support young people through shared experience rather than solely through clinical intervention. The Children's Coordinated Services Initiative is a collective of NYC-based organizations, driven by Vibrant, who come together to center the role of family and youth peer advocates within youth-serving systems. Peer navigation within family and youth programs further helps individuals access services, stay connected to care, and build long-term self-advocacy skills.

Together, these approaches demonstrate how peer integration functions not as a singular program, but as a workforce and delivery strategy that enhances care quality, strengthens trust, and addresses gaps in access across the mental health system. Grounded in shared experience, peers encourage sustainable healing and growth by focusing on what individuals can achieve rather than what they lack. Through a combination of structured, evidence-informed models and flexible, community-driven support, peer-led care helps people build their inherent strengths to create meaningful, lasting change.

Moving Forward with Peer Support at the Center

Peer specialists do rely on their lived experience to engage help seekers, which highlights a need for specialized supervision, whereby clear discussions around well-being and self-care are encouraged. Such supervision helps with professional development for peer specialists by amplifying the unique healing power of their stories. Additional career pathways, such as Peer Support Supervisors, Advisors, and Leadership positions, are critical in showcasing structural integration of and respect for peers.

Across the sector of wellness support services, many are investing in this scope of expertise, as it brings humanity to the work by lending the living story the same credence as credentials. The marriage of both lenses of expertise deepens the value of any organization and its impact on those it serves by highlighting peers as key players within the spectrum of care.

Peer support services are uniquely tailored to touch the lives of those in need from the lens of not just an ally but that of a companion in experience–a person who has been there. These individuals exude that perfectly seasoned quality that cannot be taught. Their work and life stories serve as the key agents in building trust and shepherding individuals in need across bridges to hope. It is our hope that other organizations consider adding these important roles to their staffing.

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TMS Neuromodulation from page 14

- Who greets your patient on day one.
- Who sees their progress every day.
- Who helps them work through gratitude exercises.
- Who helps them practice gratitude under the helmet while their brain relearns the possibility of change.

Because every time a patient graduates from TMS and says, "I'm glad I didn't quit," there's almost always a technician behind that sentence.

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Treatment Courts from page 24

The therapeutic alliance and formulation: A strong therapeutic alliance is one of the most robust predictors of successful outcomes across therapies and populations (Wampold BE, 2023) (Flückiger C, 2020) (Duncan, 2010). The alliance involves:

1. A safe, trusting, respectful relationship in which the participant feels valued.

2. Shared goals that make sense to both clinician and participant.

3. Agreement on strategies and tasks for reaching those goals (Frank, 2025).

Engagement improves when the alliance is grounded in a shared formulation: a collaborative understanding of who the participant is, what has happened to them, their values, strengths, community, identity, and aspirations (Cruwys T, 2023) (Nezu CM, 2015) (Johnstone, 2013). When treatment is adapted to participants' cultural identities, preferences, and lived experiences, the alliance is strengthened and outcomes improve ((COPPS), 2021).

Individualizing treatment: Standardized program requirements that do not flex to participants' needs can feel irrelevant or coercive. Tailoring services—type, intensity, format, language, and focus—to match participant preferences increases satisfaction, completion rates, and clinical gains (Lindhiem O, 2014).

Addressing basic needs: Unmet basic needs such as housing, food, transportation, safety, and childcare create constant crises that crowd out treatment. Addressing these needs directly, or by coordinating with social services and natural supports, is foundational to engagement (Medine, 2021).

Aligning motivation: Treatment is most effective when the participant's own reasons for change align with the purposes of the treatment court. If participants do not see how treatment helps them get more of what matters most to them, attendance quickly becomes about "doing time" rather than "doing treatment."

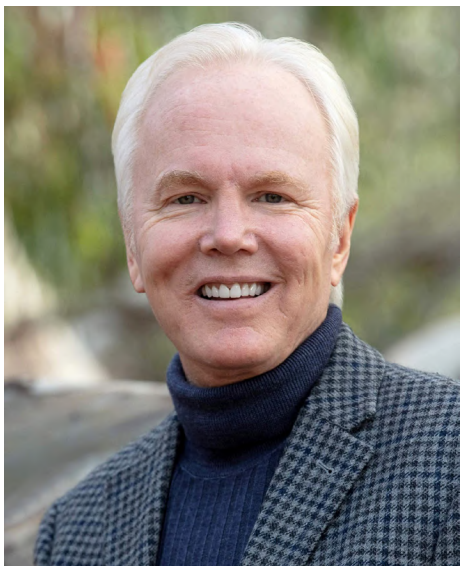
Co-occurring illness: Co-occurring mental health conditions—including depression, anxiety, psychosis, ADHD, and personality disorders—can impair insight, emotional regulation, and executive functioning, making consistent participation difficult (A., 2024).

Factors Promoting Participation

Despite the risks, several factors consistently support engagement in treatment court programs (Canada KE, 2020) (Patten R, 2015) (Randall-Kosich O, 2022).

Personal motivation and accountability: Participants who feel personally responsible for their recovery tend to remain more engaged. Clinicians and court staff can help evoke this sense of ownership by inviting self-reflection, supporting meaningful goal setting, and reinforcing small steps toward change.

Structured support systems: Peer support, mentoring, family involvement, and community-based resources provide emotional, practical, and social support that make adherence more feasible.



Michael McGee, MD, DLFAPA

Quality and availability of services: Access to skilled clinicians, evidence-informed therapies, mental health care, and addiction medicine—including medications for addiction treatment when appropriate - improves retention (Medicine, 2024).

