Stabilizing Oregon's Public Behavioral Health System

HB 2235 Workgroup Report

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Dr. Josh Porter Ed.D.

Dr. Vincent Chirimwami Ph.D.

Kadi Tchanago, RN, BSN

M.E.B. Research

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Disclaimer:

Views expressed by workgroup members in this report do not necessarily represent the views of the Oregon Health Authority.

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Executive summary

House Bill 2235 (HB 2235) passed in 2023 and declared a state of emergency in Oregon's behavioral health (BH) system stemming from severe shortages, systemic barriers and unmet community needs. This report outlines key findings and recommendations. Recommendation priorities include diversifying the BH workforce, achieving pay equity and enhancing career recruitment and development.

Key findings

A workgroup of diverse BH professionals identified barriers to stabilize this workforce crisis:

The BH workforce needs greater diversity, with more providers reflecting the cultural, linguistic and lived experiences of the communities they serve.

This crisis most affects publicly funded providers, including Community Mental Health Programs, Certificate of Approval organizations, Community-Based Organizations, Federally Qualified Health Centers, Certified Community Behavioral Health Clinics and Medicaid-focused private and public practices.

A shortage of master's-level and advanced BH professionals magnifies vacancies, increasing caseloads that require complex care, especially for publicly funded providers in communities that are rural and underserved.

Culturally and linguistically specific providers in communities that are rural or underserved face unique barriers — such as historical bias, added responsibilities or geographic burdens — compounded when these roles intersect, leading to burnout and worsening workforce shortages in critical areas.

Wages inequitably impact publicly funded care, especially those who serve culturally and linguistically specific groups or communities that are rural or underserved. This incentivizes providers to leave publicly funded care for other careers fields or practices that serve fewer publicly funded clients.

Administrative burdens undermine retention and patient care, such as strict turnaround times on progress notes and excessive time spent on complex requirements instead of patient care. These burdens increase stress, job dissatisfaction, burnout and turnover, especially for team-based and crisis care.

There is a lack of a supported career pathway, from entry-level to advanced roles, driven by insufficient funding, licensing and certification complications and barriers for providers that serve communities that are culturally and linguistically specific, rural or underserved. These obstacles worsen workforce shortages, keeping qualified professionals out of the workforce.

Recommendation themes

HB 2235 requires recommendations based on these themes: (a) improve recruitment; (b) improve retention; (c) reduce administrative burdens; (d) increase pay and reimbursement rates; (e) reduce workload; (f) reduce burnout; and (g) diversify the behavioral health workforce. Another theme, workforce development, was added to separate general workforce-building efforts from recruitment. Below is a sampling of recommendations from the workgroup.

Improve recruitment

▪ Promote publicly funded BH careers ▪ Tuition assistance ▪ Covering costs for clinical supervised experience for licensure or certification ▪ Support clinical supervision expansion grants ▪ Incentivize recruitment for providers in acute care settings

Improve retention

▪ Improve safety for BH staff ▪ Support client-facing workforce retention ▪ Enhance workforce well-being initiatives ▪ Address burnout with workplace support ▪ Childcare and housing stipends ▪ Promote retention through workforce development options

Reduce administrative burdens

▪ Streamline program evaluations and grant applications ▪ Sustainable funding reduces application processes ▪ Collaboration with state advisory groups

Increase reimbursement and pay

▪ Develop equity-focused reimbursement models that address the unique needs of publicly funded providers. ▪ Focused stipends, bonuses, childcare and housing support ▪ Ongoing career support like tuition aid and loan repayment

Reduce workload

▪ The upcoming HB 2235 report will explore staffing models and caseload guidelines and ratios to inform future legislation aimed at creating balanced workloads in Oregon's behavioral health system

Reduce burnout

▪ Improved safety support ▪ Paid professional development time ▪ Long-term funding to build capacity in small organizations ▪ Non-cash incentives and wellness programs

Diversify the BH workforce

▪ Fund career development of culturally and linguistically specific and peer support providers ▪ Grants for culturally specific services, such as community events and traditional practices ▪ Tuition support for diverse providers

Workforce development

▪ Covering costs in statewide training programs ▪ Paid internships and early career support ▪ Regional consortiums to strengthen workforce development ▪ Sustained workforce incentive funding ▪ High school BH career and technical education

Conclusion

This report focuses on stabilizing Oregon's behavioral health workforce crisis and implementing forward-thinking solutions, directly supporting the Oregon Health Authority's (OHA) 2024-2027 strategic plan to transform behavioral health and eliminate health inequities by 2030. To achieve this vision, coordinated efforts among agencies and departments as well as legislative action are essential. The recommendations in this report serve a critical function to inform legislative decisions on OHA's budget for the biennium starting July 1, 2025.

Introduction

What is this report?

This report, mandated by Oregon's 2023 House Bill 2235 (HB 2235), presents actionable solutions to address the crisis in the state's public behavioral health (BH) system. It focuses on improving recruitment, retention, workforce diversity and pay while reducing administrative burdens, supporting culturally specific providers and addressing barriers in rural and underserved communities.

Who is Oregon's public behavioral health system?

For the purposes of this report, the "public BH system" refers to the interconnected network of organizations, providers and services that deliver behavioral health care primarily funded by public sources, such as Medicaid, state funds and federal grants. This system includes Community Mental Health Programs (CMHPs), Certificate of Approval (COA) organizations, Community Based Organizations (CBOs), Federally Qualified Health Centers (FQHCs) and Certified Community Behavioral Health Clinics (CCBHCs). The public BH system often delivers integrated care, combining behavioral health, substance use treatment and primary care services, with a significant portion of this care financed through public sources. Additionally, private practices that predominantly or entirely serve Medicaid clients are considered part of this system due to their alignment with the challenges faced by publicly funded providers. Where HB 2235 names "community-based behavioral health services system," this report names the public BH system as defined above.

Not a public vs private crisis

The current crisis in Oregon's behavioral health system affects both public and private practices. According to Reinert, Fritze, and Nguyen in The State of Mental Health in America report (1), Oregon ranked 49th out of 50 states and the District of Columbia due to a higher prevalence of mental illness combined with lower rates of access to care. Workgroup members report that providers are now facing an unprecedented level of client/patient acuity and challenging work conditions.

As such, the workgroup is clear on this point: this crisis affects the whole field, and the public BH system in Oregon has additional challenges that need to be addressed.

Workgroup Insights

"I'm one of those therapists that worked in community behavioral health, got licensed and promptly left because it was not a sustainable place for me to work at all. I loved the clients and families that I worked with, but all the barriers that we're talking about in this group were the things that made it very, just unsustainable for me to work. I was having health issues. My own mental health was poor, it just was not a place where I felt like I could make a career."

~HB 2235 Workgroup Member

Throughout this report are sections such as this labeled "Workgroup Insights" that include a quote from a workgroup member, a professional in Oregon's behavioral health system.

Overview of HB 2235 and its mandate

HB 2235 established a workgroup convened by the Oregon Health Authority (OHA) to address barriers to workforce recruitment and retention in Oregon's public BH system.

Workgroup makeup

HB 2235 mandated the workgroup to include active nonmanagement practitioners: a peer mentor, a clinical social worker licensed under ORS 675.530, a certified alcohol and drug counselor, a qualified mental health associate and a qualified mental health professional as well as two members who manage caseloads and supervise employees working toward certification or licensure.

Additionally, the group must feature directors or designees from four community mental health programs (CMHPs) and four non-CMHP providers, as well as representatives from an association of BH provider employees, an association of BH provider organizations, a mental health consumer organization, a substance use disorder consumer organization and two coordinated care organizations (CCOs).

The workgroup must also include representatives from at least four providers of culturally specific services and aim to reflect Oregon's geographic, racial, ethnic and gender diversity.

Recommendation themes

HB 2235 required the workgroup to generate recommendations to address the BH workforce crisis based on these provisions:

(a) Improve recruitment of the BH workforce
(b) Improve retention of the BH workforce
(c) Reduce administrative burdens on the BH workforce
(d) Increase the reimbursement paid to BH providers and increase pay for the BH workforce
(e) Reduce the workload of the BH workforce, including caseload guidelines or ratios, and consider national and local studies of existing program staffing
(f) Reduce burnout within the BH workforce
(g) Diversify the BH workforce

Another theme, **workforce development,** was added to this report to separate general workforce-building efforts from recruitment.

Framework for prioritizing recommendations

Three key priorities emerged among the recommendations: Diversity, Pay Equity and Career Recruitment and Development. To guide legislative action and funding effectively, this report indicates recommendations as a priority with the following icons based on a framework informed by survey feedback from the workgroup, alignment with the OHA Strategic Plan for 2024–2027 and the goals of the Behavioral Health Workforce Incentives (BHWI) program.

Diversity

Culturally and linguistically specific providers are essential for addressing health inequities and meeting the needs of diverse communities. Prioritizing these services ensures care is responsive, equitable and aligned with Oregon's health equity goals. Additionally, increasing diversity in the behavioral health field — especially in leadership and advanced degree roles — is critical. Addressing these gaps fosters a workforce that better reflects and understands the lived experiences of the communities it serves.

Pay Equity

Equitable compensation is fundamental to recruiting and retaining skilled professionals in the public BH system. Public BH system providers often face high demands, complex cases and administrative burdens that are not adequately reflected in current pay structures. Ensuring fair pay and reimbursement aligns compensation with the realities of this work, making these roles more sustainable and competitive while stabilizing critical safety-net services.

Career Recruitment and Development

This priority focuses on supporting professionals throughout their careers, from recruitment through advanced levels, with an emphasis on the public BH system. For instance, financial support for education, licensure, certification, internships and clinical supervision is key to building a strong and lasting workforce. It is important to think across the whole trajectory of a professional's career to build a skilled, sustainable behavioral health workforce ready to meet the diverse needs of Oregon's communities.

Chapter 1: Recruitment

In this chapter

This chapter emphasizes strategies to expand the workforce, remove barriers to entry and build capacity to meet the urgent and growing needs of Oregon's communities. The recommendations focus recruitment efforts, including financial support for education, professional development and practical training, with a focus on culturally and linguistically specific providers and professionals in areas that are rural and underserved.

These initiatives are critical to creating a workforce that reflects the diverse communities it serves while addressing complex care needs. By implementing these strategies, Oregon can stabilize its behavioral health system and lay the foundation for a sustainable and equitable workforce.

Provide ongoing funding for tuition assistance and paid time for career development and educational pursuits

Career recruitment and development

The problem

Behavioral health organizations face ongoing challenges in recruiting and retaining qualified professionals due to the high cost of advanced education and career development. The public BH system is particularly affected, especially providers in rural and underserved areas, as many employees cannot afford the tuition or certifications required for critical roles, including master's-level degrees.

Current funding models direct tuition assistance primarily to higher education institutions. While these institutions are essential for training future professionals, this approach disconnects funding from the organizations experiencing the most severe workforce shortages. Graduates are not guaranteed to work in high-need settings, leaving critical positions unfilled and perpetuating workforce gaps in areas that are underserved.

Recommendation statement

Provide ongoing funding in the public BH system, especially for providers in rural and underserved areas, with tuition assistance and paid time for career development, and educational pursuits. This funding would help employees pursue degrees or certifications, with a priority for master's-level degrees, in fields related to their current or future work in behavioral health at their organizations. Additionally, funding would support 40 hours of paid time for educational advancement and career development opportunities in behavioral health. Where available, funding for trainers to travel is recommended to further reduce barriers for rural providers.

Workgroup insights

"If we want to retain the workforce in the publicly financed behavioral health system, we're really talking about CMHPs so community mental health programs, organizations that hold a certificate of approval or COAs and integrated behavioral health and primary care, that's where the bulk of people are served in the publicly financed system. And so, that's really where I think a lot of the incentives need to be prioritized and focused. So, I think about, what is the workforce we want to reach? And that's where we target or put the incentives. If we want to increase the cultural and linguistic diversity of the staff, if you want to increase the rural workforce, that's where you put money, that's where you put investment."

~HB 2235 Workgroup member

This insight emphasizes the need to focus funding — such as tuition assistance — and in sectors within the public BH system where there is the greatest need. Reducing financial barriers for employees pursuing advanced degrees or certifications, tuition assistance and paid time for career and educational development can help attract and retain a diverse, culturally responsive, workforce, ensuring more equitable access to care across Oregon.

Context and supporting research

Tuition assistance is a workforce solution. Studies consistently show that financial constraints are a primary barrier preventing individuals from pursuing advanced degrees in behavioral health fields (2) (3) (4). Tuition assistance has been proven to alleviate this barrier, increasing access to higher education for diverse populations. Tuition assistance programs encourage employees to pursue advanced degrees while remaining committed to their organizations, promoting career progression and reducing turnover rates. This approach is particularly effective in addressing workforce shortages in areas that are underserved.

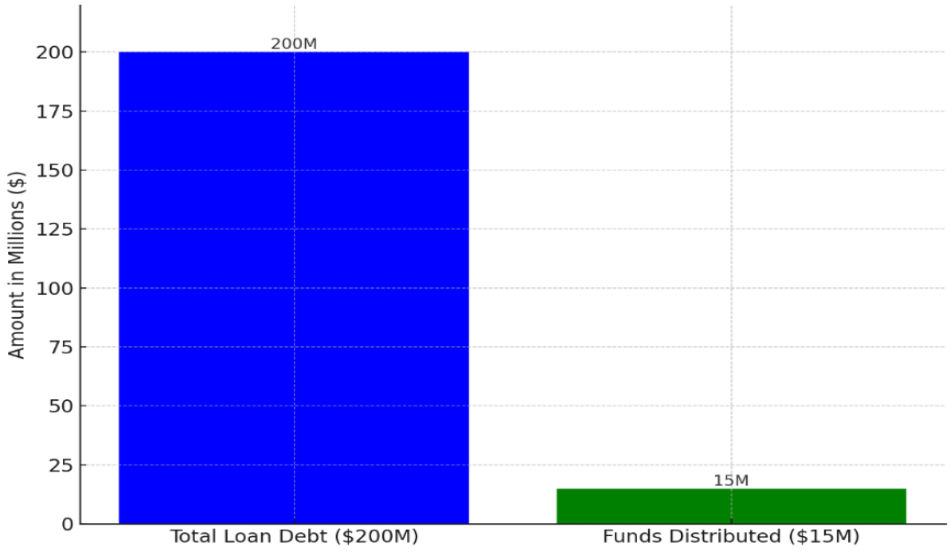
The Oregon Behavioral Health Loan Repayment Program (OBHLRP), launched in April 2022, exemplifies how focused financial support can help address behavioral health workforce shortages in areas that are underserved. Funded through House Bills 2949 and 4071, the program offers loan repayment for providers who commit to two years of service in public or nonprofit mental health facilities. Prioritizing rural, frontier and other high-need areas, OBHLRP reduces financial barriers that often discourage professionals from entering or remaining in these essential roles.

A significant strength of OBHLRP is its focus on diversity and inclusion, which aligns with the goals of improving equitable access to care. Among its awardees, 72% identified as Black, Tribal members, or people of color and 44% were multilingual, reflecting the program's prioritization of culturally and linguistically specific providers. Additionally, 32% of recipients worked in rural or frontier areas and 28% were employed at CMHPs. The program also supported a balanced mix of licensed and certified providers, with 53% holding licenses and 69% holding certifications. These outcomes underscore how funding initiatives like OBHLRP not only address workforce shortages but also foster a diverse and inclusive behavioral health workforce capable of meeting the needs of communities that are underserved.

While loan repayment programs have proven effective in diversifying the workforce, they require individuals to take on significant debt and complete their education before receiving assistance.

These burdens highlight the need and opportunity to provide upfront tuition support instead of loan repayment to reduce barriers earlier in professionals career pathway. Despite its success in encouraging service in regions that are underserved, the loan repayment program has been hindered by underfunding. This funding shortfall highlights the need and opportunity for expanded investment to meet workforce demands effectively. The graph below (see Figure 1) represents distribution of funds in the OBHLRP program, highlighting the total loan debt of $200 million submitted by applicants where $15 million (7.5%) of funds had been allocated, benefiting 279 providers. This demonstrates the disparity between the need and the actual resources allocated to support providers.

