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Scalable Strategies to Expand the Behavioral Health Workforce

MARCH 2026

Meadows Mental Health Policy Institute

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Executive Summary

The behavioral health workforce shortage is one of the most urgent challenges facing our nation. Across the United States the demand for care far exceeds the available supply of licensed professionals including psychiatrists, psychologists, therapists, counselors, and clinical social workers, leaving millions of individuals waiting months for treatment or unable to access care at all. National projections indicate that the supply of psychologists, psychiatrists, social workers, therapists, and counselors is expected to continue declining as retirements outpace new entrants, leaving the licensed behavioral health workforce well below the level needed to meet current or future demand[1] Today, more than 122 million Americans live in Mental Health Professional Shortage Areas, or geographic areas within the United States that have been designated by the federal government. [2] For psychiatrists, "too few" is a population to provider ratio of 20,000 [3]one. Workforce shortages are most pronounced in rural areas, where 22% of counties are without a social worker, compared to 5% of urban counties. This gap is even wider for psychologists, with 45% of rural counties and 16% of urban counties [4]. Although recent investments such as loan forgiveness and pipeline programs are designed to reduce barriers to entering the behavioral health care field, they primarily strengthen the future workforce and offer little relief to the patients and providers experiencing strain today. Addressing this crisis requires solutions that go beyond building pathways to licensure. Effective strategies must both reflect the needs of the communities being served and be actionable now.

This paper examines a complementary path forward: expanding the role of trained providers without a clinical license to deliver effective behavioral health services. Drawing on more than two decades of global research on the lay counselor model, and a growing body of U.S. evidence, this paper highlights how organizations are equipping providers without a clinical

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[1] Health Resources and Services Administration. (n.d.). *Behavioral health workforce projections, 2017-2030* [Fact sheet]. U.S. Department of Health and Human Services, National Center for Health Workforce Analysis. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/bh-workforce-projections-fact-sheet.pdf

[2] Health Resources and Services Administration. (2026, January 26). *Health workforce shortage areas*. Bureau of Health Workforce, Division of Policy Shortage Designation. Retrieved January 26, 2026, from. https://data.hrsa.gov/topics/health-workforce/shortage-areas/dashboard

[3] Bureau of Health Workforce. (2025, December 31). *Designated health professional shortage areas statistics* [Report]. US. Department of Health & Human Services, Health Resources and Services Administration. Retrieved January 26, 2026, from https://data.hrsa.gov/default/generatehpsaquarterlyreport

[4] National Center for Health Workforce Analysis (2025). *State of the U.S. health care workforce*, 2025. U.S. Department of Health and Human Services, Health Resources and Services Administration. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/State-of-US-Health-Care-Workforce-2025.pdf

license to deliver core evidence-based behavioral health interventions under structured supervision. Rather than limiting these staff to only screening and referral, emerging models show that well-trained, well-supported behavioral health providers, including peer support specialists, community health workers (CHWs), and lay counselors can provide effective brief behavioral interventions, support measurement-informed care, address social needs, and meaningfully expand access to underserved communities.

To understand how these approaches are being implemented on the ground, the Meadows Mental Health Policy Institute conducted key informant interviews with 11 organizations pioneering workforce innovations within integrated care settings. Four promising pathways emerged from those interviews:

- Employing behavioral health care managers (BHCM) with bachelors-level training within the Collaborative Care Model (CoCM);
- Training community members with high school diplomas or high school equivalency (HSE) credentials to deliver culturally grounded behavioral health support services;
- Building internship and practicum models that strengthen early-career training pipelines; and
- Partnering with higher education institutions to develop scalable, skills- and competency-based training pathways into behavioral health support roles.

Together, these strategies point to several clear paths for policymakers and system leaders. By investing in competency-based training, supervision, and reimbursement models, we can equip providers without a clinical license to deliver, not just refer to, evidence-based behavioral health care within their scope of practice, creating a workforce that is accessible, equitable, sustainable, and representative of the communities most impacted by today's behavioral health crisis.

Scalable Strategies to Expand the Behavioral Health Workforce

The United States continues to face a severe behavioral health workforce shortage that limits access to timely, effective care. Although more than 20% of adults experience mental illness each year, one in four report an unmet need for treatment, often due to long wait times, limited provider availability, cost barriers, and stigma.[5,6] These access challenges are compounded by persistent shortages across the licensed behavioral health workforce. In 2024, there were approximately 320 people for every one behavioral health provider, and nearly one-third of Americans (122 million people) lived in a designated mental health workforce shortage area.[7,8]

Despite increased investment in education and licensure pipelines, the supply of psychiatrists, psychologists, and licensed mental health clinicians continues to lag far behind both current and projected demand. Structural barriers including high educational costs, lengthy training timelines, limited career pathways, licensure restrictions, wages that do not reflect advanced training levels, provider burnout, and geographic maldistribution, further cons[9].□ Because dismantling many of these barriers will take time, expanding access to behavioral health care in the near term requires new scalable approaches that extend beyond physicians and licensed clinicians.