Judicial engagement and incentives: Active, respectful involvement by judges and court personnel can powerfully shape motivation. Clear incentives—such as privileges, phase advancement, or reduced supervision - combined with consistent, fair responses to nonadherence, reinforce accountability and progress.

Treatment duration and intensity: Programs that offer a flexible continuum of care allow participants to receive more intensive services when risk is high and step down as stability improves.

Promoting Participation: Cultivating Constructive Collaboration

Promoting participation requires more than enforcing compliance. It calls for a collaborative approach that emphasizes safety, respect, empathy, and shared responsibility (Law, 2020) (AllRise, 2025). Successful engagement is built on three interlocking elements:

1. Therapeutic engagement

2. Participant-centered formulation and recovery planning

3. Ongoing monitoring and adaptation

Therapeutic engagement: A strong therapeutic relationship is the cornerstone of effective treatment. Master clinicians continually cultivate both their therapeutic spirit and their relational skills (Miler, 2021). These manifest as:

- unconditional positive regard
- warmth and acceptance
- genuineness
- evoking hope
- affirmation
- empathy
- collaborative, participant-centered guidance

These capacities are developed over a professional lifetime through feedback, reflection, deliberate practice, supervision, and coaching (Chow, 2020). Building cultures of clinical excellence within treatment courts helps support this development.

Clinicians should begin where participants are, engaging first with what participants most want that led them to accept treatment court, rather than focusing solely on program rules. Mutual respect, open communication, and consistent support help participants feel seen and valued rather than managed or judged.

Participant-centered formulation and recovery planning: Engagement makes it possible to co-create a shared, compassionate, and coherent understanding of the participant—the formulation. This shared story includes problems and risks but also strengths, values, culture, community, hopes, and identities. Based on this understanding, clinicians and participants co-author the recovery plan, with the participant positioned as the primary author of their healing journey.

A good recovery plan addresses clinical needs (e.g., substance use, mental health) and broader human service needs (e.g., housing, employment, family relationships) for both the participant and their ecosocial system. It should be understandable in the participants' own words and clearly linked to outcomes that matter to them.

Monitoring and adapting: Participant needs and circumstances change over time. Effective care plans are therefore adaptive, iterative, and feedback informed. Routine monitoring of progress, satisfaction, and engagement—using brief tools and collaborative conversations—helps identify problems early. Clinicians then adjust goals, methods, or intensity to maintain relevance and effectiveness.

Motivation management: Motivation is not a fixed trait; it fluctuates. Techniques such as motivational interviewing, values clarification, and collaborative goal setting help participants explore ambivalence, strengthen commitment, and build confidence. Recognizing small successes, celebrating incremental change, and setting achievable milestones all foster a sense of efficacy and hope.

Rewards, privileges, and accountability: Positive reinforcement—verbal recognition, incentives, privileges, and visible acknowledgment of achievement—can be powerful in sustaining participation. Sanctions are often more effective when framed as loss of privileges or missed opportunities rather than punishment, and when they are delivered predictably, proportionally, and respectfully.

Transparency and expectations: Participants need a clear understanding of program expectations, roles, and potential consequences. Transparent communication about requirements, available supports, and decision-making processes fosters accountability and allows participants to make informed choices about their recovery (Stinson, 2017).

What to Do When Participants Aren't Participating: The 5 As

Even in the best programs, disengagement is inevitable. The question is not whether participants will struggle, but how teams respond when they do. The 5 As framework—Attend, Abstain, Appreciate, Assess, Act—offers a structured, humane process for understanding and addressing nonparticipation.

1. Attend - The first step is to pay close attention. Clinicians and teams should systematically monitor attendance, participation, attitudes, and outcomes, watching for signs that participants are "doing time" rather than "doing treatment." Feedback-informed methods can help track well-being, progress, and satisfaction in real time.

Attending also includes checking in on the therapeutic alliance. Brief tools and open conversations about "how we are working together" can reveal ruptures in trust, misaligned goals, or tactics that are not meaningful to the participant. Clinicians must also attend to their own internal reactions—frustration, anxiety, hopelessness.

2. Abstain - Once problems are noticed, the second step is to abstain—from blame, impulsive action, and premature conclusions. It is tempting to label participants as unmotivated or resistant, but such labels close curiosity and can damage the alliance. Except in situations of imminent risk, it is usually best to refrain from action until the situation is better understood.

Clinicians also have a professional duty to maintain hope. Losing faith in the participant's capacity to change is itself a powerful barrier to engagement.

3. Appreciate - The third step is appreciation—accepting the situation as it is and recognizing its complexity. Approaching nonparticipation with an "of course" mindset ("Of course there are obstacles; of course, engagement is hard") cultivates equanimity and compassion (Holiday, 2014). Participants often face trauma histories, mental health symptoms, poverty, unstable relationships, and discrimination. Staff may be overextended and working in under-resourced systems.

Appreciation means allowing the reality of the moment without harsh judgment—toward the participant or oneself. This stance creates space for curiosity rather than anger and makes it more likely that participants will feel safe enough to be honest about their struggles.

4. Assess - With curiosity and acceptance in place, the team moves to assessment: a collaborative inquiry into what is and is not working, involving the participant, clinicians, court staff, and—when appropriate—family or other supports.

The team should revisit the original assessment, formulation, and care plan: Have circumstances changed? Are the goals still meaningful to the participant? Are services mismatched to their stage of change or cultural context?