Figure 1. Distribution of Oregon Behavioral Health Loan Repayment Program (OBHLRP) funds and total loan debt submitted by applicants.



Potential impact

Providing tuition assistance directly to organizations, rather than solely to educational institutions, has the potential to strengthen career pathways within the behavioral health workforce. Empowering organizations within the public BH system to fund employees' advanced education, certifications and training, promotes professional growth while keeping staff actively engaged in their roles.

With equity in mind, expanding access to education through organizational funding reduces financial barriers for diverse professionals, increasing the cultural and linguistic responsiveness of the workforce. This strategy supports a sustainable behavioral health system, better equipped to meet the growing needs of Oregon's communities, while maintaining continuity of care in high-need regions.

Continue to fund the Clinical Supervision Expansion Grant with updated guidelines

Diversity

Career recruitment and development

The problem

Access to clinical supervision is a significant barrier for many behavioral health professionals seeking licensure or certification, particularly in areas that are underserved. Often within the public BH system, there is a lack the internal resources to offer consistent, high-quality supervision. As a result, emerging individual clinicians often pay out of pocket for supervision, leading them to choose lower-cost options that may not align with their practice specialty. This shortage limits the ability of professionals to advance in their careers, exacerbating workforce shortages and creating blockages in the behavioral health system. Current grant programs for clinical supervision can be improved by specific funding guidelines to implement innovative and scalable solutions. With focused support to engage pre-existing supervisors with established businesses or models, many organizations can leverage local expertise and expand access to certification and licensure.

Recommendation statement

Continue to fund the Clinical Supervision Expansion Grant with updated guidelines to expand access to high-quality clinical supervision for licensure and certification. These guidelines, as outlined in Oregon Administrative Rule (OAR) 833-130-0050 (5), should be detailed and include mentoring groups of clinicians, supervision of supervision to become an approved supervisor, offering group supervision and continuing to prioritize contracts with experienced culturally responsive and culturally specific supervisors in Oregon who have established businesses or proven models. This approach leverages local expertise to strengthen the behavioral health workforce and support licensure pathways.

Workgroup insights

"Something I've heard from various people in the field of having interns, and a big worry a lot of time, they're being supervised under that person's licensure. So, just the responsibility and components that takes when you're supervising someone and especially with people who are still in their master's program. So, I'm just curious, kind of how that's balanced. Especially because they do need a lot more one-on-one work or training and how that kind of takes away from some of the responsibilities and things that a supervisor may be doing — especially if they're working in an agency and overseeing staff."

~HB 2235 Workgroup member

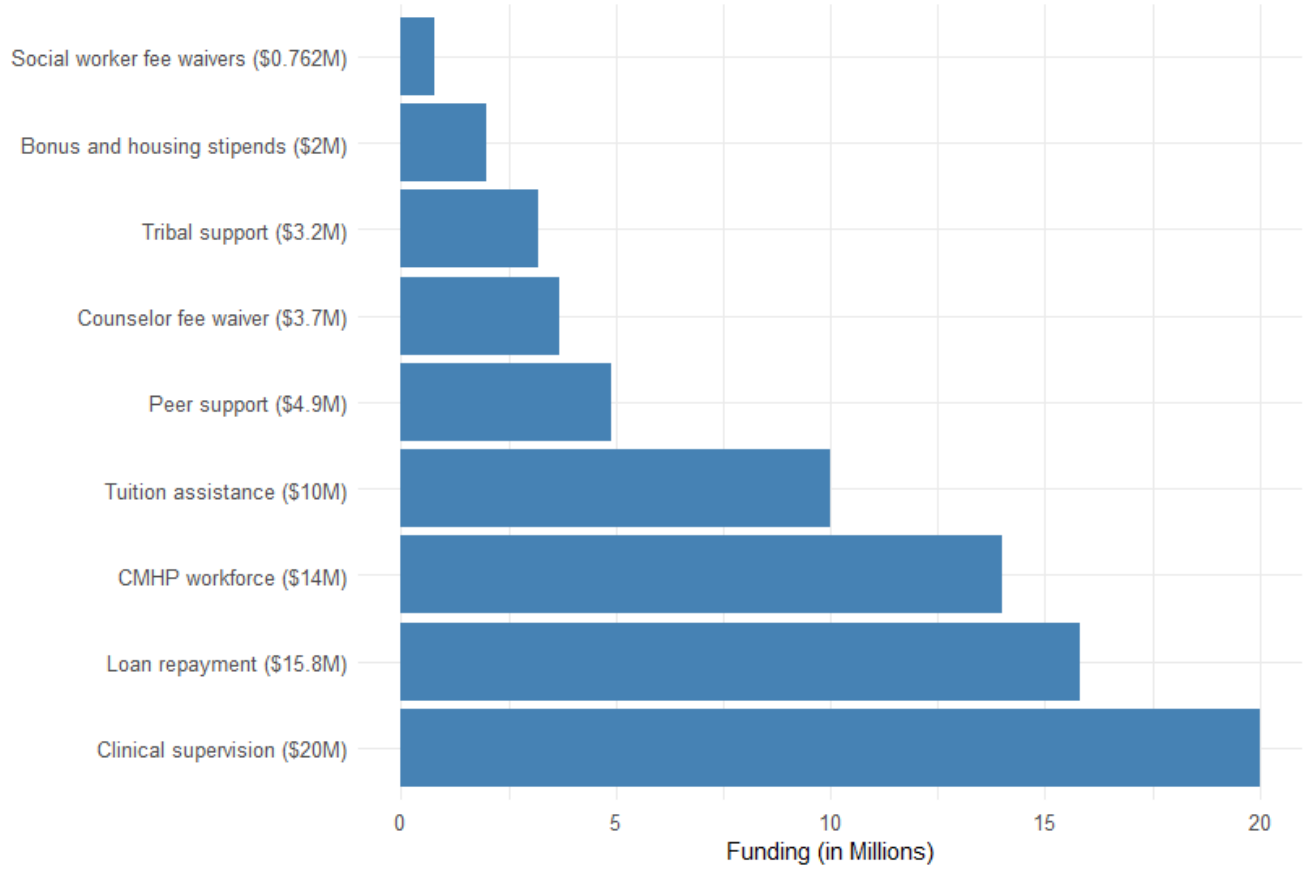
This member highlights concerns from the field about the challenges of supervising interns, particularly those still in master's programs. Supervisors bear significant responsibility when overseeing interns under their licensure, which requires extra one-on-one training and support. This additional workload can impact supervisors' ability to manage their regular duties.

Context and supporting research

Investing in clinical supervision is a pillar of workforce development. In 2021, Oregon lawmakers passed House Bill 2949, allocating $80 million to address critical shortages in the behavioral health workforce (see Figure 2). This initiative included $20 million specifically dedicated to expanding clinical supervision, emphasizing its importance as a key strategy for strengthening the workforce. By increasing access to supervision, the state aimed to help behavioral health providers complete licensure requirements and advance in their careers, addressing a significant barrier to workforce retention and development.

The remaining $60 million was allocated to broader workforce development initiatives, including loan repayment, tuition assistance, peer support and Tribal support programs. These efforts were designed to reduce financial and professional barriers while promoting a more diverse and inclusive workforce. Together, these investments demonstrate the critical role clinical supervision plays in a comprehensive approach to workforce development, helping to attract and retain skilled behavioral health providers across the state.

Figure 2. Allocation of $80 million for Oregon behavioral health workforce development under House Bill 2949



Investing in clinical supervision strengthens workforce retention and care quality. Clinical supervision is a cornerstone of effective behavioral health care, offering critical support for providers and improving patient outcomes. Research highlights its role in enhancing provider skills, confidence and adherence to evidence-based practices. A systematic review by Alfonsson and colleagues (6) found that supervised therapists deliver better cognitive behavioral therapy, leading to improved patient outcomes. Similarly, Ogbeide, Bauman, and Beachy (7) emphasized that clinical supervision mitigates burnout, fosters professional development and prepares providers for the complexities of integrated care models. Despite these proven benefits, supervision requires significant resources including time, trained supervisors and infrastructure. Funding clinical supervision programs is essential to address workforce shortages, improve care quality and ensure that providers are well-supported in delivering effective behavioral health services. Without adequate investment, organizations may struggle to sustain these programs, jeopardizing both workforce retention and patient care.

The state of Washington has proposed solutions to address workforce shortages by improving supervision and training programs.

Presenting to the HB 2235 Workgroup, Kelli Bosak (Three Rivers Health Center Coos Bay, Oregon) (8) indicated that key efforts in Washington include creating a general behavioral health supervisor qualification, supporting tele-precepting models to expand access to supervision and providing funding to encourage agencies to offer supervision. These initiatives aim to remove barriers to licensure and training while ensuring that supervision meets competency.

Potential impact

Expanding access to clinical supervision is essential to strengthening Oregon's behavioral health workforce. Funding programs like the Clinical Supervision Expansion Grant help remove barriers to licensure, ensuring that professionals in areas that are underserved can advance in their careers. High-quality supervision enhances provider skills, reduces burnout and improves patient outcomes, while also addressing workforce shortages by creating a reliable path for career development. Without adequate investment, organizations risk losing valuable providers, which jeopardizes workforce stability and limits access to care for communities in need. This critical funding is a necessary step to ensure a resilient, well-supported behavioral health system.

Provide free training for Certified Recovery Mentors, Peer Support Specialists and Peer Wellness Specialists

Diversity

Career recruitment and development

The problem

Oregon faces a shortage of Certified Recovery Mentors (CRMs), Peer Support Specialists (PSSs) and Peer Wellness Specialists (PWSs), particularly those equipped to provide culturally and linguistically specific services. For instance, according to the Oregon Health & Science University gap analysis on Oregon behavioral health services (9), there is a 28% gap in the availability of CRMs statewide, particularly in communities that are underserved. The high cost of training and certification creates barriers for individuals from historically marginalized backgrounds, including those with lived recovery experience, who are uniquely positioned to fill these roles. Without accessible pathways for both initial certification and continuing education, the state struggles to recruit and retain these vital professionals. This shortage limits the availability of culturally responsive care, perpetuates inequities and hinders the state's ability to build a workforce that reflects the diversity and needs of its communities.

Recommendation statement

Provide free training and certification through a statewide program for CRMs, PSSs and PWSs, ensuring equitable access and continuing education for individuals from diverse backgrounds, including those with lived recovery experience.

This program could include:

- Partnerships with educational institutions: Collaborate with community colleges, universities and specialized training

organizations to offer CRM, PSS and PWS training programs. These programs should be available in multiple languages and formats (e.g., online, in-person, hybrid) to meet the needs of a diverse population.

- Outreach and recruitment strategies: Implement focused outreach to recruit individuals with lived experience, especially from communities that are disproportionately affected. Partnerships with community organizations, recovery programs and cultural centers can help identify and encourage candidates to join the program.
- Support services for trainees: Provide essential support services for individuals enrolled in the training program, including childcare, transportation assistance and other resources to reduce barriers to participation.
- Expansion of existing initiatives: Build on existing efforts, such as the Mental Health & Addiction Certification Board of Oregon agreement, which has successfully provided free CRM certifications and training.
- Pathways for continuing education: Create opportunities for continuing education to support career growth and long-term success for CRMs, PSSs and PWSs.
- Support for culturally and linguistically specific services: Allocate funding to train and certify staff who can provide culturally and linguistically specific services to better meet the needs of diverse communities.

Workgroup insights

"For the CRM, just because I've had helped people get through a number of the trainings, can cost upward of $500, and a lot of people don't even have that money to pay out of pocket for the training. So, this is a really good recommendation I feel just because of the population I work with and [for] getting more people into the behavioral health profession as a whole."

~HB 2235 Workgroup member

This member underscores the financial barriers many individuals face when pursuing CRM, PSS and PWS training and highlights the importance of making certification accessible to expand the behavioral health workforce, particularly for populations that are underserved.

Context and supporting research

According to the Mental Health and Addiction Counselor Board of Oregon, the BHWI program has made significant strides in supporting CRMs. Between October 2022 and June 2024, the program provided free CRM registrations and waived exam fees for CRM II candidates which contributed to over 2000 newly certified CRMs and CRM IIs. Continuing funding for this program, along with offering free training, is a critical step toward establishing a statewide initiative to provide free training and certification for CRMs, PSSs and PWSs. This recommendation aims to ensure equitable access to education and ongoing professional development for individuals from diverse backgrounds, including those with lived recovery experience.

Diversity and peer support improve outcomes. Recent studies by Rice and Harris (10) and Wilbur and Snyder (11) highlight the importance of a diverse behavioral health workforce in addressing disparities in care. Research shows that clients report greater satisfaction and better outcomes when matched with providers who share similar lived experiences or cultural and linguistic backgrounds. Peer support, provided by individuals with lived experience of recovery, is increasingly recognized as a critical element of mental health services. According to Burke and colleagues (12), peer support improves recovery-related outcomes by fostering empowerment, building self-efficacy and reducing internalized stigma.

Oregon faces a significant shortage of CRMs, with an average gap of one CRM for every 1,307 residents.

The disparities are even more pronounced in certain counties, such as Tillamook (one CRM per 3,427 residents), Hood River (one CRM per 3,392 residents) and Benton (one CRM per 2,874 residents). Addressing these gaps is essential to meeting the recovery and support needs of communities across the state.

Potential impact

Creating a statewide program for free CRM, PSS and PWS training and certification will help build a stronger, more diverse behavioral health workforce. By reducing financial and logistical barriers, the program will allow individuals from diverse backgrounds, including those with lived recovery experience, to enter these critical roles. Partnerships with educational institutions and community organizations will expand access to training, while support services like childcare and transportation assistance will make it easier for trainees to succeed. This initiative will also ensure more providers are available to deliver culturally and

linguistically specific care, reducing health disparities and improving access to behavioral health services across Oregon.

Include childcare and housing stipends as part of a grant for publicly funded behavioral health entities

The problem

Behavioral health providers face significant challenges related to the high costs of housing and childcare, which contribute to workforce shortages, high turnover rates and recruitment difficulties. While existing incentives such as the Behavioral Health Workforce Bonus and Housing Stipend Grant have provided critical support, they do not currently address the burden of childcare costs.

The public BH system, which serves as an essential safety net for Oregon's communities, is particularly impacted by barriers to workforce attraction and retention. Without focused support for childcare expenses, organizations and providers within this system face additional challenges, especially in underserved areas or regions with high need. Expanding the grant to include childcare stipends, with a dedicated priority for providers and organizations most impacted by these barriers, would address a significant obstacle, enhance workforce retention and improve the overall sustainability and equity of Oregon's behavioral health system.

Recommendation statement

Include childcare and housing stipends as part of grants for entities in the public BH system, offering upfront funding to cover these essential costs.

Workgroup insights

"Childcare is important, and I think some of the issues to think about when it comes to wages is that there are ways to put money back into people's pockets other than raising wages. Among that is helping to subsidize other costs through providing other kinds of benefits either through the workplace or figure out how state dollars can be leveraged to help provide subsidies. Childcare is very expensive, and this is just a slide [participant presented a slide to the workgroup] from the Department of Labor showing that for the median annual price of childcare for one child, for one that is in

an infant center-based setting, is about $15,000 for one child, and keep in mind many people have more than one child."

~HB 2235 Workgroup participant

This quote underscores the critical role of childcare support in addressing workforce challenges in the behavioral health sector. It suggests that high childcare costs can create significant financial strain for providers, particularly those with multiple children. The participant emphasizes that providing subsidies or other benefits, rather than solely focusing on wage increases, is a practical way to alleviate this burden.

Context and supporting research

High housing costs in urban areas and limited availability in rural regions create critical barriers to recruiting and retaining professionals in communities that are underserved. As reported by Esu and colleagues (13), housing stipends are an essential strategy for addressing these challenges, making it financially feasible for workers to serve in high-need areas. This approach directly improves access to care for populations that are underserved, ensuring that essential services reach the communities that need them most. Similarly, reliable childcare allows professionals to concentrate fully on their work responsibilities, leading to higher productivity and improved service quality (14).