For more than two decades, evidence from around the globe has demonstrated that well-trained, well-supervised community-based workers can effectively deliver behavioral health services. Lay counselor models in Africa and Asia, with evidence from studies conducted in [10],□

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[5] Anderson, A., Eisenberg, M. D., Kennedy-Hendricks, A., Castrucci, B. C., Galea, S., & Ettman, C. K. (2025). Mental health crises and help-seeking among US adults in 2024-2025. *Health Affairs Scholar*, 3(9). https://doi.org/10.1093/haschl/qxaf166

[6] Substance Abuse and Mental Health Services Administration. (2025). *Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health* (HHS Publication No. PEP24-07-021, NSDUH Series H-59) [Report]. https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report

[7] Health Resources and Services Administration. (2026, January 26). *Health workforce shortage areas*. Bureau of Health Workforce, Division of Policy Shortage Designation. Retrieved January 26, 2026, from https://data.hrsa.gov/topics/health-workforce/shortage-areas/dashboard

[8] Substance Abuse and Mental Health Services Administration. (2025). *Key substance use and mental health indicators in the United States: Results from the 2023 National Survey on Drug Use and Health* (HHS Publication No. PEP24-07-021, NSDUH Series H-59) [Report]. https://www.samhsa.gov/data/report/2023-nsduh-annual-national-report

[9] National Conference of State Legislatures. (2024, June). *Behavioral health workforce shortages and state resource systems* [Report]. https://documents.ncsl.org/wwwncsl/Labor/Workforce-Shortages-State-Resource-Systems.pdf.

[10] Patena, J., Adenikinju, D., Lanka, P., Hameed, T., Kulkarni, S., Osei-Tutu, N., Zuniga, S., Ruan, C., Shenoy, S., Thakkar, D., Noble, E., Angulo, B., Vieira, D., Gyamfi, J., & Peprah, E. (2025). Evaluating implementation research outcomes for a task-sharing mental health intervention: A systematic review of the Friendship Bench. Cambridge Prisms: *Global Mental Health, 12*, e65. https://doi.org/10.1017/gmh.2025.10025

Uganda, Ethiopia, [11], Pakistan, and the Philippines show that lay counselors and paraprofessionals can deliver structured interventions, such as problem-solving therapy, psychoeducation, and behavioral activation, with clinically meaningful[12.13,] These programs highlight ingredients for success, including structured training and supervision, defined scopes of practice, and culturally responsive care. They also offer potential models for the United States, particularly as communities grapple with limited clinician availability and growing behavioral health needs.

In the United States a growing body of evidence supports the use of providers without a clinical license, including peer specialists, community health workers (CHWs), case managers, and behavioral staff with bachelor's-level training, to enhance engagement, care coordination, and behavioral health outcomes.[14,15,16] Implementation challenges for workforce innovations such as these are common and include variability in role definition, inconsistent credentialing requirements, and inadequate reimbursement structures.[17,18] At the same time, organizations across the country are beginning to operationalize task-sharing principles within both integrated behavioral health care in primary care settings and community-based models. These innovations offer practical avenues to expand behavioral health capacity while maintaining quality and fidelity to evidence-based care.

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[11] Patel, V., Weiss, H. A., Chowdhary, N., Naik, S., Pednekar, S., Chatterjee, S., Bhat, B., Araya, R., King, M., Simon, G., Verdeli, H., & Kirkwood, B. R. (2011). Lay health worker led intervention for depressive and anxiety disorders in India: Impact on clinical and disability outcomes over 12 months. *The British Journal of Psychiatry, 199*(6), 459-466. https://doi.org/10.1192/bjp.bp.111.092155

[12] Connolly, S. M., Vanchu-Orosco, M., Warner, J., Seidi, P. A., Edwards, J., Boath, E., & Irgens, A. C. (2021). Mental health interventions by lay counsellors: A systematic review and meta-analysis. *Bulletin of the World Health Organization, 99*(8), 572. https://doi.org/10.2471/BLT.20.269050

[13] Triece, P., Massazza, A., & Fuhr, D. C. (2022). Effectiveness and implementation outcomes for peer-delivered mental health interventions in low-and middle-income countries: A mixed-methods systematic review. *Social Psychiatry and Psychiatric Epidemiology, 57*(9), 1731-1747. https://doi.org/10.1007/s00127-022-02294-y

[14] Bruce, M. L., Pepin, R., Marti, C. N., Stevens, C. J., & Choi, N. G. (2021). One year impact on social connectedness for Homebound older adults: Randomized controlled trial of Tele-delivered behavioral activation versus Tele-delivered friendly visits. *The American journal of geriatric psychiatry, 29*(8), 771-776. https://doi.org/10.1016/j.jagp.2021.05.005