A key task is to distinguish "can't" from "won't." Some participants cannot engage because of low self-efficacy, inadequate coping skills, cognitive limitations, severe psychiatric symptoms, external stressors, or lack of support. Others technically can engage but are not doing so because of waning motivation, ruptures in the alliance, competing loyalties, or trauma-based "hidden agendas." Understanding these drivers allows interventions to be targeted rather than generic.

see Treatment Courts on page 50

Treatment Courts from page 49

5. Act - Only after careful assessment is it time to act. Action should flow from what has been learned, and whenever possible, be co-designed with the participant.

Maintain equipoise: Clinicians and court personnel should maintain calm, balanced, and compassionate demeanors. Participants need to see that the team is both invested in their success and steady enough to tolerate setbacks without retaliation.

Strengthen relational skills: Teams may need to refine foundational interpersonal skills—empathy, acceptance, warmth, clarity, and evocation of hope. Seeking supervision, peer consultation, and training communicates that the system is willing to grow alongside the participant.

Seek feedback and reflect: Soliciting feedback from participants, supervisors, and colleagues—and engaging in honest self-reflection—helps clinicians recognize when their own behavior, assumptions, or blind spots are contributing to disengagement (de Cossart L, 2012).

Review the treatment contract and goals: When appropriate, teams can revisit treatment contracts and expectations, emphasizing both autonomy and accountability. The message should be: "This is your life and your recovery, and we are here to support you within real-world constraints."

Repair ruptures and renegotiate the plan: If the alliance has been damaged, explicit rupture repair is crucial. This may involve naming the rupture, apologizing for mis attunements, clarifying misunderstandings, or, at times, changing clinicians. The care plan may need to be renegotiated to better reflect the participant's preferences, capacities, culture, and current priorities.

Arrange additional supports: When disengagement is driven by external barriers—housing, transportation, childcare, legal stress, lack of social support—the team should collaborate with community partners, families, and peer supports to secure needed resources.

Reinforce motivation: When motivation is low, targeted motivational interventions can help participants clarify values, envision desired futures, and explore discrepancies between their goals and current behavior.

Ongoing Monitoring and When Engagement Cannot Be Sustained

Re-engagement is rarely a single event. Teams must continually cycle through the 5 As—attending to new information, abstaining from premature reactions, appreciating evolving realities, reassessing, and adjusting actions.

Sometimes, despite thoughtful and persistent efforts, participants continue to disengage. In these situations, treatment teams should maintain open communication with the court, provide honest information about progress and risk, and advocate for responses that balance accountability with compassion. Even when a participant leaves or is terminated from the program, clinicians can convey that the door remains open for future help.

Post-program reviews ("post-mortems") can identify lessons learned for the team and highlight structural barriers that could be addressed for future participants.

Conclusion

Nonparticipation is not an aberration but an expected feature of treatment court work. Rather than interpreting disengagement as failure, teams can approach it as a signal that something in the complex interaction among participant, provider, program, and context needs to change. The 5 As framework—Attend, Abstain, Appreciate, Assess, and Act—offers a practical, compassionate roadmap for responding.

By emphasizing strong therapeutic alliances, participant-centered planning, flexible and feedback-informed care, and collaborative responses to nonparticipation, treatment court teams can enhance engagement and outcomes. Expecting, monitoring, and thoughtfully addressing participation problems is essential to the long-term success of treatment courts and to the healing of the people they serve.

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Recruitment from page 28

Stigma remains one of the most powerful deterrents. Individuals may hesitate to seek treatment or participate in research because they fear judgment, labeling, or confidentiality breaches. Even when someone is interested in contributing to scientific advancement, concerns about how their data will be used or how their mental health status will be perceived can significantly restrict engagement. This reluctance can reduce the pool of potential participants and disproportionately exclude individuals from communities where mental health stigma remains especially strong.

Symptom variability adds an additional layer of complexity. Many mental health conditions fluctuate significantly over time. Individuals who appear eligible during initial outreach may later experience changes in symptom severity that temporarily disqualify them from participation. This fluidity can disrupt scheduling, complicate protocol adherence, and contribute to frustration or disengagement among participants.

High screen-fail ratios are common. Strict inclusion criteria—such as stable medication regimens, specific symptom thresholds, comorbid conditions, or safety considerations—can disqualify many otherwise interested individuals. Because mental illness doesn't follow a linear treatment path, it can make it extremely difficult to capture the right cohort at the right moment.

Operational challenges further impede recruitment. As stated above, mental health care pathways are often fragmented, with many individuals receiving minimal or inconsistent care across different settings and providers. Unlike areas such as oncology or cardiology, there is still no standardized, predictable, or structured pathway in which patients with mental health conditions can get referred into clinical trials.

Retention presents its own difficulties. Even after enrollment, participants may face emotional fatigue, transportation challenges, caregiving responsibilities, or other life stressors that hinder their ability to continue in a study. Dropout rates in mental health trials often exceed those in many physical health studies because participants must balance both the demands of the trial and the pressures of daily life while managing their symptoms.

Finally, site capacity constraints can limit progress. Many research sites still lack dedicated psychiatric research staff, or the specialized training necessary to manage complex assessments, safety monitoring requirements, and nuanced patient communication. Even highly experienced clinicians may face overwhelming workloads that limit their ability to support participants effectively.

Suzanne Harris

All these barriers demonstrate the need for smarter, patient-first recruitment strategies that reflect both human needs and operational realities.