Providing housing and childcare support also advances equity and workforce diversity, addressing systemic barriers that disproportionately affect professionals with lower incomes and otherwise disproportionately affected. The National Council on Mental Wellbeing (15) highlights that diverse teams are essential for delivering culturally responsive care, and these stipends are pivotal in attracting and retaining such talent. Furthermore, reducing turnover and burnout through these supports stabilizes the workforce, fostering consistent, high-quality care. Research by the Substance Abuse and Mental Health Services Administration (16) demonstrates that continuity of care, driven by a stable workforce, results in stronger therapeutic relationships and better client outcomes.

Providing childcare and housing stipends is a proven strategy to recruit and retain behavioral health professionals. A behavioral health workforce bonus and housing stipend implemented by OHA demonstrates the effectiveness of this approach, offering a model for addressing workforce challenges through focused financial support (17).

Key Features of the Program:

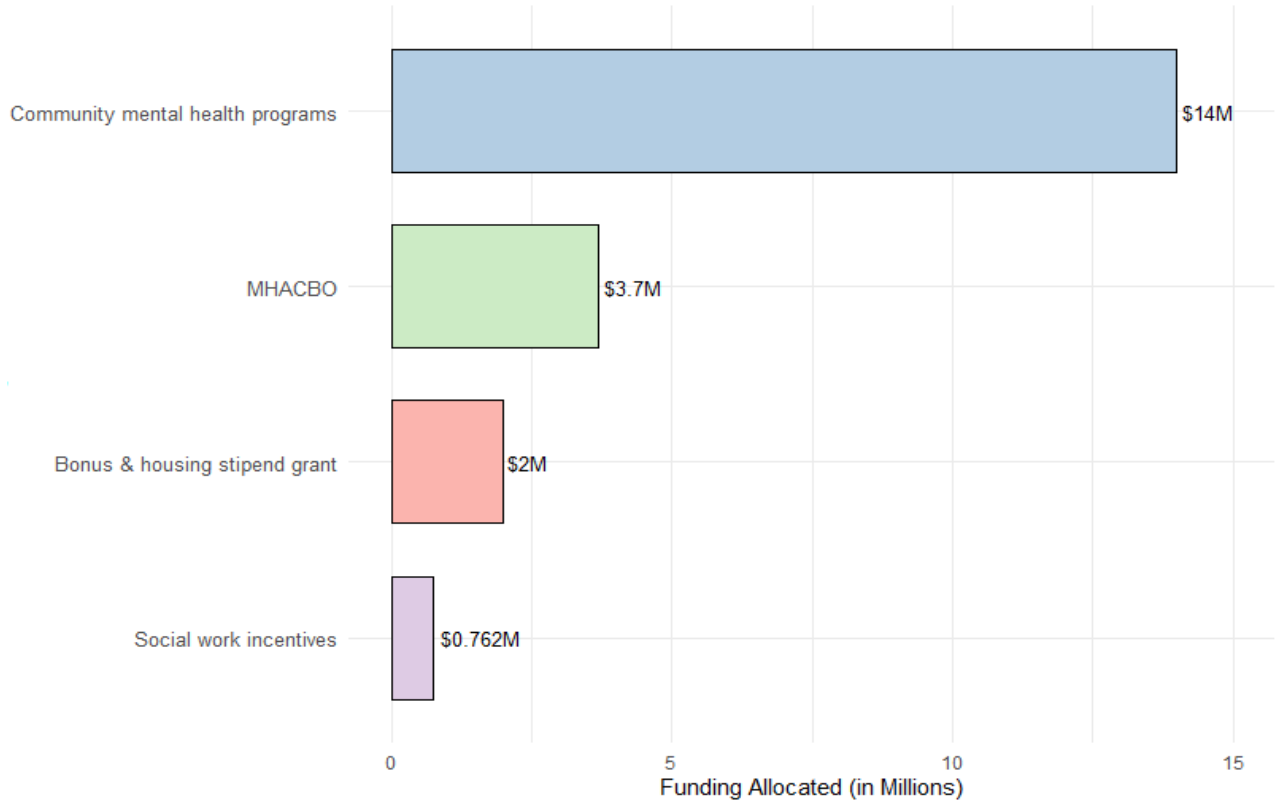
- Housing stipends: Eligible behavioral health workers can receive housing stipends ranging from $3,000 to $10,000 annually. These stipends support workers who:
    - Relocate to rural areas for employment.
    - Move from outside Oregon to take positions within the state.
    - Fill vacant, permanent positions that the organization plans to sustain.
    - Provide direct behavioral healthcare services (fully telehealth positions are ineligible, but hybrid positions are eligible).

- Funding allocation: Organizations can access up to $120,000 over two years to offer sign-on bonuses, retention bonuses and housing stipends.

This initiative highlights how OHA is addressing workforce shortages by alleviating housing-related barriers, a key factor in attracting and retaining skilled professionals.

The graph below (see Figure 3) illustrates the allocation of funding for BHWI including $2 million for bonus and housing stipend grants. This funding is part of a broader investment strategy that includes $762,000 for social work incentives, $3.7 million for the Mental Health and Addiction Counselor Board of Oregon and $14 million for CMHPs. These focused allocations reflect OHA's commitment to strengthening the behavioral health workforce and ensuring care for populations that are underserved.

Figure 3. Allocation of Behavioral Health Workforce Incentives (BHWI) funding



By including funding childcare and housing stipends as part of a grant for entities in the public BH system, Oregon can further enhance its workforce recruitment and retention efforts while supporting critical behavioral health services statewide.

Potential impact

By reducing the financial burden of childcare and housing, particularly for providers with young families, this initiative would help create a more stable and sustainable workforce within Oregon's public behavioral health system. Prioritizing support for those providers and organizations most impacted by these challenges, particularly in high-need areas, would enable the system to attract and retain skilled professionals who serve as critical safety nets for their communities.

Providing these stipends would also improve the overall quality of life for behavioral health professionals, fostering long-term commitment to their roles. This strategy complements existing efforts to address wage-related challenges by offering direct, impactful benefits that alleviate essential living costs. Ultimately, these focused investments in housing and childcare support would enhance the resilience and equity of Oregon's public behavioral health system, ensuring consistent access to care for the communities that rely on it most.

Create an incentive program to support trained providers in acute care settings

The problem

Providers in acute care settings, such as Substance Use Disorder residential facilities, secure residential facilities and stabilization and crisis units face overwhelming challenges that contribute to burnout, high turnover and recruitment difficulties. These roles require managing the highest-acuity patients with complex care needs, placing immense physical and emotional safety risk on staff. Despite these challenges, the workforce in these settings is often underpaid, under-supported and apprehensive about taking on these critical roles.

OHA has committed to increasing psychiatric bed capacity by nearly 3,500 beds across the state by the end of the third quarter of 2029 (18) signaling an urgent need for additional staff to service these new and existing facilities. However, without focused incentives including higher pay, improved safety measures and employee wellness programs, these difficult-to-fill positions will remain vacant, jeopardizing the success of this initiative.

Recommendation statement

Create a new BHWI program to support trained providers in acute care settings, such as inpatient facilities, residential programs and stabilization units. This program should focus on increasing pay, improving safety measures and enhancing employee wellness, including options like sabbaticals and overtime pay for required documentation. Priority should be given to culturally specific and linguistically specific providers as well as those from disproportionately affected communities.

Workgroup insights

"Inpatient is going to require skilled folks because the acuity is going to be higher. I think let's not minimize the environment that these are folks that are at risk in terms of assaulted behaviors. And so, what I hear from providers running these programs is it takes a lot to get someone attracted to working in a potentially assaultive kind of work environment."

~HB 2235 Workgroup member

This quote highlights the difficulty of attracting skilled providers to inpatient behavioral health settings where high-acuity patients and the risk of assaultive behaviors create a challenging work environment. It underscores the need for the following recommended incentive program, which focuses on increasing pay, improving safety and prioritizing employee wellness to recruit and retain staff in these critical roles.

Context and supporting research

Address burnout to build an equitable behavioral health workforce. The "Joint Task Force on Improving the Safety of Behavioral Health Workers" (19) emphasizes the importance of addressing burnout as a key strategy for building an equitable behavioral health workforce. Employers are urged to implement safety training programs covering de-escalation techniques, workers' rights and emergency procedures, with mandatory onboarding and periodic updates. To support employer compliance, grants and technical assistance are recommended for risk assessments, physical safety upgrades and compliance monitoring. These measures support workforce retention, reduce violence-related risks and ensure equitable and comprehensive safety measures within behavioral health settings.

Low wages, insufficient support and demanding workloads contribute to burnout. According to Nagle and associates (20), burnout not only undermines staff retention but also compromises the quality of patient care. According to the Substance Abuse and Mental Health Services Administration, interventions like wellness programs and improved safety measures are essential for workforce stability.

Potential impact

Implementing a BHWI program for acute care settings could significantly improve staff recruitment and retention in these high-acuity environments. By increasing pay, enhancing safety measures and supporting employee wellness, the program would

help address workforce shortages, reduce burnout and create a more stable and skilled workforce. Prioritizing culturally and linguistically specific providers and those from disproportionately affected communities would also ensure more equitable care for diverse populations. This initiative would strengthen Oregon’s behavioral health system and support the state’s efforts to expand psychiatric bed capacity, ensuring quality care for patients with the most complex needs.

Promote CMHPs, COAs and CBOs through a state-led marketing and community engagement initiative

The problem

CMHPs, COA organizations and CBOs play a vital role in Oregon's publicly funded BH system, yet they face significant challenges in attracting and retaining skilled professionals. Many potential employees remain unaware of the unique benefits, growth opportunities and ongoing efforts to improve workplace environments and conditions within this system.

Without efforts to transform the perception of CMHPs, COA organizations and CBOs, Oregon risks continued workforce shortages in publicly funded behavioral health roles, further limiting access to care for communities that are underserved. A state-led marketing initiative is necessary to promote these organizations as excellent places to build a rewarding career as we strengthen and reform the public BH system to meet the growing needs of Oregon's communities.

Recommendation statement

Promote CMHPs, COAs and CBOs through a state-led marketing and community engagement initiative. This effort should prioritize funding for a statewide marketing campaign focused on raising awareness about career opportunities within publicly funded behavioral health organizations, led by OHA.

Workgroup insights

"These are the types of things that make working in or could make working in the publicly funded behavioral health sector, really unique and really attractive. And so, you know…maybe it [is] like cheesy, right? "Making the publicly funded behavioral health workforce the best place to work!" But I truly honestly believe that that's the direction that we need to go. Because we're not going to compete with the money that can be made in private practice and we're not going to be able to compete with the, you know, the flexibility and all of the things that [the other workgroup member]

> talked about in, in his presentation. And so there has to be different things that attract people to the publicly funded sector. And I think that unique benefits like this could really make that difference for people."
>
> ~HB 2235 Workgroup member
>
> This quote highlights the need to reframe and promote the publicly funded behavioral health sector as an attractive and unique workplace. Referring to another member's presentation on the ways providers are currently incentivized to go into non-publicly funded private practice, the member illuminates how providers can be attracted by offering distinctive benefits, career opportunities and a sense of purpose.

Context and supporting research

Many roles in the public BH system offer unique benefits, such as team-based care, career advancement and the ability to make a meaningful impact. Research by Hobfoll (21) emphasizes that promoting the mission-driven nature of public-sector work is an effective strategy to attract professionals motivated by purpose over pay. Highlighting the vital role of publicly funded behavioral health organizations in delivering equitable care can shift these perceptions and draw motivated candidates.

Such an effort could highlight:

- The expertise required to manage complex cases.
- The benefits of team-based care, including collaboration across disciplines and departments.
- Available training opportunities and leadership support.
- Career pathways and opportunities for advancement.
- Workforce incentives, such as tuition assistance and bonuses.

Evidence from recruitment campaigns in other sectors demonstrates that focused marketing initiatives can successfully transform perceptions and improve workforce recruitment. For example, Australia's public health campaign for rural nursing increased its applications by showcasing the value of community-focused care and career pathways (22). Similarly, a campaign focused on the benefits of working at CMHPs, COA organizations and CBOs — such as collaboration, leadership support and training opportunities — can effectively attract professionals who prioritize meaningful work.

Potential impact

Promoting the publicly funded behavioral health sector as a unique and rewarding workplace while concurrently making significant investments and improving working conditions can improve workforce recruitment and retention. This strategy can attract professionals who are motivated by more than just salary. Over time, this shift in perception can strengthen the workforce, reduce turnover and ensure that vital services remain accessible to those who need them most.

Chapter 2: Retention

In this chapter

This chapter focuses on solutions to retain skilled staff by improving workplace conditions faced by client-facing and culturally and linguistically specific providers. Retention is a cornerstone of workforce stability in Oregon's public BH system. High turnover and burnout among behavioral health professionals jeopardize the continuity and quality of care for communities in need.

Recommendations in this chapter prioritize flexible funding for retention strategies, workforce well-being initiatives and measures to foster a supportive and equitable work environment. By addressing the systemic barriers that drive professionals out of the field, these strategies aim to create a stable, resilient workforce capable of delivering consistent, high-quality care across Oregon.

Dedicate funding to address the psychological and physical safety needs of behavioral health staff

Career recruitment and development

The problem

Behavioral health staff face significant psychological and physical safety challenges, yet there is insufficient funding to adequately address these needs. Staff frequently encounter complex and intense scenarios without the necessary tools, training or de-escalation strategies to ensure their safety, resulting in increased stress, burnout and turnover.

The 2024 "Joint Task Force on Improving the Safety of Behavioral Health Workers: Final Report and Recommendations" indicates that insufficient funding and lack of standardized approaches exacerbate safety challenges for behavioral health staff (19). The report highlights that behavioral health workers frequently deal with complex and high-risk situations, including violent encounters and crisis management, without adequate access to safety training, equipment and psychological support. This deficit leads to increased stress, burnout and turnover among staff, compounding workforce shortages and undermining care quality.

While some local efforts, such as post-traumatic stress management training, have begun addressing these issues, the lack of standardized funding and implementation models limits their overall effectiveness. A statewide solution is needed to provide flexible funding for safety improvements, equipment and training that can be tailored to the specific needs of organizations while aligning with proven strategies. Without dedicated funding and clear expectations, Oregon risks further workforce shortages and a decline in the quality of care provided by its behavioral health system.

Recommendation statement

Provide dedicated OHA funding to address the psychological and physical safety needs of behavioral health staff, including investments in safety improvements, essential equipment and related training programs.

The safety of behavioral health staff is a critical concern, particularly in high-acuity settings such as inpatient facilities, residential programs and stabilization units. Incidents of workplace violence and safety lapses have been documented, underscoring the need for comprehensive safety measures.

Workgroup insights

"Our work environment looks very different. I've been in the field for 20 years, and I don't think I've ever experienced things in the way that they are. I just did a debrief today because we lost another client by an accidental overdose. I did a debrief at the same site earlier this week because we had a client assault one of our clinicians. So, it does look very different."

~HB 2235 Workgroup member

This quote highlights the increasing challenges faced by behavioral health staff in their work environments. The member reflects on how the field has changed over the years. These experiences underscore the urgent need for dedicated funding to improve the psychological and physical safety of staff, ensuring they have the tools, training and support to navigate high-risk situations and continue providing quality care.

Context and supporting research

To address the challenges faced in acute care settings, workgroup members suggested targeted strategies to enhance safety and support for staff, including:

- Preparation for critical incident management by training staff in an evidenced-based critical incident stress management program (Psychological First Aid, Post Traumatic Stress Management, etc.).
- Technology upgrades that ensure adherence to behavioral health care workplace safety policies and best practices, such as badge entry systems for doors or duress alarms (e.g. "panic buttons") to alert first responders of critical incidents.
- Communication and safety devices for providers to stay in contact and track locations as providers travel to visit clients.