[15] Choi, N. G., Marti, C. N., Wilson, N. L., Chen, G. J., Sirrianni, L., Hegel, M. T., Bruce, M. L., & Kunik, M. E. (2020). Effect of telehealth treatment by lay counselors vs by clinicians on depressive symptoms among older adults who are homebound: A randomized clinical trial. *JAMA network open, 3*(8), e2015648-e2015648. https://doi.org/10.1001/jamanetworkopen.2020.15648

[16] Renn, B. N., Sams, N., Areán, P. A., & Raue, P. J. (2023). A low-intensity behavioral intervention for depression in older adults delivered by lay coaches: Proof-of-concept trial. *Aging & Mental Health, 27*(7); 1403–1410. https://doi.org/10.1080/13607863.2022.2084709

[17] Areán, P. A., O'Connor, S., & Sherrill, J. (2025). The promise and perils of using peers and other paraprofessionals as mental health service professionals. *JAMA psychiatry*, *82*(2), 107-108. https://doi.org/10.1001/jamapsychiatry.2024.4276

[18] Smit, D., Miguel, C., Vrijsen, J. N., Groeneweg, B., Spijker, J., & Cuijpers, P. (2023). The effectiveness of peer support for individuals with mental illness: Systematic review and meta-analysis. *Psychological Medicine, 53*(11), 5332-5341. https://doi.org/10.1017/S0033291722002422

The Collaborative Care Model (CoCM) is one of the most effective, evidence-based approaches for integrating behavioral health care into the primary care space. By embedding behavioral health care services in primary or specialty care, CoCM increases access, reduces stigma, and brings evidence-based treatment to settings where patients are already receiving care. CoCM consistently demonstrates improved clinical outcomes[19,20] and reduced cost of care,[21] making it a critical strategy for expanding behavioral health access. Relying on a population-based team-driven workflow and measurement-informed care, CoCM enables a small number of licensed psychiatric providers to reach a larger number of patients.[22]

The traditional CoCM team includes a primary care provider (PCP), a behavioral health care manager (BHCM),[23] and a psychiatric consultant. Centers for Medicare & Medicaid Services (CMS) guidelines do not require BHCMs to hold licensure or advanced educational credentials in order to provide services; however, requirements from state Medicaid agencies vary. Many programs continue to staff BHCM roles with pre-licensed social workers, licensed clinical social workers, psychologists, or nurses.[24] The BHCM role includes responsibilities such as coordinating patient care, delivering brief behavioral interventions, monitoring symptoms using validated tools, and supporting stepped-care adjustments in collaboration with the PCP and psychiatric consultant. Licensure requirements create a structural bottleneck for the expansion of CoCM as the supply of licensed clinicians is insufficient to meet demand, particularly in rural and underserved areas. This dynamic limits CoCM's scalability despite strong evidence and widespread policy support for the model.

To address this gap between policy flexibility and real-world implementation, some organizations are beginning to expand hiring pathways by training providers without a clinical license through competency-based curricula, structured supervision, and clearly defined scopes

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[19] Archer, J., Bower, P., Gilbody, S., Lovell, K., Richards, D., Gask, L., Dickens, C., & Coventry, P. (2012). Collaborative care for depression and anxiety problems. *Cochrane Database of Systematic Reviews*, (10), CD006525. https://doi.org/10.1002/14651858.CD006525.pub2

[20] Unützer, J., Carlo, A. C., Arao, R., Vredevoogd, M., Fortney, J., Powers, D., & Russo, J. (2020). Variation in the effectiveness of collaborative care for depression: Does it matter where you get your care? *Health Affairs*, *39*(11), 1943-1950. https://doi.org/10.1377/hlthaff.2019.01714

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[22] Carlo, A.D., McNutt, C., & Talebi, H. (2024). Extending the clinical impact of behavioral health prescribing clinicians using the Collaborative Care Model (CoCM). *Journal of General Internal Medicine,* 39(8):1525-1527.

[23] Behavioral health care managers (BHCMs) are referred to by a variety of titles across settings, including behavioral health care coordinator, behavioral health case manager, behavioral health support staff, behavioral health clinician, behavioral health counselor, and behavioral health therapist.

[24] Mental Health Treatment and Research Institute. (2025, December). *Collaborative care service organizations (CSOs): Providing CoCM implementation support and/or staff to health systems and primary care practices (2nd ed.).* Bowman Family Foundation. Retrieved January 26, 2026, from https://filesmhtari.org/CoCM_Service_Organizations_Directory.pdf

of practice. In these CoCM implementations, providers without a clinical license can perform core BHCM functions, such as patient outreach, brief skill-based behavioral interventions, psychoeducation, and ongoing symptom monitoring, while allowing licensed clinicians to focus on more complex cases.