A Deeper View into the Patient Experience

One emerging and scientifically grounded strategy involves the use of burden indices to quantify and address the factors that influence participant decision-making and site operations. Tools such as the Patient Burden Index (PBI) and Site Burden Index (SBI) provide structured ways to evaluate stress points that may undermine enrollment or contribute to dropout.

The Patient Burden Index evaluates the real-world demands placed on participants throughout the course of a trial. For individuals already navigating mental health challenges, like depression, anxiety, PTSD, bipolar disorder, or schizophrenia, seemingly manageable tasks can become substantial barriers. Requirements such as frequent site visits, long travel distances, invasive procedures, extensive questionnaires, digital monitoring expectations, or lifestyle restrictions may significantly influence a participant's willingness or ability to stay engaged.

High PBI scores can predict where participants might struggle or disengage, enabling sponsors to make more informed decisions early in the trial design process. For example, if the frequency of site visits is disproportionately burdensome, adjustments such as remote assessments, simplified procedures, or transportation support may substantially improve feasibility. Understanding participant burden can also guide tailored outreach, helping potential participants see how the study aligns with their needs and how the research team intends to support them.

Predicting and addressing these burdens leads to:

- More realistic expectations for enrollment timelines
- Greater feasibility and accuracy in forecasting recruitment
- More empathetic communication that aligns with participant concerns
- Better retention strategies informed by likely pain points

By anticipating where drop-offs may occur, trials can adapt to meet participants' needs rather than expecting participants to adapt to rigid structures that may be unsustainable.

Ground Your Site Strategy in Operational Reality

The Site Burden Index offers an equally important lens into the operational environment. Mental health trial sites frequently manage high patient volumes with limited resources. Screening processes are often lengthy and multi-layered, assessments may be time-intensive, and safety monitoring can demand frequent check-ins or staff intervention.

Quantifying this burden helps sponsors identify which sites are best equipped to manage a protocol's requirements and where additional support may be needed. Sites with high burden scores may face workflow bottlenecks, have limited staffing, or require more training to manage complex eligibility assessments. By understanding these dynamics early, sponsors can set more realistic enrollment expectations, reduce screen failures, and allocate operational support where it will meaningfully improve participant flow.

Together, PBI and SBI offer a more complete understanding of the ecosystem in which mental health research takes place, enabling trial designs that are more inclusive, more achievable, and more efficient.

Tailor Your Patient Engagement for the Realities of Mental Health

In addition to scientific modeling, mental health trials require engagement strategies that reflect the lived experiences of participants. Each diagnosis is unique and comes with a decision-making pattern that reflects that. Recruitment efforts that overlook these nuances risk disengagement, misunderstandings, or reinforcement of harmful stereotypes.

Best practice is to have professionals who are trained in behavioral health communication help patients navigate the emotional and logistical challenges that often accompany trial participation. For individuals who may feel uncertain, overwhelmed, or hesitant, having a knowledgeable and empathetic point of contact like a Patient Companion can make the process more approachable. Professionals like these can help address stigma, clarify complex screening procedures, normalize symptom fluctuations, and troubleshoot practical challenges such as transportation or scheduling.

When these supportive approaches are paired with burden insights from tools like PBI, the recruitment experience becomes more aligned with patient realities. Participants feel better informed, less anxious, and more confident in their decision to engage in research and increases the likelihood of long-term retention.

Advancing Mental Health Research Through Smarter, Human-Centered Recruitment

The world cannot respond effectively to the mental health crisis without more inclusive, robust, and timely clinical trials. We must improve recruitment strategies to be both scientific and empathetic so we can attract more untreated and undiagnosed populations and speed approval of therapies for those that need them most.

By understanding how human and operational burdens shape participation, embracing diagnosis-specific engagement approaches, and leveraging scientific tools that reveal where challenges lie, sponsors can make mental health research more predictable, equitable, and effective.

Mental disorders present a global public health crisis that demands we rise to the occasion with a model that respects the lived experience of participants, supports the realities of site operations, and strengthens the integrity of clinical evidence. This is how progress is made—one trial, one participant, and one insight at a time.

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Footnotes

1. World Health Organization, Mental Health Disorders Fact Sheet

2. World Health Organization, Mental Health of Adolescents Fact Sheet

3. World Health Organization, Alcohol Fact Sheet

4. World Health Organization, Special Initiative for Mental Health

5. McKinsey Health Institute, Investing in the future: How better mental health benefits everyone

Peer Storytelling from page 28

employees at a global financial services firm requested monthly *What's on Your Mind* sessions, where employees connect to supportive mental health and wellness resources, as well as build community. At a leading technology services company, peer presentations led employees to advocate for *Mindful Mondays*, a weekly guided meditation series that reinforces the importance of rest. These examples show how peer-based programs can encourage employees to connect with professional or community-based support outside of the workplace (Greenwood).

Reducing stigma and increasing hope are additional benefits. One attendee shared that the honesty of the presenter made their day brighter and reduced feelings of isolation, saying, "Thank you for the honesty and sharing. This made my day a little brighter and made me feel less alone." A family member reported that the presentations helped them understand that tools exist to support caregivers, saying, "This seminar gave me hope there are tools are out there to help family members understand mental illness." Independent evaluations of *In Our Own Voice* showed a significant reduction in stigma among participants (Corrigan, Kanter, Perlick).