In their research on Behavioral Emergency Response Teams, Rajwani, Clark, and Montalvo (23) highlight how trauma-informed training, such as post-traumatic stress management, can empower staff to handle high-stress situations effectively and recover from exposure to traumatic events. Moreover, Rajwani, Clark and Montalvo's research supports the use of advanced communication and safety devices, such as badge systems with emergency buttons, as integral components of rapid response frameworks that ensure staff safety during crises.

Psychological safety is key to improving care and reducing burnout in behavioral health. Recent studies highlight the critical need for psychological safety to improve patient care and staff well-being. A study by Hunt and colleagues (24) emphasizes organizational-level initiatives, such as fostering an ethos of psychological safety and embedding it into workplace culture, while O'Donovan and McAuliffe (25) identify specific team and individual-level factors that facilitate safety, such as supportive leadership and inclusive team dynamics.

For behavioral health staff, these insights suggest the need for focused interventions that integrate organization-wide strategies with team-level practices. Key recommendations include:

- Encouraging inclusive and supportive leadership to address power dynamics and hierarchy.
- Fostering a culture of continuous learning and improvement to reduce fear of making or reporting mistakes.
- Implementing team-based initiatives to build trust and collaboration among colleagues.

By addressing psychological safety comprehensively, organizations can reduce burnout, improve workforce retention and enhance the quality of care in behavioral health settings.

Potential impacts

Prioritizing investments in the psychological and physical safety of behavioral health staff can significantly enhance workplace conditions, alleviate stress and improve staff retention rates. Equipping staff with appropriate training, tools and support systems ensures they feel empowered and better prepared to manage high-stress situations, ultimately reducing workplace incidents and fostering a safer environment. Over time, these measures will build a more resilient workforce, mitigate burnout and elevate the quality of care provided to individuals receiving behavioral health services.

Establish a grant to support retention strategies for all client-facing staff within the the public BH system

Career recruitment and development

The problem

Many client-facing staff within the public BH system, including administrative and clinical staff, face significant challenges that contribute to high turnover rates and burnout. Many of these roles are understaffed, leading to increased workloads, reduced connection among colleagues and a lack of support networks to address shared challenges. Without focused retention strategies that prioritize workforce well-being and foster a sense of community, these issues will continue to strain staff and diminish the quality of care provided. Flexible funding for retention strategies is essential to improve staff satisfaction, build supportive workplace environments and ensure the sustainability of the behavioral health workforce.

Recommendation statement

Establish a grant to support retention strategies for all client-facing staff within the public BH system. This program should prioritize workforce well-being strategies that are adaptable to the diverse needs of frontline staff, including intake, front desk and supervisors. Grants should provide organizations with flexible funding to implement initiatives such as professional development opportunities, wellness programs and non-cash incentives that promote retention without conflicting with labor agreements. By allowing organizations to tailor strategies to their workforce needs, this program ensures improved staff satisfaction and retention across a range of client-facing roles.

Workgroup insights

“It does matter what happens with all of the staff from the front door on. So, meaning the folks who are answering the phones, the folks who are doing the scheduling, all of that space needs to be welcoming for both the clients and welcoming and safe for both the clients and for the staff. And so, this is something I've just been struggling with, is how to recreate connection, or spaces for connection, when we don't have as many staff as we did at one point in time. And is there a space? And are there professional networks or OHA sponsored ways for folks to come together and have that community who are working in community mental health programs, et cetera, to have those affiliation connections and share those challenges. That's what I've been struggling with lately.”

~HB 2235 Workgroup member

This quote highlights the vital role that all client-facing staff play in creating a welcoming and safe environment for both clients and staff in behavioral health organizations. There is a challenge in fostering connection and community among staff, especially as workforce shortages make it harder to maintain supportive work environments.

Context and supporting research

Ohio launched initiatives to address the growing demand for behavioral health care by focusing on workforce development and retention.

Presenting to the HB 2235 Workgroup, Bosak (8) revealed that Ohio's Department of Mental Health and Addiction Services introduced focused funding and programs to stabilize and expand the behavioral health workforce. Key measures included:

- Retention incentives for frontline workers: Ohio provided up to $50,000 in one-time retention incentives to each of the 115 certified community behavioral health centers to support and retain frontline staff critical to the delivery of mental health and addiction services.
- Scholarship and loan repayment programs: The state established financial assistance programs to alleviate educational debt for behavioral health professionals, especially in areas that are underserved.

- Training and workforce development: Ohio invested in training initiatives to improve workforce readiness. This included efforts to enhance clinical supervision and expand the career pathway of qualified behavioral health professionals.
- Focus on areas that are underserved: Special attention was given to addressing shortages in rural and frontier regions, with initiatives focused on recruitment and retention in these high-need areas.

These strategies reflect Ohio's commitment to addressing workforce shortages, supporting current providers and building a sustainable behavioral health system capable of meeting the state's growing needs.

Potential impact

Implementing a grant program for retention strategies focusing on client-facing staff at publicly funded BH organizations will enhance workforce stability, improve staff morale and create a more supportive work environment. By providing flexible funding for professional development like Qualified Mental Health Associate certification opportunities, wellness programs and other non-cash incentives, organizations can address the diverse needs of this front-line workforce. This investment will reduce burnout, strengthen staff connections and improve the ability to maintain welcoming and safe environments for both clients and employees. Over time, these measures will lead to higher retention rates, better client experiences and a more resilient behavioral health workforce.

Chapter 3: Administrative Burden

In this chapter

This chapter focuses on strategies to streamline administrative processes and alleviate burdens on providers. Administrative inefficiencies significantly impact Oregon's behavioral health workforce, diverting time and resources from direct client care. Excessive documentation, complex reporting requirements and insufficient administrative support contribute to provider stress and burnout, undermining workforce retention and service quality.

Recommendations include implementing formal program evaluations that include a focus on reducing administrative burden and increasing the cap on allowable administrative expenses. Importantly, the HB 2235 Workgroup, in the subsequent report, will be working with the House Bill 4092 (2024) workgroup that is dedicated to reducing the administrative burdens on behavioral health care providers and increase system efficiencies. By aligning efforts with the HB 4092 workgroup and the directives of HB 4092, the HB 2235 workgroup aims to decrease workforce burnout, lower system costs and enhance person-centered care.

Raise the maximum for administrative expenses in BH workforce incentive programs to 12-15%

The problem

BHWI programs are critical for addressing workforce shortages, but caps on administrative expenses limit the ability of community-based organizations to meet growing administrative demands. This restriction places additional strain on organizations, contributing to provider burnout and detracting from patient care. While the Behavioral Health Workforce Initiative group has already raised the cap across its programs, other workforce-related grants from OHA still lack sufficient administrative support.

Recommendation statement

Raise and maintain the maximum allowance for administrative expenses in BHWI programs to 12-15%. This increase will help cover costs associated with meeting the program's requirements and reporting obligations.

Current caps on administrative expenses in BHWI programs pose significant challenges for publicly funded organizations. This limitation hinders their ability to manage essential administrative tasks, such as grant reporting and compliance with OHA requirements, leading to increased strain on providers and detracting from patient care.

Raising the administrative expense cap to 12-15% would alleviate financial pressures on providers, particularly smaller and community-based organizations, enabling them to allocate more resources toward essential care.

Workgroup insights

"I've been writing grants for about 15 years. I've been working with the Oregon Health Authority for about the last, almost 10 years. So, I have some pretty direct experience with this particular issue of administrative expenses for grants, and right now there's a cap of 10%. So, I'm only given 10% funds to do the paperwork that the Oregon Health Authority asks me to do and that might be

> evaluation measures, that is the actual grant reporting, that is all associated with the things that the Oregon Health Authority is asking me to report back to them. That's separate from the program and the administration of the program. Now, it's been my experience in all the years that I've done this, 10% is never enough to take care of the actual expenses. So, bumping it up to 15% is a very necessary thing because otherwise you have to find that money somewhere else, but you have to complete the requirements that the Oregon Health Authority asks you for whether it's reports or feedback about the success of the program, all of those things. So, it's probably been a long time coming to increase that to 15%. [It's] pretty standard in a lot of the grants that they have raised it up to 15%. Also good to note that the time it takes to write grants is never reimbursed by the grant funder. It is always done without pay, so almost a double whammy to not get enough administrative funds when you start out with many hours already unpaid.
>
> ~HB 2235 Workgroup member
>
> This quote underscores the challenges organizations face in managing grant-related administrative tasks under a 10% cap on expenses, emphasizing that it is insufficient to cover essential reporting and compliance requirements set by OHA.

Context and supporting research

Raising administrative expense caps can ease workforce strain in behavioral health programs. A study by Lu and Zhao (26) examining nonprofits receiving government funding found that once administrative capacity exceeded a certain threshold and administrative costs became relatively stable, the organization operated more efficiently. In another study, Burkart, Wakolbinger, and Toyasaki (27) examined the impact of administrative expense ratios on nonprofit operations. They found that excessively low administrative expense ratios hurt efficiency by underfunding necessary capacities, such as infrastructure and management systems, which are vital for achieving organizational goals. Conversely, high administrative expense ratios did not consistently lead to better efficiency and were often associated with donor skepticism and reduced confidence. The researchers emphasized that nonprofits must strike a balance, as spending above or below optimal levels can negatively affect both operational effectiveness and donor trust (27).

Potential impact

Raising the administrative expense cap to 12-15% would provide the right-size critical resources for community-based organizations to manage essential grant-related tasks, such as reporting, compliance and evaluation. This adjustment would reduce strain on providers, alleviate burnout and enable organizations to focus more resources on direct care. By improving administrative capacity, the change would enhance organizational efficiency, workforce retention and the quality of behavioral health services. Over time, it would encourage greater participation in public programs, expanding access to care and strengthening Oregon's behavioral health system, particularly in communities that are underserved.

Establish a formal evaluation process for OHA Behavioral Health Workforce Incentives (BHWI) programs

The problem

The BHWI program grants, introduced in 2022, do not have a formal evaluation process to assess their impact, successes and areas for improvement. Currently, the BHWI team does not have the capacity to evaluate these programs, leaving a gap in understanding their effectiveness and the value they provide to the behavioral health workforce. Without evaluation, legislators lack the necessary data to make informed decisions about continued funding, risking the sustainability of potentially impactful programs.

Recommendation statement

OHA should establish a formal evaluation process for BHWI programs to track outcomes and report them regularly to the public. To implement such evaluations efficiently, it's recommended that the process utilizes minimal state resources, not exceeding 1% of a grant program's budget. This approach balances the need for comprehensive assessment with fiscal responsibility. Additionally, including an assessment of administrative burdens on applicants and recipients can identify areas for process improvement, enhancing program accessibility and effectiveness.

To ensure unbiased and credible results, contracting with independent program evaluators is preferable over relying solely on internal staff. Independent evaluations provide objective insights, fostering trust among community partners and informing data-driven decisions.

Context and supporting research

Research conducted on the Rural Interprofessional Behavioral Health Scholars Program demonstrates the importance of assessing program outcomes to improve workforce development strategies (28). Implemented during COVID-19, the program used systematic data collection methods like pre- and post-surveys and focus groups to evaluate its impact on trainees' skills in rural behavioral health practice. The findings highlighted the value of tailored programs that address workforce shortages in areas that are underserved while stressing the need for evaluation tools to adapt and improve these efforts over time.

Along similar lines, Nove, Cometto, and Campbell (29) **proposed an impact assessment tool to evaluate the effects of health workforce policies and programs.** Their review of the literature revealed that many workforce initiatives lack rigorous evaluation frameworks, creating gaps in understanding their long-term effectiveness. The study emphasized how evaluation processes can uncover unintended consequences, guide the design of future programs and align them with broader health system goals. Their proposed tool underscores the importance of systematic evaluations that focus on workforce distribution, equity and sustainability.

Potential impact

Implementing a program evaluation process for BHWI programs will improve transparency and accountability with minimal resource use. By capping evaluation costs at 1% of each grant's budget and regularly publicizing outcomes, this approach ensures efficient oversight and focused impact. Including a measure of the administrative burden on applicants and recipients promotes a streamlined, user-friendly experience, ultimately boosting program effectiveness and supporting workforce retention across Oregon's behavioral health system.

Chapter 4: Reimbursement rates and pay

In this chapter

This chapter includes a recommendation highlighting the need for a more equitable reimbursement model for the publicly funded BH system. Current Medicaid structures fail to account for the unique demands faced by providers serving populations that are high-need or underserved, perpetuating workforce shortages and limiting access to care.

Providers within the public BH system often handle complex cases, deliver time-intensive team-based and community care and meet demanding regulatory requirements—all without adequate compensation for additional costs.

HB 2235 mandated the workgroup to consider the impact of its recommendations on "the ability to transition to value-based payment methodologies." After future consultation with subject area experts, the workgroup looks to provide greater consideration of how to move forward with more equitable reimbursement models. Reforming reimbursement rates is a critical step in creating a sustainable and resilient behavioral health system especially for providers that are culturally and linguistically specific or support communities that are rural or underserved.

Prioritize equity in rate increases, focusing on specific activities and the context in which those activities are completed.

Pay equity

The problem

Medicaid reimbursement rates are the same for all behavioral health providers, regardless of the unique challenges faced. These challenges can include administrative and regulatory requirements under OAR 309-019, working conditions and providing services to rural or culturally and linguistically specific clients and other significant costs faced by publicly funded BH organizations and providers. Examples include:

- Travel and transportation costs: Serving rural and remote communities often requires providers to travel long distances, which incurs costs for mileage, fuel and time that are not reimbursed.
- Translation and interpretation services: Culturally and linguistically specific providers frequently handle language translation, interpretation and culturally tailored care.
- Frequent client absences: Providers serving predominantly Medicaid clients face a higher acuity, higher client absences and policies prohibiting billing for missed appointments.
- Administrative compliance: Meeting extensive documentation requirements for Medicaid billing, fidelity reporting and quality assurance programs increases administrative burdens without added reimbursement.
- Services provided after hours or in the field, particularly in team-based models, are more expensive than routine outpatient visits, yet the reimbursement rates remain the same across providers.

- Coordination of care between providers: Providers must often coordinate complex cases involving multiple agencies, which is labor-intensive and not directly reimbursable.
- Training and workforce development: Investing in mandatory training, continuing education, participation in learning collaboratives and supervision for licensure or certification of new professionals adds financial strain, especially for organizations in high-need areas.
- Overhead and operational expenses: Safety-net organizations face unique challenges in maintaining facilities, technology and equipment required to meet regulatory standards.
- Higher costs related to delays in reimbursements, onboarding new clinicians, credentialing and paying wages during investigations (such as protective services). These costs are often higher for organizations subject to higher mandated administrative requirements.

Recommendation statement

Future rate increases should prioritize equity and focus on specific activities and the context in which those activities are completed. This includes both clinical and non-clinical factors, such as whether services are provided in-person or via telehealth, the location of work (in-person, in-office, mobile, remote etc.) and the use of team-based care compared to individual care. Additionally, considerations should include compliance with required fidelity programs, the capacity to offer comprehensive clinical supervision and training for associates and the organization's ability to address client needs through team-based care or wraparound services.

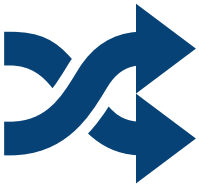
The HB 2235 workgroup will continue to study the complexities and specific needs of different publicly funded behavioral health providers regarding rate adjustments. Other state advisory groups will be consulted to enhance the workgroup's understanding of this statewide issue. This will inform future recommendations for reimbursement rate adjustments for the second HB 2235 report.

Workgroup insights

"I can tell you sometimes our no-show rate for certain services is fairly high. I mean, if you're looking at some of my ACT [Assertive Community Treatment] team and some of the front-end work. You know, people are stressed, clients are, they got a lot going on and their attendance to appointments isn't great. Even if we go to their house, and transportation is another big cost, and the time, and

> especially in rural and frontier. Those are all costs and again, they're not reimbursable, typically.
>
> And so, I think we need to we need to include those costs in how we do it. I mean, I can sit in my office and do a telehealth appointment. I don't have an office cost necessarily. I have very little overhead, and so I can realize a good benefit. But If I'm in a community mental health setting, and I'm in the car half the time, and I have quite a few no-shows, and I have team meetings that I have to attend, then the only way that makes that work is that I've got to work, and my team has got to work, harder, to cover and bring in the revenue to make the whole thing work."
>
> ~HB 2235 Workgroup member
>
> This member illustrates the financial challenges faced within the public BH system. Frequent client absences, travel costs for home visits and the additional demands of team-based care create significant expenses that are not typically reimbursed under current Medicaid structures. Therefore, these providers must navigate higher costs and greater demands, particularly in rural areas, making it difficult to sustain services without more equitable reimbursement models.

Context and supporting background



Moving toward alternative reimbursement models. House Bill 2235 specifies the workgroup to consider how Oregon's behavioral health system might transition to value-based payment methodologies when developing its recommendations. The input gathered from the workgroup highlights that the current fee-for-service model is inequitable. That model pays providers based on the volume of services delivered, which fails to account for the complexity of cases, the time-intensive nature of team-based care or the unique challenges faced by safety-net providers working in areas that are underserved. Providers in these settings often absorb substantial, uncompensated costs for travel, translation services and crisis response, creating significant financial strain. The workgroup also noted that reimbursement rates may not directly lead to higher provider pay especially in unionized settings where wage structures are fixed.

The workgroup recognizes that the fee-for-service structure does not adequately support equitable access to care or incentivize quality outcomes. As a result, they will explore alternative reimbursement models, including those that prioritize equity and sustainability, for inclusion in the next report due in December 2025. These models will aim to ensure providers

are equitably compensated while improving care delivery for Oregon's communities with the greatest behavioral health needs.

Potential Impact

Implementing equitable reimbursement rates will reduce financial strain on community-based and safety-net providers, particularly those serving rural and culturally diverse communities. Adjusting reimbursement models to account for the unique challenges of these providers — such as travel costs, administrative burdens and team-based care — will strengthen workforce retention and sustainability. By ensuring fair compensation, this recommendation supports equitable access to behavioral health care, improves provider capacity and fosters a more resilient system to meet Oregon's growing mental health needs.

Chapter 5: Reducing workloads and burnout

Balancing workload: addressing ratios and caseloads

Workload challenges in Oregon's behavioral health workforce — such as high caseloads, inadequate staffing ratios and uneven workload distribution — are significant contributors to stress and burnout. House Bill 2235 specifically mandates that staffing ratios and caseload guidelines be examined to establish actionable recommendations. These efforts will be explored in greater depth in the final report due in December 2025. To address this, the HB 2235 workgroup will convene subcommittees to develop detailed, data-informed recommendations aimed at ensuring fair and sustainable workloads for behavioral health providers.

Burnout: an aftereffect of complex stressors

Burnout is a cumulative response to multiple systemic stressors, including excessive workloads, insufficient resources, administrative inefficiencies and inequitable working conditions. Many of these stressors are being directly addressed through the recommendations in this report, making progress toward a healthier workforce. Recommendations addressing these root causes include:

- Supporting client-facing staff: Enhancing workforce retention and well-being through flexible funding, wellness programs and non-cash incentives.

- Supporting behavioral health staff safety: Prioritizing workforce safety by addressing both physical and psychological risks.
- Reducing administrative burdens: streamlining grant processes to reduce paperwork, allowing providers to focus on patient care and raising administrative expense caps.

Future Steps on Burnout

The HB 2235 workgroup will further prioritize burnout prevention in its December 2025 report. These efforts will incorporate strategies to promote resilience and sustainability in the behavioral health workforce, integrating findings from national models, such as the Substance Abuse and Mental Health Services Administration's (16) recommendations, to improve job satisfaction and well-being.

This report underscores that burnout is not an isolated issue but a consequence of structural and organizational challenges. Through these focused recommendations, the workgroup lays the foundation for reducing burnout and building a resilient, sustainable workforce that meets the needs of Oregon's communities.

Chapter 6: Supporting equity

In this chapter

This chapter emphasizes focused investments to recruit, retain and elevate culturally and linguistically specific and peer providers. These efforts align with OHA's 2024-2027 strategic plan, which emphasizes diversifying the behavioral health workforce as a foundational strategy for eliminating health inequities by 2030.

While culturally and linguistically specific providers and peer roles are integral to equitable care, there is a critical need to remove barriers preventing a diverse range of individuals from advancing into leadership and advanced behavioral health roles. This limitation reduces the system's capacity to provide culturally responsive services, particularly for historically underserved populations.

Addressing these systemic barriers is vital for creating equitable career pathways and ensuring that individuals from diverse backgrounds have opportunities to advance within the field. By implementing the following recommendations, Oregon can build a more inclusive behavioral health workforce that meets the needs of all communities while strengthening overall system capacity.

Prioritize BHWI program funding for culturally and linguistically specific roles, including peer services and related OHA-approved positions

Diversity

Career recruitment and development

The problem

Oregon's behavioral health system struggles to provide equitable and culturally responsive care due to insufficient support for culturally and linguistically specific roles and peer providers. By failing to prioritize these roles within behavioral health workforce initiatives, Oregon risks perpetuating health disparities and missing an opportunity to build a diverse, community-centered workforce.

Recommendation statement

OHA should set aside funding and prioritize support within BHWI programs for culturally and linguistically specific roles, including peer services and other related OHA-approved positions. Incentives such as tuition support, continuing education stipends, scholarships or bonuses for those who commit to working in areas that are underserved will help attract and retain workers in these critical roles. This approach will reduce disparities in care and strengthen Oregon's behavioral health workforce.

Workgroup insights

"I really want to see organizations have to be responsible for providing culturally responsive environments for all people to work in our organizations, not just to provide culturally responsive services, but what is it about our organizations that are not welcoming or unsafe? What is it about our communities that are

> not welcoming, that are unsafe? I'd like to see some expectations implemented across the board for some change. We recently hired a Black male therapist who moved to rural Oregon from Hawaii, and he stayed with our organization for a week before he realized that our community was pretty inherently racist. And that's rural Oregon, right? That's across, that's across the board, rural Oregon. The metro area is a little bit different. So, we lost him. He left. So, that's super real. If we don't pay attention to this stuff, the impact that it has is real, and we need to do better."
>
> ~HB 2235 Workgroup member
>
> This member's comment highlights a complex issue, but also the need for organizations to create culturally responsive, supportive and welcoming environments not only for clients but also for staff. Without addressing these issues, organizations risk losing valuable staff and perpetuating inequities within the behavioral health workforce.

Context and supporting research

Fund culturally specific care to advance health equity. OHA's 2024–2027 Strategic Plan prioritizes eliminating health inequities by 2030, underscoring the need to allocate funding for culturally and linguistically specific organizations and peer services through initiatives like the Office of Recovery and Resilience. Without dedicated support, the system risks perpetuating health disparities and leaving culturally specific needs unmet.

Culturally and linguistically specific roles and organizations address the unique needs of disproportionately affected communities based on factors such as race, language, disability and immigration status. These services enhance access to high-quality care by aligning with patients' cultural and linguistic needs. Peer providers — individuals with lived experience in mental health or substance use — bridge gaps between clients and traditional healthcare providers, fostering trust and promoting recovery. Despite their critical role, funding and prioritization for these providers remain inadequate.

Research confirms the value of culturally competent care. A study by Handtke and colleagues (30) found that language services, cultural training and tailored health education materials improve patient satisfaction, adherence to treatment and reduce health disparities. Organizations that integrate cultural competence also report improved service delivery and communication.

Potential impact

Investing in culturally and linguistically specific behavioral health roles will improve access to care, reduce health disparities and foster trust between providers and diverse communities. Patients are more likely to seek and remain in care when they feel understood, leading to better outcomes and earlier interventions. A workforce reflective of Oregon's populations strengthens community connections, enhances patient-provider communication and ensures culturally tailored care. The BHWI programs currently prioritize culturally and linguistically specific providers and trainees from communities who are underserved which aligns with this recommendation. This approach also supports workforce resilience, reducing burnout while promoting retention, equity and alignment with OHA's goal to eliminate health inequities by 2030.

Create or expand state-funded BH workforce incentive programs with multiyear funding opportunities

Diversity

Career recruitment and development

The problem

Behavioral health organizations, particularly those that are culturally and linguistically specific or peer-run, face significant challenges in building capacity and sustaining their services. Many smaller organizations struggle to access funding due to complex grant processes, limited administrative resources and a lack of long-term financial support. Additionally, these organizations often lack the resources needed for leadership development, staff training, technology upgrades and career advancement opportunities for their workforce. Without specialized funding and equitable grant opportunities, these organizations risk burnout among staff, limited-service reach and difficulty retaining culturally and linguistically specific providers.

Recommendation statement

Create or expand state-funded BHWI programs with multiyear funding opportunities to support strategic planning and reduce reliance on short-term project-specific grants. These programs could include the following features:

- Prioritize funding for staff retention and organizational capacity building in smaller organizations (under 50 employees) to improve service delivery, access grant opportunities and build networking capabilities, ensuring equity with larger providers.
- Include technology upgrades such as AI solutions for translating forms and accessible Electronic Health Record systems to reduce administrative burdens for culturally and linguistically specific providers.
- Provide funding to expand services and workforce development for culturally and linguistically specific and peer-run

organizations through hiring, training and professional development initiatives.

- Create leadership training, mentorship programs, networking opportunities and career advancement pathways for behavioral health professionals, including culturally and linguistically specific and peer providers.
- Ensure grant processes are equitable and accessible, including simpler applications with language support and prioritization of funding for peer-run organizations and culturally and linguistically specific providers to expand their reach and impact.

Workgroup insights

There are these workforce development programs "…but you give them seed money and a little grant money and then it, it goes away. And so, you see these promising programs do not have sustainable funding. So, I think exploring some sustainable funding for communities across Oregon to develop their own programs that would, specifically, be around QMHP [Qualified Mental Health Professional] or master's level workforce development since that really has been the biggest gap in our state for creating pathways for people."

~HB 2235 Workgroup member

This quote highlights the challenges faced by behavioral health programming that lack sustainable funding, leading to the loss of promising initiatives. This insight aligns with the following recommendation to provide multiyear grants and resources that empower organizations to develop long-term solutions for workforce development, ensuring pathways for individuals to enter and advance in behavioral health careers.

Context and supporting research

Administrative tasks worsen burnout in mental health workers. Reapplying to yearly grants places additional administrative burden on already overworked providers and organizations within the public BH system. O'Connor, Muller Neff, and Pitman (31) conducted a systematic review and meta-analysis of burnout among mental health professionals. Burnout was linked to work-related factors such as high workloads, unclear job roles, insufficient organizational support and excessive administrative tasks. The study highlights the widespread issue of burnout among

mental health professionals, with significant rates of emotional exhaustion (40%), depersonalization (22%) and low personal accomplishment (19%). The study emphasizes that these non-clinical responsibilities, such as documentation, compliance reporting and coordination efforts, divert time and energy away from direct patient care. This misallocation of resources increases stress and diminishes job satisfaction, particularly for professionals who entered the field with a primary focus on client interaction and therapeutic work.

Potential impact

Implementing multiyear funding for BHWI programs will provide critical stability for smaller, culturally and linguistically specific and peer-run organizations. This approach reduces reliance on short-term grants, enabling organizations to focus on staff retention, service expansion and professional development. By addressing administrative burdens, fostering leadership pathways and prioritizing equitable access to resources, these programs will strengthen the behavioral health workforce, reduce burnout and enhance care delivery for communities that are underserved. Sustained funding ensures long-term growth and equity in Oregon's behavioral health system, directly improving outcomes for diverse populations.

Fund culturally specific practices not covered by insurance through dedicated grants.

Diversity

The problem

Culturally specific practices, such as community gatherings, mental health education events and other traditional Indigenous health care practices that were recently approved in October 2024 for Oregon Health Plan and Children's Health Insurance Program (32), are essential for supporting mental health and preserving cultural connections in communities that are underserved. However, for many cultures, these practices are often not covered by insurance, placing the financial burden on providers and clients. Providers struggle to absorb the costs while clients may face barriers to accessing culturally meaningful care due to limited resources.

Recommendation statement

Provide grant funding for culturally specific practices not covered by insurance such as the traditional health care practices that were recently approved under Oregon Health Plan and Children's Health Insurance Program.

Workgroup insights

"When it comes to like more of the cultural linguistic services, it really comes down to having enough time to really attend to everything that an individual is needing. Whether it's the resources or the documentation pieces. There's so much that happens in care that are non-billable services. So, I think sometimes that can get disrupted in just being able to provide more time and care for people. So, that's the one thing that I feel stands out the most, is all the other things that people are not going to get reimbursed for or see a return on, but it is a super, super big component in being able to provide the necessary care for people who are trying to get help."

~HB 2235 Workgroup member

This quote highlights the challenge of providing culturally specific practices, which often include non-billable tasks. These activities are crucial for delivering comprehensive care but are not reimbursed, placing a financial burden on providers and limiting the time they can dedicate to clients.

Context and supporting research

Culturally specific mental health practices such as those recently approved for Oregon's Indigenous communities can better address mental health needs. A study by Gone (33) highlights that mainstream evidence-based practices often fail to meet the cultural and spiritual needs of Indigenous communities, as these models are grounded in Western frameworks that may not resonate with Indigenous worldviews. Subsequently, Mongelli, Georgakopoulos, and Pato (34) identify systemic barriers, such as stigma, lack of access to care and culturally incongruent services, as major challenges in meeting the mental health needs of these groups. The authors emphasize the importance of integrating peer-led and community-based interventions that incorporate cultural practices, as these approaches resonate more deeply with populations that are underserved. This research highlights the need to apply similar support to other communities in Oregon that are underserved.

OHA recognizes the importance of providing culturally responsive services. Effective February 1, 2023, OHA introduced enhanced payments for non-residential behavioral health culturally and linguistically specific services provided to Oregon Health Plan members. Eligible providers receive a uniform payment increase for services rendered to fee-for-service members and coordinated care organizations reimburse contracted providers through a Behavioral Health Directed Payment. These enhanced payments help support culturally specific practices by offsetting some of the costs to meet the unique cultural and linguistic needs of diverse populations. These enhanced payments help offset some of the costs associated with culturally specific services, but they are limited in scope and do not cover the broad range of needed services among Oregon's diverse communities.

Potential impacts

Providing grant funding for culturally specific practices will preserve vital cultural practices ensuring communities that are underserved have access to meaningful, culturally aligned care. Supporting these services will reduce barriers to mental health support, foster trust and engagement in behavioral health systems and address long-standing disparities in care. Ultimately, this investment strengthens the cultural and mental health connections needed to improve outcomes for Oregon's diverse populations.

Chapter 7: Workforce development

In this chapter

Initiatives in this chapter address both immediate needs and long-term sustainability by reducing barriers to education, strengthening training opportunities and fostering growth at every stage of career advancement.

Key recommendations include covering all costs for training at community colleges, paid internships with mentoring and supervision and tailored support for culturally and linguistically specific providers. Additionally, the chapter highlights the creation of a career and technical education (CTE) pathway for high school students, building on successful CTE efforts already underway in Oregon. This program would generate early interest in behavioral health careers, offer foundational knowledge and establish a direct route into the field, ensuring a long-term career pathway of homegrown professionals. The chapter also emphasizes the role of regional behavioral health consortia to align local workforce needs with training programs, particularly in areas that are underserved or rural.

Ensure state-funded behavioral health scholarships cover all costs for training with added funding for paid internship and education support

Career recruitment and development

The problem

The high cost of behavioral health education and training creates significant barriers for students and organizations, limiting the growth of Oregon's behavioral health workforce. Many students, especially those pursuing graduate degrees, struggle to afford tuition, internships and certification exams, delaying their entry into the workforce. At the same time, publicly funded organizations face challenges in managing and funding internships, particularly in communities that are rural and underserved, where workforce shortages are most severe. Without adequate financial support, many organizations cannot offer paid internships or cover the costs of supervision and administrative needs.