Peer storytelling also supports supervisors and leaders who may feel uncertain about how to approach employees who seem to be struggling. Many leaders rely on assumptions or media portrayals of

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mental illness. After NAMI-NYC delivered peer-based presentations at a U.S. law firm, managers and partners reported a greater understanding of how to recognize signs of mental health challenges in their colleagues and have the tools to support them early on to decrease the risk of crisis. Feedback showed that a key barrier for many managers was not knowing the language to use. Hearing peers share their experiences helped bridge that gap.

Peer-based storytelling strengthens individual recovery and contributes to healthier workplaces. It increases connection, supports early help-seeking, reduces stigma, and builds a sense of community. When organizations incorporate real stories of lived experience into their wellbeing efforts, employees feel seen, leaders gain practical tools, and the workplace moves closer to a culture where mental health is acknowledged and supported.

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Private Practice from page 29

experienced practitioners preserves client access and helps maintain the stability of practices that have built deep relationships in their communities. Private practice clinicians enter this field because they want to provide meaningful care and supporting them in that work is essential for long-term, systemwide sustainability. AI offers critical support by shifting time away from routine tasks and back to client care, creating space for what matters most: the therapeutic relationship.

The Role of AI in Workforce Sustainability

AI returns time to clinicians by streamlining non-clinical workflows. A *JMIR Mental Health study* from 2024 found that 43 percent of behavioral health professionals surveyed reported using AI in practice, primarily for research and report writing. Some examples of effective use of AI in clinical practice include:

- **Documentation**: Instead of generating full notes from scratch, many clinicians use AI to expand brief session notes into structured clinical documentation. This keeps the clinician's insights at the center while saving time on formatting and compliance.

- **Template customization**: AI tools can help clinicians build documentation templates that reflect their therapeutic approach or insurance requirements, then refine them over time as workflows evolve.

- **Language refinement**: AI can strengthen clinical language and improve clarity while maintaining the practitioner's voice. This is especially helpful for early career clinicians who are still developing their documentation style.

Jonathan Seltzer

The purpose of AI tools is not to replace clinicians but to amplify their expertise. The right tools give clinicians more time for the work they can do. In private practice, each hour reclaimed directly increases time available for client care, allowing clinicians to stay present and effective in their work.

Technology That Supports, Not Replaces

Autonomy keeps private practice clinicians in practice. It allows clinicians to control how they practice, who they see, and how much time they spend with clients. Technology should support, not override, these decisions.

The best AI tools are designed with clinicians at the center. For example, a clinician should always review AI-drafted notes before submitting them, preserving their therapeutic framing and clinical judgment while still saving meaningful time. Technology adapts to the clinician's practice—not the other way around.

But technology alone isn't enough. Systemic changes are needed to truly support independent practice.

Building Systems That Support Independence

The 2024 State of the Behavioral Health Workforce report projects significant shortages of counselors and psychologists by 2037. Workforce development must focus on more than recruitment. Retention, operational support, and sustainable practice models are essential to keeping clinicians in practice.

Training programs and continuing education must prepare clinicians for emerging tools and workflows, such as AI-assisted documentation, telehealth, and hybrid practice models. Reimbursement and credentialing systems must also evolve so that private practice clinicians are not at a disadvantage compared to large organizations with extensive administrative resources. Improving these systems reduces friction and helps clinicians focus more on care.

Private practice clinicians must also have a voice in the broader innovative conversation so that new policies, training standards, and technologies reflect their real-world needs. Supporting the sustainability of independent practice through smart technology, training, and autonomy strengthens the entire behavioral health care system.

Redefining Workforce Innovation Around Clinician Sustainability

The future of behavioral health care depends on supporting the clinicians already in practice today. Workforce innovation should begin with the clinician experience, reducing administrative burden, restoring purposeful work, preserving independence, and making private practice sustainable.

Clinician sustainability must become a shared priority among industry leaders, educators, policymakers and technology partners. Without it, we lose the independent practitioners who deliver accessible, affordable care to millions of Americans.

Jonathan Seltzer is CEO of SimplePractice. To get in touch or learn more, you can connect with Jonathan on LinkedIn or visit the SimplePractice website.

Relapse from page 30

And then there's romanticizing substance use, reminiscing about the "good old days" and focusing only on the parties and fun moments. That nostalgia isn't harmless. It's a warning that the brain is beginning to rewrite the past.

When those warning signs appear, our response matters just as much as the signs themselves. Too often, people in recovery are met with shame instead of support. That shame doesn't inspire change; it only deepens isolation. It convinces people they're broken, beyond help, and alone. And when you can't lean on anyone, you lean on the one thing that's always been there: the substance.

I always encourage families to respond with care when these signs arise. Avoid shaming them. Because compassion, not condemnation, is what keeps people alive long enough to heal.

And if you're the one in recovery, remember that you're human, and that it's okay to say you're struggling and need more help.

Relapse Is an Opportunity to Adjust the Playbook

While it's certainly not inevitable, relapses are a normal part of the recovery journey for many and a chance to learn valuable lessons about what works—and what doesn't.

Chris Cummins

Think about it: professional football players drop the ball, then study the replay and come back stronger. Musicians hit the wrong note and mark their scores to refine their performance. Like any skill, growth in recovery comes from practice and persistence, not perfection.

We must try to let go of the belief that recovery happens in one transformative moment. In truth, recovery happens one day at a time, one moment at a time, and there are going to be challenges and setbacks. Each challenge is a chance to build resilience, insight, and a stronger foundation for lasting change.