Recommendation Statement

Modify existing state funded behavioral health scholarship programs to cover all costs for behavioral health training at community colleges, technical colleges, apprenticeships and CBOs, with additional funding for administrative support of paid internships and education.

For state funded graduate behavioral health incentive programs, provide financial assistance to students for behavioral health education in exchange for paid internships at publicly funded organizations, as well as for behavioral health license and certification preparation and exams. Additionally, allocate funding to

organizations for paid internship programs, including pre-credentialing, internship management, administrative costs and clinical supervision, particularly for rural, Tribes, CBOs, COA organizations and CMHPs.

Workgroup insights

"One thing that I was thinking about was more programs kind of like some sort of grant proposal for organizations to have a grant, like a stipend for interns. So, I know there's a model that sometimes the school has a stipend, but kind of putting it more on different organizations to apply for a grant to take interns, because I'm also hearing the training aspect of it too. So, how are they going to train the interns to work in this field? …I was just kind of thinking of putting it more on organizations to apply for the grant. That way interns can also be paid to do that paid internship while also gaining the experience."

~HB 2235 Workgroup member

This quote highlights the importance of empowering organizations through grants that allow them to provide funding directly to interns, enabling paid internships while ensuring comprehensive training for undergraduate and graduate students entering the behavioral health field.

Context and supporting research

The Ohio Great Minds Fellowship provides a model for expanding the behavioral health workforce.

In line with the current recommendation, the Ohio fellowship includes up to $15,000 in financial assistance to students for costs of obtaining degrees in eligible behavioral health programs and in paid internships at one of Ohio's Community Behavioral Health Centers (equivalent to a CMHP in Oregon). This model provides a bridge from education to practice with communities who are underserved which is also an issue that has been identified with the HB 2235 workgroup (35).

The current Scholars for Healthy Oregon-Like (SHOI-Like) BHWI program has awarded $2 million to behavioral health training programs.

The current recommendation builds on existing work that provides scholarships, prioritizing trainees from underserved communities. This Scholars for Healthy Oregon program offers a framework to implement this recommendation and could be adjusted to make the training costs covered to further lower barriers to quality training and experience for students who are a part of communities who are underserved (36).

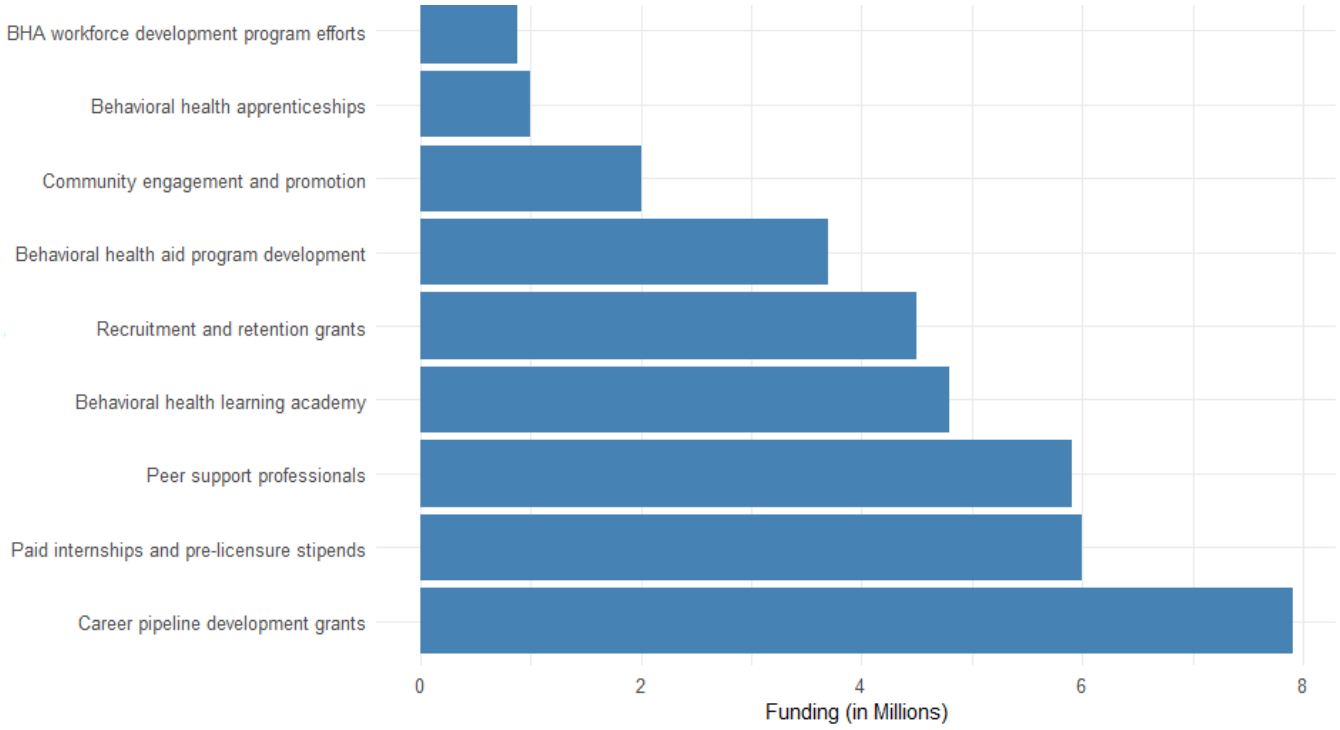
Colorado has developed a robust strategy to address healthcare workforce shortages.

As part of a successful strategy, Colorado's approach emphasizes workforce career pathway expansion through community colleges and a dedicated AmeriCorps program, the Colorado Healthcare Corps. Managed by the Community Resource Center, a nonprofit focused on capacity building, these initiatives aim to quickly prepare individuals for critical roles in healthcare. Programs like Care Forward Colorado offer subsidized tuition (SB22-226 allocated ~$26M), short-term training at community and technical colleges, allowing trainees to gain certifications as nursing assistants, emergency services professionals and other essential positions, with potential for expansion into behavioral health roles (8).

Accessible training programs empower a skilled and inclusive workforce. Additionally, in 2022, the Colorado General Assembly allocated $36 million (see Figure 4) in federal stimulus funds to bolster the behavioral health workforce. The state's workforce development efforts include expanding peer support roles, piloting the Certified Behavioral Health Aide model, providing paid internships and pre-licensure stipends and offering career pathway development grants. The Certified Behavioral Health Aide program, adapted from Alaska, focuses on addressing health disparities in rural and frontier areas by training individuals connected to their communities to serve as counselors, health educators and advocates.

Colorado's strategy also includes behavioral health apprenticeships, a learning academy for workforce training and focused engagement to promote job opportunities. Paid internships and pre-licensure stipends prioritize students from historically excluded communities and those training in settings that serve individuals with adverse life experiences.

Figure 4. Allocation of $36 Million in Colorado Behavioral Health Funding



Available research also underscores the critical need to remove financial barriers like tuition fees and unpaid internships to expand and diversify the behavioral health workforce. For example, Covino (37) highlights the severe shortage of skilled professionals and the importance of financial incentives, such as higher reimbursement rates and education support, in attracting and retaining workers. Last and colleagues (3) point out that strategies like offering scholarships, stipends and loan forgiveness programs can significantly improve access to education and training for aspiring professionals. They also underline the importance of providing paid internships, which not only alleviate the financial strain on trainees but also ensure equitable access to hands-on experience. Such initiatives align with broader goals of improving health equity, as a diverse workforce is better equipped to provide culturally competent and responsive care. By adopting these strategies, Oregon can strengthen its behavioral health workforce, improve care in communities that are underserved and enhance mental health outcomes statewide.

Potential impact

Removing financial barriers to behavioral health education and training will accelerate the growth of Oregon's workforce, ensuring more professionals can enter and sustain careers in the field. By covering all costs for training, paid internships and certification support, this recommendation will increase opportunities for students and strengthen organizations' capacity to offer progressive

solutions to workforce development. These initiatives will improve equity by diversifying the behavioral health workforce and expanding access to skilled care in communities that are underserved, particularly in rural and tribal areas.

Fund regional behavioral health consortiums across Oregon to address workforce challenges

The problem

Oregon has an opportunity to expand a proven approach to addressing its behavioral health workforce crisis through regional behavioral health consortiums like existing consortiums including Central Oregon, Mid-Valley and NW Pathways consortiums. These consortiums have shown success in recruiting and retaining behavioral health providers by offering training, mentorship and workforce development initiatives tailored to local needs. However, without increased funding and support, the state risks losing the potential to scale this powerful model.

Recommendation statement

Fund regional behavioral consortiums across Oregon to address workforce challenges through collaboration among organizations that employ behavioral health providers, educational institutions (K-12 and higher education) and other community partners. These consortiums will identify local workforce needs and implement region-wide plans to support workforce development, with a focus on culturally and linguistically specific providers and prioritized populations. Consortium activities might include:

- Offer training on clinical topics to enhance provider knowledge and skills.
- Develop new training or education programs, including those tailored to culturally and linguistically specific needs.
- Support student cohorts by providing stipends, enhanced training opportunities and culturally specific mentorship.
- Fund training programs for individuals to become PSS, PWS and CRM.
- Provide supportive services for students and the emerging workforce, such as gas cards, interview clothing, technology, utilities, groceries, childcare and learning supplies.

- Pay stipends for master's-level graduate students completing internships in high-need settings like CMHPs, COAs, rural areas and child/family-focused programs.
- Fund clinical supervision for associates working toward licensure.
- Cover the cost of advanced training needed to become a Clinical Supervisor.
- Cover the cost of specialized certifications and advanced training, such as Eye Movement Desensitization and Reprocessing (EMDR) or attachment-based family therapy, to ensure providers have the skills needed to excel in their roles.
- Provide retention support for mid-career behavioral health professionals who are not yet supervisors, addressing the gap between early-career support and advanced supervisory roles.
- Invest in marketing campaigns to recruit new providers and raise awareness about career opportunities.
- Bring together behavioral health providers and educators to improve curricula and ensure master's-level graduates are well-prepared for behavioral health careers.

Workgroup insights

"I would love to see some consistent funding for regional collaboratives because I think at the end of the day the fact that we have to constantly apply and be hounding, you know, looking and looking under every rock for a new resource to fund things that are highly effective. And like, what's the new thing you're doing? If the thing we're doing is effective, why do we have to do a new thing every time I turn around? Oregon loves to do that stuff. They love to pilot something and then not fund it even if it's successful. So, I'd like to just see some consistency there."

~HB 2235 Workgroup member

This quote underscores the importance of consistent funding for regional behavioral health consortiums, aligning with the recommendation to expand and sustain these collaboratives. It highlights the frustration of relying on short-term grants and pilots, even when existing programs have proven effective, emphasizing the need for a stable funding model to ensure long-term success.

Context and supporting research

Consortiums strengthen the behavioral health workforce and expand equitable care. Behavioral health consortiums play a vital role in strengthening the behavioral health workforce by pooling resources, aligning strategies and fostering partnerships among community partners. According to Gotham, Paris, and Hoge (38), these collaborative models are particularly effective in addressing workforce retention, improving training opportunities and enhancing care delivery in areas that are underserved. Barnett and Fong (39) emphasize the critical role that interconnected behavioral health agencies play in meeting the complex needs of children and youth. Their findings show that such networks enhance service delivery and allow providers to collectively address multifaceted challenges that no single organization can handle alone.

The Central Oregon Behavioral Health Consortium addresses workforce challenges by uniting resources across three counties to train and retain culturally competent behavioral health providers.

Presenting to the HB 2235 Workgroup, Heather Ficht, (40) explained that the Central Oregon Behavioral Health Consortium focuses on workforce development and culturally sensitive care through structured programs that prepare providers to serve diverse populations. Key initiatives include an Intern and Associate Training Program, offering flexible learning options like in-person, virtual and self-paced training, along with specialized clinical training in therapies like Cognitive Processing Therapy and Cognitive Behavioral Therapy for psychosis. To address supervision gaps, the Regional Supervision Training Program provides funding for supervisors' continuing education and contracts supervision services for sites with limited capacity.

By offering stipends, clinical supervision and continuing education, this consortium supports employers and students alike, enhancing job retention and aligning training across sites. These efforts directly strengthen the behavioral health workforce, making it better equipped to serve Central Oregon's diverse communities. This work is scalable and serves as an example of how this recommendation can help to expand these types of initiatives.

Potential impact

Expanding funding and support for regional behavioral health consortiums like the current ones that exist, Central Oregon, Mid-Valley and NW Pathways, has the potential to significantly strengthen Oregon's behavioral health workforce. By addressing critical gaps in training, mentorship and workforce preparedness, these consortiums can help recruit and retain providers in high-need areas, including rural regions and culturally specific

organizations. Supporting these programs will lead to a more skilled and diverse workforce, improved access to care and better health outcomes for Oregon’s communities.

Invest in a CTE pathway for BH in Oregon high schools

Career recruitment and development

The problem

Oregon faces a critical shortage in the behavioral health workforce, compounded by an aging workforce and limited awareness of behavioral health careers among young people. Current efforts to recruit and train new providers often focus on individuals already in the workforce, missing the opportunity to engage students early and build career pathways of future professionals. Without early exposure to behavioral health as a viable career path, many students, particularly in those communities that are underserved or rural, remain unaware of these opportunities.

Investing in a CTE pathway for high school students can help address this gap by engaging interest in behavioral health careers, providing foundational knowledge and creating a direct route into the field. Programs like Salem-Keizer's Behavioral Health and Human Services CTE program demonstrate the potential of this approach to cultivate a homegrown workforce, ensuring long-term sustainability and diversity in Oregon's behavioral health sector.

Recommendation statement

Invest in a CTE pathway for behavioral health in Oregon high schools to engage interest in critical behavioral health careers and address workforce shortages early. Invest in a CTE pathway for behavioral health in Oregon high schools to facilitate interest in critical behavioral careers and address workforce shortages early. This pathway would provide students with foundational knowledge about mental health and related issues, introduce them to career opportunities in the field and offer hands-on learning experiences to prepare them for future roles. By

focusing on high school students, particularly in communities that are underserved or rural, this initiative creates a direct route into behavioral health professions and engages a new generation of skilled, compassionate providers.

Workgroup insights

"I think then there's this other piece, right? This CTE place where a person can actually go to community college within 18 months or so, get a certificate, begin to work in the field and work and learn all the way to a master's level clinic is a really awesome thing to think about.

And I also think support from an OHA standpoint, if you're a person who's working and learning all the way through. Wow! What amazing way to find funding to do something great for that person or persons who go that pathway."

~HB 2235 Workgroup member

This quote highlights the value of CTE programs in creating accessible pathways into behavioral health careers. It emphasizes the "work and learn" model, allowing individuals to earn certificates, gain experience and advance to higher-level roles with support, such as funding from OHA.

Context and supporting research

Research supports the value of CTE programs, showing they significantly improve student outcomes, including increased graduation rates and higher post-graduation earnings, while preparing students for in-demand careers (41). CTE programs foster hands-on problem-solving, creativity and career readiness, which are critical in addressing workforce gaps in high-need fields like behavioral health (42).

Investing in CTE programs in Oregon high schools, particularly for behavioral health, aligns with evidence demonstrating CTE's effectiveness in preparing students for essential workforce roles.

In February 2024, Oregon Department of Education announced a Career Readiness Expansion of $7.629M invested in hands-on learning for 74 Oregon high schools, serving more than 36,000 students. While the grant amounts vary among school districts and offered programming, these 31 grants work out to an average investment per grant of $246,096 or $103,094 per high school. These awarded grants helped to create or expand CTE programs focusing on the high-wage, high-skill and in-demand workforce fields of health care, manufacturing and construction.

In review of the applications and intended uses of the aforementioned grant funds, only $1,310,855 was awarded to 5 districts for existing or potential health sciences CTE programs, none specifically for behavioral health programs.