For families and friends, that perspective shift matters. It means moving from judgment to curiosity. Instead of pointing the finger and asking, "Why did you relapse?" ask, "What wasn't working?" For the person in recovery, it's an invitation to adjust the playbook and consider what you might need to do differently this time.

At my treatment center, we have a specific program for those who have experienced chronic relapse. And we look closely at the factors that may have contributed to a patient's relapse risk, such as lack of aftercare follow-up, and ensure that we put a plan into place to mitigate those risks. It's all about avoiding blame and shame and instead delving into what we can do better to thrive in the future.

Those Who Recover Try Again (and Again and Again)

Recovery simply is not linear. Great days, weeks, or months are often followed by difficult ones. As providers, we know to expect that. Recovering individuals or families often have an expectation that once treatment is done, it will be smooth sailing and find themselves frustrated, exhausted and hopeless when setbacks arise.

In truth, millions of people have relapsed (sometimes multiple times) and gone on to live long, fulfilling lives in recovery. How did they do it? They tried again. And again. And again. It may be going back to treatment or simply working to change an unhelpful habit. Each time, they learned something new about what they needed to heal and what it would take to stay well.

No hero's journey is without setbacks, and no meaningful story unfolds without struggle. Recovery is the same. When we take shame out of relapse, see it as an opportunity to renew our efforts, and let it be part of our story (not the end), that's when we can truly embrace recovery.

Chris Cummins is the Chief Operating Officer at Laguna Treatment Center, a provider of addiction and co-occurring disorder treatment specializing in chronic relapse prevention.

Finance Problem from page 33

Before adopting a workforce-funding opportunity, I ask:

- Can we deliver at full cost?
- What happens when the funding ends?
- Does the initiative help build a service model that payers will buy into? Grant funding is best viewed as prototype capital—not a permanent patch.

Technology as a Workforce Asset

At a recent industry conference, technology discussions kept returning to the same theme: documentation support tools, workflow automation, scribe services. The underlying driver? Non-clinical tasks consume clinician time.

One place where AI has made a meaningful contribution is in post-visit clinicians' notes. We have heard numerous instances where the time commitment related to documenting patient sessions was significantly reduced using AI, greatly reducing clinicians' burden of a highly tedious task. At the same time, AI and technology in general are not a magic panacea for everything. When evaluating AI and technology, do it through the lens of measurable benefit to the organization.

The ROI only holds if we include all actual costs: IT integration, training, compliance, and change management. The financial model must link technology to workforce capacity and ultimately, to revenue and margin.

Seeing the Real Cost of Turnover

Turnover is often treated as an HR KPI. From a financial lens, it is one of the clearest risk indicators.[7] I encourage organizations to build a basic dashboard that includes the following key metrics: turnover rate by role, fully loaded cost per replacement, time-to-productivity for new hires, and the margin shift in programs due to vacancies. When that data is combined with patient-experience scores, overtime statistics, and caseload variance, the insight becomes undeniable.

Carter Freeman

Burnout, high caseloads, and staffing instability are correlated with poorer patient experiences, more visits declined or delayed, and higher costs.[8] In behavioral health settings, where therapeutic relationships and continuity matter deeply, that correlation can play out faster and more visibly.

Whenever CEOs share patient experience or satisfaction concerns with us, we review them alongside staffing data. The overlapping trends are striking. Clinics with the most stretched staff also have the most frustrated patients. The result: rising denials, longer waits, lower throughput, and margin pressure.

So, staff well-being is not only a human resources discussion but also a finance and operational one. A behavioral health CFO needs to connect the dots among burnout, clinician turnover, patient experience, and financial viability.

What Finance Leaders Can Do Right Now

The most practical first step: build a dashboard that places turnover, vacancy, time-to-full-productivity, and average replacement cost beside operating margin. Once those workforce indicators sit next to financial indicators, conversations change.

From there: align wages with local market realities, integrate Medicaid enhancements and grants into long-term strategic planning, invest in technology that meaningfully benefits the organization rather than simply adds another cost line, and treat workforce planning as continuous financial design, not a one-time project.

Behavioral health organizations cannot simply hire their way out of the workforce shortage. However, they can design financial models that embrace recruitment, retention, and innovation to occur. The CFO is no longer in a back-office role. They are now the architects of workforce stability and organizational resilience.

Carter Freeman is the Vice President for vcfo's Western Region. An accomplished professional with more than 30 years of senior-level financial and accounting experience, Carter embraces new situations, establishes trust and develops workable game plans. To produce results, Carter leads his clients through their challenges by assessing a set of circumstances and "cutting to the chase."

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NIATx Process from page 31

3. Pick a powerful change leader

4. Get ideas from outside the field

5. Use PDSA rapid cycle change

The first of these factors, knowing and understanding the customer, was found to be the most critical factor. This emphasis on the customer has been central to the influence of NIATx over the decades as we have focused on the unique experiences and needs of each person served.

It has been a logical pivot for us to shift from service recipients to the workforce as we apply these principles. Understanding the applicant, interviewee, or new hire as the customer has helped us to apply the NIATx tools and principles to determine how best to enhance their customer experience during the hiring and onboarding process.

The workforce challenges of the behavioral health industry have led leading NIATx thinkers to consider how best to apply these NIATx tools to support critical workforce goals. Our current model considers workforce issues through four key processes:

Recruit > Hire > Retain > Promote

With this new process orientation, we can start asking the right process questions.

What do we need to do to enhance the recruitment, hiring, retention, and promotion processes to increase the number of people who apply, interview, accept positions, and are successfully onboarded and retained in those positions?