Potential impact

Investing in a behavioral health CTE pathway for Oregon high schools will engage students who are passionate about serving individuals in their communities. This program provides early exposure to meaningful careers in behavioral health, offering hands-on experience and foundational knowledge. By focusing on students in areas that are rural and underserved, it creates a clear, accessible route into the field. This investment will help build a diverse, homegrown workforce committed to improving mental health outcomes and meeting the unique needs of Oregon's communities.

Conclusion

Oregon's behavioral health workforce is facing a serious crisis, threatening the stability and access to care for communities across the state. This report provides a roadmap for addressing immediate and systemic challenges identified by the HB 2235 workgroup. The recommendations, grounded in the voices of those working in the field, emphasize urgent, focused actions to stabilize the workforce and create a sustainable behavioral health system that meets the diverse needs of Oregon's communities.

The workgroup made clear that culturally and linguistically specific providers are indispensable to delivering equitable and responsive care. Yet these providers face immense challenges, including heavier caseloads, are overburdened with extra responsibilities like translation and cultural advocacy workplace environments that can be unwelcoming or unsafe. Without investments in culturally specific roles and practices, Oregon risks perpetuating health disparities and losing the critical workforce needed to serve its populations that are most underserved. Prioritizing funding for these roles and addressing systemic inequities is not optional—it is a necessity for achieving health equity statewide.

Equitable reimbursement rates are also essential to sustaining Oregon's behavioral health safety net. Providers in rural and publicly funded behavioral health settings face unique and costly challenges, from long travel distances to frequent client absences and uncompensated administrative burdens. Current reimbursement rate structures fail to account for these realities, leaving safety-net organizations and providers inequitably funded. The workgroup emphasized the urgency of adopting equity-focused reimbursement models to ensure that providers working in the most challenging conditions can best serve their communities.

Workforce development and recruitment must go hand in hand. Oregon must grow and sustain career entry and pathways for skilled professionals prepared to meet future behavioral

health needs. Recommendations like state-supported training, tuition assistance tied to service in high-need areas and paid internships directly address barriers to entering the field. High school CTE pathways will bolster early interest in behavioral health careers, creating a long-term recruitment strategy to grow a diverse, homegrown workforce. Additionally, regional consortiums can align local workforce needs with education and training programs, ensuring that recruitment and retention strategies are tailored to the unique challenges of each community. These initiatives are critical to building a behavioral health system that is not only larger but also more equitable and inclusive.

Workforce well-being must remain central to Oregon’s efforts. Administrative inefficiencies, unsafe working conditions and burnout are driving behavioral health professionals out of the field at alarming rates. Recommendations to improve workplace safety, reduce administrative burdens and provide robust retention supports are essential to stabilizing the workforce and ensuring high-quality care for Oregon’s communities. The workgroup repeatedly emphasized that no single incentive or program will fix these systemic issues; a comprehensive approach including partner agencies and departments and legislative action are required.

This report is a step toward transformational change. It lays the groundwork for this change with immediate actions and systemic interventions, with additional recommendations to come in December 2025. The findings and solutions presented here demand immediate action. Oregon must prioritize investments in its behavioral health workforce to address the crisis and build a system that is equitable, resilient and sustainable. The time for incremental change has passed. Bold coordinated action is needed to support those who deliver care and ensure that every Oregonian has access to reliable and culturally responsive behavioral health services.

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Diane Bocking — Chief Operations Officer, OYEN Emotional Wellness Center
Belindy Bonser — Health Care Navigator, Columbia Care
Kelli Bosak — Lead Behavioral Health Therapist, Three Rivers Health Center
Chris Bouneff — Executive Director, National Alliance on Mental Illness
Mario Cardenas — Latinx Recovery Latino/a/x Communities, Multnomah County Health Department
Cheryl Cohen — Provider Workforce Development Program Manager, PacificSource Health Plans
Sarah Conyers — Residential Counselor, Clatsop Behavioral Healthcare
Deanna Cor — Program Coordinator, Associate Professor of Counseling, Portland State University
Anthony Cordaro — Child & Adolescent Psychiatrist, Kaiser Permanente Northwest
Lorie DeCarvalho — Vice President for Behavioral Health Services, Aviva Health
Melinda Del Rio — Licensed Clinical Social Worker & Director of Outpatient Psychotherapy — Portland Mental Health & Wellness
Jerylyn Dimeo — Primary Therapist, Providence
Jose Luis Garcia — Executive Director, Juntos
David Geels — Behavioral Health Director, Coos Health and Wellness
Qurynn Hale — Behavioral Health Manager, Children Youth and Families, CareOregon / Columbia Pacific CCO
Tammy Harty — Therapist, Licensed Professional Counselor, Wellness Through Horses, LLC
Clark Hazel — Mental Health Therapist, Health Allies Counseling
Jenn Inman — Division Manager, Jackson County Health & Human Services
Chantay Jett — Executive Director, Wallowa Valley Center for Wellness
Tony Lai — Advanced Practice Behavioral Health Clinician, Yamhill County Family and Youth Programs
Lucia Mendoza-Meraz — Executive Director, Fortaleza Atravez Barreras
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Diane Benavides Wille — VP Equity, Inclusion & Workforce Development, LifeWorks NW
Lamar Wise — Political Director, Oregon AFSCME

Supporting contributors and acknowledgements:

Jen Allen — Community and Advisory Group Coordinator, Oregon Health Authority
Jill Boyd — Health Care Provider Incentives Coordinator, Oregon Health Authority
Heather DeSart — Executive Director, Northwest Oregon Works
Nirmala Dhar — Older Adult Behavioral Health Services Lead, Oregon Health Authority
Heather Ficht — Executive Director, East Cascade Works
Lea Forsman — PhD, Project Lead Benefit Update Project, Oregon Health Authority
Andy Friedman — Executive Director, United We Heal
Bianca Frogner — PhD, Director, Center for Health Workforce Studies, University of Washington
Bret Golden — Incentives Coordinator, Oregon Health Authority
Neelam Gupta — Director of Clinical Supports, Integration, and Workforce Unit, Oregon Health Authority
Anna Heard — Senior Policy Analyst, Center for Best Practices, National Governor's Association
Christa Jones — Deputy Director, Oregon Health Authority
Sahand Kianfar — Sr. Operations and Policy Analyst, Oregon Health Authority
Dishanta Kim — Behavioral Health Equity Specialist, Oregon Health Authority
Mick Kincaid — Business Operations Director, Oregon Health Authority
Nicholas Lervick — Forensic Technical Assistance and Contract Administrator, Oregon Health Authority
Craig Mosbaek — Behavioral Health Equity, Integration & Accountability Analyst, Oregon Health Authority
Tim Nesbitt — Behavioral Health Workforce Manager, Oregon Health Authority
Vitalis Ogbeama — Clinical Settings Coordinator, Oregon Health Authority
Daniel Page — Planning and Program Coordinator, Oregon Health Authority
Kim Parker-Llerenas — Executive Director, Willamette Workforce Partnership
Bill Phunder — Program Manager – Incentives Program, Oregon Office of Rural Health
Alfonso Ramirez — Interim Director Equity and Inclusion Division, Oregon Health Authority
April Rohman — Behavioral Health Advisor, Oregon Governor's Office
Evelyn Salinas — Behavioral Health Equity Program Manger, Oregon Health Authority
Caryn Stockwell — Incentives Coordinator, Oregon Health Authority
Kelli Taylor — Contract and Program Support Specialist, Oregon Health Authority
Amanda Winters — Program Director, Center for Best Practices, National Governor's Association

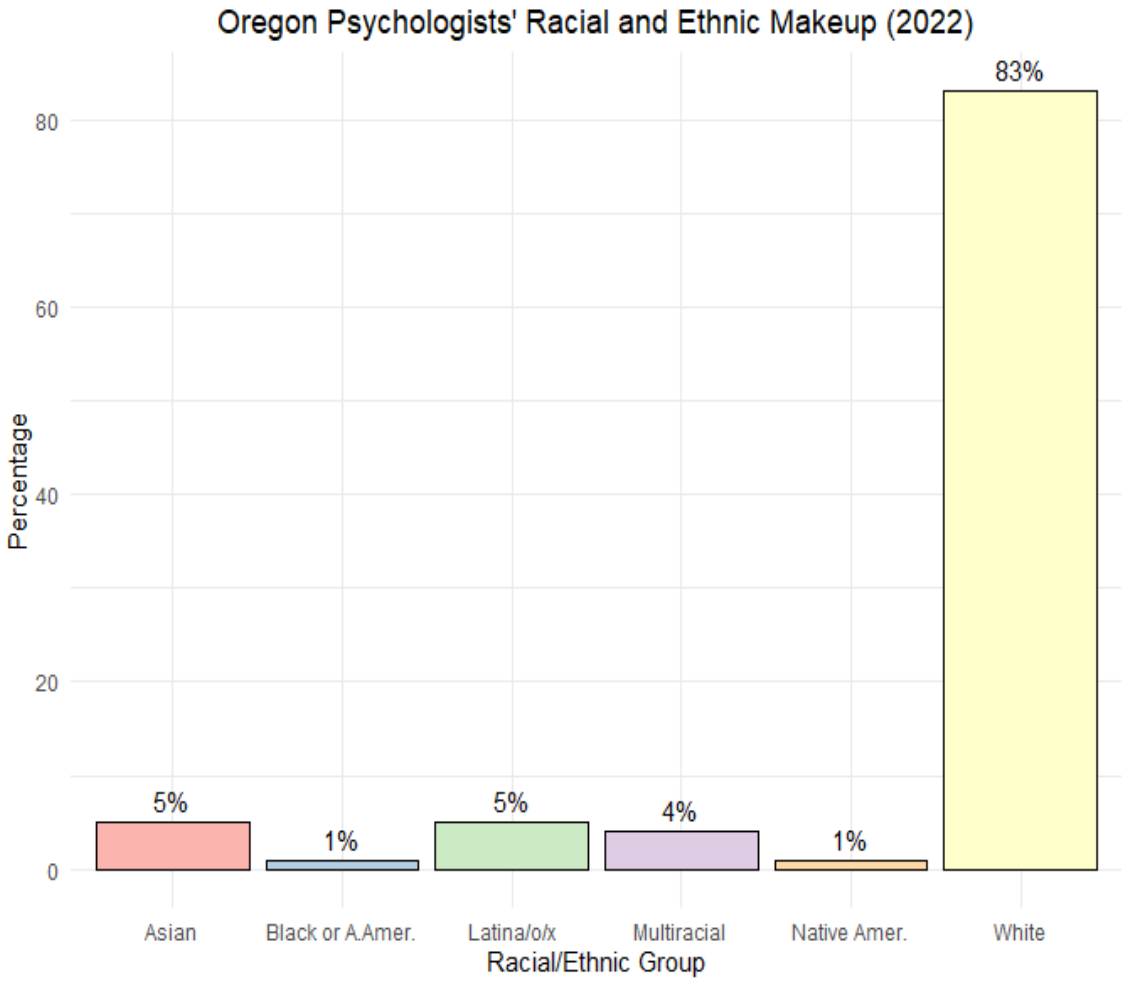
Appendix

A. Key findings: challenges and barriers

This section outlines the major challenges impacting Oregon's BH workforce, based on insights gathered from the HB 2235 workgroup. These findings reveal systemic barriers that hinder the recruitment, retention and development of professionals across the state, particularly in the public BH system.

The BH workforce needs more diversity, with more providers reflecting the cultural, linguistic and lived experiences of the communities they serve.

Many populations in Oregon face underrepresentation among care providers, which limits the system's ability to deliver equitable and culturally responsive services. For example, among psychologists in Oregon there are significant disparities.



According to the Health Care Workforce Reporting Program in 2022 (43), 74.2% of Oregon's population is white, yet 82.7% of psychologists are white. Latino/a/x individuals comprise 12.3% of the population but account for only 4.8% of psychologists. Asian individuals making up 5.7% of the population are slightly underrepresented with 5.2% of psychologists who are Asian. 3% of the population is Black or African American, compared to just 1.3% of psychologists. American Indian and Alaska Native individuals, who make up 3.1% of the population, are represented by 1.3% of psychologists. Native Hawaiian and Pacific Islander individuals, who comprise 0.9%, are both severely underrepresented among psychologists. Additionally, although 9.2% of Oregonians identify as multiracial, only 4% of psychologists identify as multiracial or from other racial or ethnic groups.

These disparities among psychologists exemplify the broader underrepresentation across the behavioral health workforce, underscoring the need for more providers who reflect the diverse identities and experiences of Oregon's population. A workforce that mirrors the cultural and demographic makeup of its communities is better equipped to understand and address unique needs, foster trust and provide equitable care.

This crisis most affects publicly funded providers, including Community Mental Health Programs, Certificate of Approval organizations, Community-Based Organizations, Federally Qualified Health Centers, Certified Community Behavioral Health Clinics and Medicaid-focused private and public practices.

The public BH system is essential and serves communities with significant behavioral health needs. They provide critical services, such as care coordination and crisis response, that are often not adequately reimbursed based on the context that they provide care. While reimbursement rates in these organizations is comparable to private practices, it is inequitable due to the added burden of uncompensated tasks, high caseloads and complex cases.

These providers face heavy administrative demands, including Medicaid documentation and compliance requirements, which reduce time for direct care and lead to burnout and turnover. Culturally and linguistically specific providers now receive enhanced Medicaid payments but face additional challenges, including disproportionately high demand for their services, tailoring care to meet their clients' unique cultural needs and the emotional toll of addressing bias, microaggressions and systemic inequities for their clients and themselves.

Providers in areas that are rural and underserved face additional challenges, with providers traveling long distances, managing frequent client absences and addressing social determinants of health — tasks that remain unreimbursed.

A shortage of master's level and advanced degree behavioral health professionals limit access to care.

The shortage of master's-level and advanced behavioral health professionals is a major issue that limits access to care across Oregon. These highly trained professionals play a critical role in the system by developing individualized treatment plans that guide care for many clients, especially those with complex needs. Their expertise ensures services are tailored, effective and aligned with best practices. The demand for filling these positions is growing and growing faster than statewide averages of other sectors. For example, substance abuse, behavioral disorder and mental health counselor positions are projected to grow by 27.4% by 2032 according to a June 12, 2024 presentation to the Health Care Workforce Committee of the Oregon Employment Department (44).

In rural regions, it's challenging to attract clinicians due to geographic isolation and fewer incentives, leading to long wait times for care. The shortage also creates a bottleneck for new professionals working toward licensure, as costs and access to qualified supervisors limit the ability to complete the required clinical supervision hours.

Without access to supervision, new clinicians can't advance their careers, further slowing workforce development.

This impacts the entire system, as fewer professionals are available to design and oversee treatment plans or provide direct care. This shortage is particularly harmful for individuals needing crisis care or specialized services, like trauma recovery or addiction treatment. Without enough advanced professionals to create and manage these treatment plans, many clients with serious mental health needs are left without timely or adequate care. The added pressure on the existing workforce leads to burnout, making it even harder to retain skilled providers.

Culturally and linguistically specific providers and those in communities that are rural or underserved face unique barriers.

Culturally and linguistically specific providers are underrepresented among the BH workforce and can often feel isolated, particularly if they are the only staff members from their cultural or linguistic background. These workers may face bias, microaggressions, or even overt discrimination in their workplaces or communities, which adds to their stress.

These providers face unique challenges that go beyond their regular job responsibilities. They are often in high demand because they provide specialized care to clients who need culturally responsive support or speak languages other than English. They are often expected to take on extra tasks, such as translating materials, interpreting during meetings, or otherwise supporting culturally specific clients' unique needs. These responsibilities add to their already full workloads. These added burdens make it difficult for culturally and linguistically specific providers to feel supported in their roles, leading to burnout and turnover.