Each of these four processes link together to reflect the full worker experience. Each process requires separate considerations and distinct indicator metrics to determine whether PDSA tests of change have achieved the desired results.

Too often, behavioral health provider systems talk about "the workforce challenge" without focusing on the specific subprocess that requires attention. This would be similar to walking into an unfamiliar grocery store and asking the staff for help in finding the "dinner food." The "ingredients" needed to improve recruitment are different from those required to address hiring or retention.

Mathew R. Roosa, LCSW-R

NIATx got its start with a focus on patient access to care and retention in care. These original improvement aims addressing wait times, admissions, no-shows, and continuation have been retooled to focus on the needs of the behavioral health workforce. NIATx has worked with multiple provider systems through training and technical assistance to engage in PDSA rapid-cycle testing of specific workforce improvement strategies.

- If we change the job posting by doing A, will that result in more eligible applications?
- If we engage applicants using strategy B, will more of them attend interviews?
- If we create a kinder, more empowering interview process using strategy C, will more applicants accept the positions offered to them?
- If we provide meaningful growth opportunities using strategy D, will staff members be retained in certain positions for longer periods?

Each of these examples can be explored through the core NIATx tools sequence.

Providers use small ***change teams*** to ***walk through*** the customer experience by role-playing the process of completing an application or an interview. They then complete a ***flowchart*** that reveals the details of the workflow associated with the process. Once an area of focus has been identified, the team uses ***Nominal Group Technique*** to brainstorm and select a strategy to test using a ***Plan-Do-Study-Act (PDSA) change cycle***. Each effort is designed to be completed with existing resources and to focus on a clear business case for the organization.

One common approach to improvement NIATx uses is the learning collaborative. We have found that providers who come together and share ideas can benefit greatly from collaborative learning opportunities. The application of this collaborative model to workforce issues has had some key challenges. It can be difficult for providers to share their workforce struggles with peer organizations that operate in the same marketplace. Many providers are hesitant to share the specifics of workforce concerns. They fear that such disclosures may damage their reputation. This is reminiscent of similar challenges addressed in the earliest days of NIATx. We have worked hard to shift the culture of behavioral health systems toward open disclosure. Organizations that understand their own challenges are typically the most successful. Sharing challenges related to the four workforce processes is the quickest path to improvement.

More providers have come to understand how the NIATx tools that they have applied to service customers can achieve similar results with workforce customers. We cannot improve what we cannot understand. And the only way to understand the four workforce processes of recruitment, hiring, retention, and promotion is to explore the details of each process, and to use tested tools to improve them. NIATx has proven itself to provide an excellent toolbox that many teams are now using to understand the process and enhance the workforce experience. Providers interested in learning more about the NIATx tools and their application to workforce needs can explore the following resources:

- NIATx tools for Continuous Quality Improvement in mental health services
- NIATx website
- Live NIATx training and NIATx e-course
- NIATx tools in substance use settings or workforce applications

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Citations for publications that describe the origins and foundational concepts and tools of NIATx:

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Telehealth from page 29

in rural areas. To these workers, attending the specialist may have taken an entire day to get there. Telehealth eliminates such a geographical penalty, allowing individuals to have equal access to care without having to lose a day of earnings or productivity. It increased the proportion of workers who were put out of commission by logistics.

A Systemic Capacity Boost

The role of telehealth magic is not limited to a single employee. It is developing systems capacity in two ingenious ways. Telehealth enables busy physical clinics and emergency rooms to be free of less acute and less urgent visits by eliminating them virtually, allowing the clinics and emergency rooms to attend to patients who require physical and practical care. This will imply that we reduce the waiting time for all people and save energy more efficiently, benefiting our valuable healthcare workers. It optimizes the entire healthcare system, which consequently helps ensure a healthier population.

Second, and arguably most importantly, it addresses professional burnout in the field of healthcare itself. The pandemic demonstrated the harsh price of an overworked medical staff. Telehealth provides clinicians with the flexibility to conduct some patient visits from a home office, eliminating the stress of commuting and allowing them to maintain more controlled schedules. It may serve as a retention tool to retain doctors, nurses, and therapists in the profession by providing a more sustainable model of practice. Through the support of our caregivers, we will be able to provide support to the entire workforce.

Conclusion

At its finest, telehealth is a powerful tool for empowerment. It provides individuals with control over their health and their time. By integrating care into the aspects of our daily lives, it prevents health maintenance as a professional barrier. It is unobtrusively opening the billions of hours of missed productivity not by causing us to work more, but by eliminating the unnecessary friction that prevents us from working well. Finally, the need to increase workforce capacity is not about increasing the number of people, but about giving everyone the ability to be present, healthy, and capable - perhaps the most essential prescription of all.

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Maternal MH from page 32

Policy Momentum for Maternal Mental Health Workforce Expansion

In recent years, federal, state and local agencies have emphasized the need for maternal mental health workforce development. The 2024 U.S. Department of Health and Human Services Task Force on Maternal Mental Health identified specialized workforce shortages as a primary cause of unmet treatment need. The Task Force recommended:

- Educating future and current clinical providers in perinatal mental health conditions and substance use by ensuring that these topics are included in the curricula for mental health care providers and in continuing education requirements.

- Increasing funding, incentivizing, and bolstering recruitment and training efforts to expand and diversify the perinatal clinical mental health and substance use workforce, particularly in under-resourced areas.

Similarly, the New York State Office of Mental Health's 2025 *Maternal Mental Health Recommendations Report* highlighted that critical maternal mental health workforce shortages drive inequities in health care across the state. The report emphasized the need to train professionals across the perinatal care continuum—including mental health counselors, substance use providers, and allied health professionals—in maternal mental health.

At the local level, The 2025 NYC Mayor's Office of Community Mental Health also underscored the importance of educational pathways in its 2025 *Bridging the Gap: Challenges and Solutions for a Thriving Behavioral Health Workforce* report, citing high vacancy rates among behavioral health providers in public institutions and organizations along with insufficient investment in workforce expansion and sustainability. The report explicitly recommends expanding access to behavioral health training and credentials through graduate-level education.

Collectively, these recommendations align directly with the proposal to expand perinatal mental health education across CUNY and SUNY MSW programs.

Why Social Workers Are Critical to Maternal Mental Health Care

Social workers comprise the largest mental health workforce in the United States and are uniquely positioned to deliver culturally responsive perinatal care. According to the Council on Social Work Education and the National Association of Social Workers, the social work field is more racially and ethnically diverse than most mental health professions – with over 22% of new social workers identifying as Black/African American and

Paige Bellenbaum, LCSW, PMH-C

14% as Hispanic/Latino. This diversity is critical given persistent racial and socioeconomic disparities in maternal mental health outcomes.

Social workers are committed to empowering marginalized individuals and communities as a core part of their mission to promote social justice and well-being. Their work involves advocating for and supporting vulnerable populations, addressing systemic inequalities, and ensuring access to resources for those who face discrimination or oppression. They are embedded across public hospitals, community clinics, early childhood programs, schools, and social service settings—precisely where pregnant and postpartum people seek support.

A 2023 NYC Department of Health and Mental Health report, *Barriers to Mental Health Treatment among New York City Adults*, found that approximately **945,000** adult New Yorkers experience unmet mental health treatment needs annually, with cost and lack of culturally attuned providers as leading barriers—especially in low-income communities and communities of color. A more diverse, perinatally trained social work workforce is essential to reducing these disparities.

The Case for a Standardized Perinatal Mental Health Elective in CUNY and SUNY MSW Programs

New York State has ten (10) MSW programs within the CUNY and SUNY public university system. With average class sizes of 25 students and two semesters per academic year, a maternal mental health elective offered in each program could train **more than 500 students annually**. These graduates would be equipped to identify PMADs early, provide psychoeducation, conduct screening and assessment, facilitate referrals, and deliver evidence-based treatment – particularly in communities with the highest need.

Currently, only one public university program—Hunter College's Silberman School of Social Work—offers a dedicated maternal mental health elective. The course provides comprehensive training on:

- PMAD signs, symptoms, prevalence, and risk factors

- Assessment, diagnostic considerations, and evidence-based interventions

- Perinatal substance use disorders

- Racial disparities and structural contributors to PMADs

- Trauma, maternal mortality, and related systemic factors

Survey responses from students enrolled in Hunter's maternal mental health course demonstrate its impact:

- **83%** reported little to no prior awareness of maternal mental health conditions

- **88%** felt very or extremely confident identifying PMAD symptoms after the course

- **93%** felt very or extremely prepared to support pregnant or postpartum people with PMADs

- **90% reported they were very or extremely likely to pursue employment in the field of perinatal mental health**

These outcomes illustrate the transformative potential of standardizing this training across all CUNY/SUNY MSW programs.

Projected Impact of Implementing the text on the a Statewide Elective

Encouraging CUNY and SUNY MSW programs to offer a perinatal mental health elective would:

- Expand New York's workforce by more than **500 culturally responsive, perinatally trained clinicians each year** while improving early identification, screening, referral, treatment, and support for PMADs

- Increase access to specialized perinatal mental health services in low-income communities and communities of color

- Align social work education with federal, state, and local workforce development priorities

- Reduce disparities that contribute to maternal mortality

Conclusion

New York's maternal mental health crisis is urgent, costly, and deeply inequitable. One of the most significant—and addressable—barriers to care is the shortage of culturally responsive, perinatally trained mental health providers. Encouraging all CUNY and SUNY MSW programs to offer a maternal mental health elective is a practical, scalable strategy to strengthen the workforce, expand access to specialized care, and advance health equity across the state. This commitment would save lives, support families, and build the foundation for a more just and effective maternal health system.

With over two decades of experience in maternal mental health public policy, advocacy and clinical practice, Paige played a key role in the passage of New York State legislation mandating PMAD education and screening in birthing hospitals and is a founding Director of The Motherhood Center of New York.

Paige is an adjunct professor at the Silberman School of Social Work at Hunter College and a frequent public speaker and media contributor. She has appeared on the Today Show and Good Morning America, and in the New York Times, The Wall Street Journal, and The Atlantic.

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Bipolar Disorder from page 30

trusted friend, a support group, or an online community, talking to others who understand can make a world of difference.

There's a lot of stigma that still surrounds bipolar disorder. People often associate it with unpredictability or danger, when it's just another medical condition that requires care and understanding. The more openly we talk about it, the more we can break those stereotypes. When someone shares their experience, it helps others feel less alone, and that matters more than most people realize.

If you know someone living with bipolar disorder, patience and empathy go a long way. Sometimes, all a person needs is for someone to listen without judgment. You don't need to have all the answers; just showing up makes a difference.

For more information on mental health resources, visit IDHS: Crisis/Emergency: Mental Health Partners/Providers.

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