Providers serving communities that are rural and underserved face significant burdens that challenge their ability to deliver effective care. Long travel distances to reach clients consume valuable time and resources that are rarely reimbursed. These providers also contend with frequent client absences due to transportation barriers, financial hardships, or other personal crises, resulting in lost time and revenue. Limited access to professional development, training and peer support in rural areas further isolates these providers, making it harder for them to advance in their careers or improve their skills.

Additionally, providers in these communities are often responsible for addressing a wide range of behavioral health needs with limited staff and resources, leading to heavy caseloads and high levels of stress. These challenges, combined with lower infrastructure support and fewer opportunities for collaboration, exacerbate workforce shortages and undermine the stability of behavioral health services in these critical areas.

Wages inequitably impact publicly funded care, especially those who serve culturally and linguistically specific groups and communities that are rural or underserved.

Wages in publicly funded BH system have significant inequities. Publicly funded providers often work under heavy administrative burdens, such as extensive Medicaid documentation and compliance requirements, which take time away from direct patient care. These providers absorb the costs of non-reimbursable yet essential services, such as care coordination, addressing social determinants of health and traveling to clients in areas that are rural or underserved. These additional demands are not reflected in their pay, making wages in publicly funded settings inequitable.

Nuances exist within private practices. Some private practices in Oregon focus primarily on Medicaid clientele, particularly in areas that are underserved. These providers face many of the same challenges as publicly funded organizations, such as high caseloads,

uncompensated responsibilities and administrative burdens tied to Medicaid reimbursement. Their financial sustainability and ability to offer competitive wages are similarly constrained, underscoring that the wage inequities in behavioral health are not just about public versus private but also about the payer mix (proportion of patients covered by different insurance types) and systemic funding challenges in Medicaid-focused care. Addressing these disparities is critical to stabilizing Oregon's behavioral health workforce across all care settings.

Administrative burdens undermine retention and patient care.

Administrative burdens in Oregon's public BH system are pervasive. Providers face extensive documentation requirements for Medicaid billing, including detailed progress notes, treatment plans and compliance reporting. These tasks are time-intensive and often require meticulous adherence to complex and changing regulations, leaving clinicians feeling overwhelmed and disconnected from their core mission of patient care.

Medicaid turnaround times for documentation often force providers to prioritize paperwork over patient interaction, creating stress and limiting their ability to provide timely care. In some cases, the administrative demands are so excessive that they require clinicians to work unpaid hours or sacrifice work-life balance to keep up. For smaller organizations, particularly in rural areas or those serving culturally and linguistically specific populations, limited resources mean providers must juggle clinical and administrative responsibilities without dedicated support staff, further compounding the strain.

Administrative burden disproportionately affects organizations serving Medicaid populations in regardless if the practice is public or private. Medicaid billing requirements often require more detailed and frequent reporting, and errors or delays can result in reimbursement denials, creating financial strain for organizations. Culturally and linguistically specific providers also face unique challenges, such as navigating additional reporting requirements for specialized programs or grants, which can divert time and resources away from direct care.

There is a lack of a supported career pathway, from entry-level to advanced roles.

The behavioral health field in Oregon suffers from a lack of supported career pathways that guide workers from entry-level roles to advanced positions. This gap is driven by

insufficient funding for education, training and professional development opportunities. Licensing and certification requirements, often complex and expensive, create additional barriers for those seeking to advance their careers.

Culturally and linguistically specific providers face added difficulties, such as finding supervisors who can meet their unique needs or navigating a system that may not fully recognize the value of their culturally tailored expertise.

Related to the challenges for culturally and linguistically specific providers and those serving communities that are rural or underserved, enrollment in CCOs is also disproportionately low among culturally and linguistically specific communities, with only 21% of English-speaking and 18% of Spanish-speaking respondents enrolled. According to the Coalition of Communities of Color (45), most enrollees are concentrated in the Portland metro area, leaving communities that are underserved outside urban areas without adequate access to culturally specific care.

Without a clear and supported career pathway, the behavioral health workforce struggles to retain and develop skilled professionals, particularly in roles that require advanced degrees or certifications. Addressing this issue requires focused investments in training programs, financial support for licensing and supervision and the development of accessible career pathways that prioritize equity and inclusion.

B. Prioritized List of Recommendations

This is a complete list of the recommendations. Recommendations are prioritized two ways.

1. Ranked in descending order of priority by workgroup members. (Left side)

2. Labeled as a priority recommendation based on the framework for prioritizing recommendations outlined on page 6. (Right side)

Workgroup Priority ranking	Recommendation Statement	Prioritization framework area
1.	**Future rate increases should prioritize equity** and focus on specific activities and the context in which those activities are completed.	Pay equity
2.	**Provide ongoing funding in the public BH system, especially for providers in rural and underserved areas,** with tuition assistance and paid time for career development, and educational pursuits.	Career recruitment and development
3.	**Establish a grant to support retention strategies for all client-facing staff** at publicly funded organizations.	Career recruitment and development
4.	**Dedicate funding to address the psychological and physical safety needs of behavioral health staff.**	Career recruitment and development
5.	**Continue to fund the Clinical Supervision Expansion Grant with updated guidelines** to expand access to high-quality clinical supervision for licensure and certification.	Diversity & Career recruitment and development

Workgroup Priority ranking	Recommendation Statement	Prioritization framework area
6.	**Prioritize BHWI program funding for culturally and linguistically specific roles,** including peer services and related OHA-approved positions.	Diversity & Career recruitment and development
7.	**Ensure state-funded behavioral health scholarships cover all costs for training** at community colleges, technical colleges, apprenticeships and CBOs, **with added funding for paid internship and education support.**	Career recruitment and development
8.	**Create or expand state funded BH workforce incentive programs with multiyear funding opportunities.**	Diversity & Career recruitment and development
9.	**Provide free training and certification through a statewide program for CRMs, PSSs and PWSs,** ensuring equitable access and continuing education for individuals from diverse backgrounds, including those with lived recovery experience.	Diversity and career recruitment and development
10.	**Raise the maximum for administrative expenses in BH workforce incentive programs to 12-15%.**	
11.	**Fund culturally specific practices not covered by insurance through dedicated grants.**	Diversity
12.	**Establish a formal evaluation process for OHA BH incentive programs.**	
13.	**Create a new Behavioral Health Workforce Incentives (BHWI) program to support trained providers in acute care settings,** such as inpatient facilities, residential programs and stabilization units.	

Workgroup Priority ranking	Recommendation Statement	Prioritization framework area
14.	**Fund regional BH consortiums across Oregon to address workforce challenges.**	
15.	**Include childcare and housing stipends as part of grants** for entities in the public BH system, offering upfront funding to cover these essential costs.	
16.	**Promote CMHPs, COAs and CBOs through a state-led marketing and community engagement initiative.**	
17.	**Invest in a career and technical education (CTE) pathway for BH in Oregon high schools.**	Career recruitment and development

B. Methodology

This methodology outlines the process used to gather, analyze and synthesize data into key findings and recommendations. The HB 2235 workgroup met a total of 20 times between November 2023 and December 2024. These meetings served as the foundation for data collection and analysis, featuring substantive discussions, expert presentations and the development of collaborative recommendations to address critical workforce challenges.

1. Data collection	A research firm, MEB, was contracted to review video recordings of the workgroup sessions, each lasting approximately 1.5–2 hours. These recordings captured discussions among workgroup members and presentations by experts and professionals on various aspects of the behavioral health workforce crisis. Participants also suggested potential recommendations during these sessions.
2. Data analysis and coding	The transcripts from the recordings were analyzed through a coding process. Key ideas and insights were tagged with labels to identify patterns, resulting in 732 distinct coded excerpts. From this analysis, 40 categories emerged, with nine categories identified as particularly significant due to their higher representation in the coding process.
3. Key findings development	The nine significant categories, which encapsulated the lived experiences of behavioral health professionals and core challenges in the workforce crisis, were used to inform the overarching key findings. These findings were confirmed by a review of current literature, which highlighted themes relevant to both local and national contexts and were validated through consultation with the BHWI program team and workgroup feedback.
4. Recommendation development	During workgroup sessions, ideas for recommendations were captured by facilitators as they surfaced in discussions. Facilitators reviewed the recordings and synthesized the suggestions into an initial set of approximately 26 recommendations. Recommendations that were closely aligned were consolidated, and some that lacked sufficient support did not pass. This refinement process resulted in 17 finalized recommendations.

5. Voting and approval	The workgroup members voted on the recommendations using formal meeting procedures. Once a quorum was established, members were asked to evaluate each recommendation, considering whether it would effectively address the workforce crisis and serve as actionable guidance for legislators. Members engaged in some open-ended discussions, before casting their votes.
6. Consultation and refinement	The finalized recommendations were reviewed in collaboration with the BHWI program team to ensure they reflected the priorities identified in the workgroup sessions. Grounding documents, such as the OHA's 2024–2027 Strategic Plan and current research, were consulted to validate and refine the recommendations.
7. Developing the priority framework	A priority framework for the recommendations was developed through analysis of workgroup discussions, alignment with the OHA Strategic Plan and consultation with the BHWI Program team. The priority framework highlights three critical focus areas: Diversity, Pay Equity and Career Recruitment and Development, serving as a guide to prioritize the recommendations for legislators.
8. Confirmation of recommendations	Recommendations were again reviewed by the workgroup, the BHWI team and OHA leadership to ensure alignment with legislative objectives and strategic priorities. This collaborative review process refined the recommendations, ensuring they were actionable, practical and reflective of the shared vision for addressing Oregon's behavioral health workforce crisis.

This methodology provided a systematic approach to understanding the behavioral health workforce crisis, capturing the lived experiences of behavioral health professionals in Oregon and identifying actionable recommendations.

C. Glossary

Disclaimer: The following definitions provide general context for this report and are not official state definitions. For official definitions please refer to the applicable Oregon Revised Statutes (ORS) or Oregon Administrative Rules (OAR).

Administrative burden:
The paperwork, compliance and reporting requirements behavioral health providers and organizations must manage. While many of these practices are necessary to protect consumers of services, some demands can detract from direct client care, raise non-reimbursable costs to provider organizations and contribute to provider stress and burnout.

Behavioral health consortia:
Collaborative networks of behavioral health organizations, educational institutions and community partners that address workforce challenges through training, mentorship and region-specific initiatives.

Behavioral Health Workforce Incentives (BHWI) program:
An Oregon Health Authority program established in 2021 and originally funded by HB 2949 (2021) to expand Oregon's behavioral health workforce through incentive programs such as scholarships, loan repayment and grants, focusing on culturally responsive care and equity-centered practices.

Care coordination:
The organized management of patient care activities to ensure the delivery of comprehensive and efficient services across multiple providers and systems.

Certificate of Approval (COA) organizations:
Organizations authorized by the Oregon Health Authority to provide behavioral health services that meet specified standards and criteria.

Certified Community Behavioral Health Clinics (CCBHCs):
Federally recognized clinics that provide comprehensive coordinated behavioral health services, including mental health and substance use treatment, with a focus on underserved populations. The practice has met the criteria in the document titled "Criteria for the Demonstration Program to Improve Community mental Health Centers and to Established Certified Community Behavioral Health Clinics" as well as the Oregon state CCBHC standards.

Certified Recovery Mentor (CRM):
A substance use disorder treatment staff member who supports individuals in recovery from substance use disorders, using their lived experience to foster trust, provide guidance and help clients access resources.

Clinical supervision:
A structured process where a licensed professional oversees behavioral health trainees or associates to ensure high-quality care and compliance with licensure or certification requirements until the associate or trainee completed the necessary requirements to become licensed or certified. Requirements for clinical supervision vary by credential and are regulated by the credentialing boards.

Community behavioral health:
A system of care that provides mental health and substance use treatment services tailored to the needs of specific communities, often focusing on underserved or vulnerable populations.

Community Mental Health Programs (CMHPs):
An organization of various services for individuals with a mental health diagnosis or addictive disorder operated by, or contractually affiliated with, a local mental health authority and operated in a specific geographic area of the state under an agreement with the state of Oregon pursuant to Oregon rules and laws (46).

Community-based organizations (CBOs):
Nonprofit or local organizations that address specific community needs, including behavioral health services, often with a focus on culturally and linguistically specific care.

Complex care:
Comprehensive, coordinated services addressing the multifaceted needs of individuals with multiple or severe physical, mental, or social challenges, often requiring tailored, interdisciplinary approaches.

Coordinated Care Organizations (CCOs):
Regional networks of healthcare providers in Oregon that deliver integrated physical, behavioral and dental care for Oregon Health Plan (Medicaid) members. CCOs in Oregon have been contracted by OHA.

Culturally and linguistically specific providers:
Behavioral health professionals trained to deliver tailored mental health, substance use, problem gambling and other behavioral health services. These services are designed specifically for distinct marginalized cultural communities, reflecting their languages and cultural values. The goal is to elevate the voices and experiences of these communities, fostering emotional safety, belonging and a collective sense of healing and recovery within the cultural group being served (47).

Culturally responsive care:
An approach to healthcare that recognizes and respects the cultural values, beliefs and needs of individuals, ensuring care is meaningful and effective for diverse populations.

Equitable reimbursement rates:
A payment model that considers the unique costs and challenges faced by behavioral health providers, especially those serving underserved or high-need populations, to ensure fair compensation.

Federally Qualified Health Centers (FQHCs):
Community-based health centers that provide comprehensive primary care and behavioral health services, often to underserved populations, with federal funding and enhanced reimbursement.

Fidelity reporting:
The process of documenting and assessing whether programs or services are being delivered as intended and is often required for compliance and quality assurance.

High-acuity care setting:
A specialized healthcare environment providing intensive, immediate services for individuals with severe or urgent conditions, such as crisis units or inpatient facilities, focusing on stabilization and recovery.

Integrated behavioral health services:
A coordinated approach where mental health, substance use and primary care providers work together to deliver comprehensive, person-centered care.

Medicaid documentation:
The detailed records and compliance reporting required for reimbursement under Medicaid, often including treatment plans, progress notes and service delivery details.

Non-billable services:
Tasks and activities essential to care, such as care coordination, client outreach, or translating materials that are not eligible for reimbursement through Medicaid or other insurance providers.

Non-cash incentives:
Workforce retention and recruitment strategies that provide benefits other than direct financial compensation, such as professional development opportunities, flexible scheduling, or wellness programs.

Peer Support Specialist (PSS):
A trained individual with lived experience of recovery from mental health or substance use challenges who provides support, guidance and mentorship to others on their recovery journeys.

Peer Wellness Specialist (PWS):
A peer professional who combines lived experience with specialized training to support individuals in achieving holistic well-being, addressing both physical and mental health needs.

Peer-led interventions:
Support programs or strategies led by individuals with lived experience, designed to foster recovery, empowerment and resilience among participants.

Provider:
A healthcare professional, such as a clinician, counselor, or therapist, who delivers behavioral health services to clients or patients.

Public behavioral health (BH) system:
The interconnected network of organizations, providers and services delivering behavioral health care primarily funded by public sources, such as Medicaid, state funds and federal grants. It includes CMHPs, COA organizations, CBOs, FQHCs, CCBHCs and private practices serving predominantly Medicaid clients. This system integrates behavioral health, substance use treatment and primary care services.

Qualified Mental Health Associate (QMHA):
An individual who meets the educational and experience requirements to provide support and services to clients under the supervision of a Qualified Mental Health Professional (QMHP).

Qualified Mental Health Professional (QMHP):
A licensed behavioral health provider, such as a counselor, social worker, or therapist, with the credentials and experience to deliver advanced mental health services and supervise other professionals.

Social determinants of health:
The economic, social and environmental factors — such as housing, education, income and access to healthcare — that influence an individual's overall health and well-being.

Supervision for licensure:
The process where associate-level or unlicensed professionals receive oversight, mentorship and guidance from a licensed supervisor to fulfill the requirements for professional licensure.

Team-based care:
A collaborative approach where a multidisciplinary group of healthcare professionals, including behavioral health providers, works together to deliver comprehensive, person-centered services.

Value-based payment methodologies:
Reimbursement models that compensate healthcare providers based on the quality and outcomes of care they deliver, rather than the volume of services provided.

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