The Meadows Mental Health Policy Institute conducted key informant interviews with 11 organizations pioneering new workforce approaches in primary care, community-based behavioral health, digital health, and startup models. Across these organizations, several innovative pathways emerged as promising solutions to increasing access and building a more sustainable behavioral health workforce within integrated care settings:

- **Behavioral Health Staff with a bachelor's degree**: Employing BHCMs with bachelor's-level training within CoCM increases service capacity and allows licensed clinicians with master's-level training to focus on complex cases.
- **Behavioral Health Staff with a High School Diploma or HSE credentials:** Training and employing local community members without behavioral health credentials or clinical licensure to deliver behavioral health services, address social drivers of health, and serve as trusted connectors in underserved communities.
- **Internship Models**: Pairing traditional instruction with real-world work experience through organized internships and strengthening professional development pathways to create more robust career pipelines.
- **Higher Education Partnerships**: Developing structured training and credentialing pathways grounded in defined skills and competencies that ready trainees for behavioral health support roles in integrated and community-based settings.

For each pathway, we highlight real-world innovations drawn from an organization's on-the-ground experience to demonstrate how behavioral health capacity can be strengthened in integrated care settings. We then outline key policy and systems-level opportunities to adapt, align, and scale these pathways, building on existing models to support a sustainable and equitable behavioral health workforce.

Behavioral Health Care Managers with Bachelor's-Level Training

Across behavioral health organizations implementing CoCM, tiered staffing models that integrate staff with bachelors-level training and licensed BHCMs with master's-level training are emerging as an effective strategy to expand access and meet the rising demand for behavioral health services. Triad Adult and Pediatric Medicine (TAPM), a Federally Qualified Health Center (FQHC) in North Carolina and Helios Behavioral Health, a Massachusetts-based non-profit providing turn-key CoCM, offer two approaches to implementing team staffing models that combine BHCMs with bachelor's- and master's-level training.

Both organizations rely on staff with bachelor's-level training as core members of the care management team, but their implementation strategies differ. TAPM uses a traditional supervision model that pairs BHCMs with bachelor's and master's-level training to increase capacity for referral, engagement, and care coordination, reducing the non-clinical workload of licensed clinicians. BHCMs with bachelor's-level training at TAPM are responsible for care coordination, patient outreach, safety planning under supervision, and warm connections, while identifying barriers to patient care and facilitating referrals as needed. BHCMs with master's-level training deliver therapeutic interventions and provide supervision to BHCMs with bachelor's-level training.

Helios employs a cohort-based workforce training model in which BHCMs with bachelor's and master's-level training are hired in groups, receive standardized onboarding and ongoing training, and participate in structured peer learning. BHCMs with bachelor's-level training are responsible for patient consent and program orientation, psychoeducation, delivery of structured, skill-based brief interventions (e.g., behavioral activation, motivational interviewing techniques), and coordination with community or specialty providers. BHCMs with bachelor's-level training have a clearly defined scope of practice that emphasizes brief behavioral interventions and skill development rather than psychotherapy and they are supported through regular supervision and clear protocols for escalation of care. When a patient would benefit from psychotherapy or more intensive clinical intervention, care is expanded to include a master's level BHCM, while BHCMs with bachelor's-level training may continue to support the patient through adjunctive skill-building activities. BHCMs with master's-level training are responsible for diagnostic assessment, delivery of psychotherapy, and other brief clinical interventions. They also provide ongoing support and consultation to BHCMs with bachelor's-level training. Caseloads are stratified by acuity: BHCMs with bachelor's-level training primarily manage patients with mild symptoms and BHCMs with master's-level training manage patients with moderate to severe symptoms. This tiered model allows licensed clinicians to focus on diagnostic clarification for complex patients, while fully leveraging BHCMs with bachelor's-level training within an appropriate and well-defined scope of practice. This approach is designed to mirror the career ladder used in medical settings, where medical assistants, licensed nursing assistants, nurses, and physicians work closely together with a clearly defined scope of practice.

In addition to expanding patient access to care, these hybrid staffing models produce distinct organizational benefits. TAPM's model emphasizes cost efficiency and expanded capacity, enabling the CoCM program to grow its caseload without overextending its limited pool of licensed clinicians. Helios' hybrid model of broadening hiring pathways enables recruitment of BHCMs who better reflect the populations served, including Spanish-speaking staff. Its cohort-based model mirrors medical training with structured supervision and opportunities for shadowing, offering a clearer professional development ladder within the behavioral health field. Helios has developed an effective and unique curriculum to train both bachelor's-level

and master's-level team members in CoCM, based on identified core competencies. Helios also provides consultation and direct training for other organizations seeking to replicate this model.

> "Our approach has always been about creating a team where different levels of training complement each other, allowing everyone to work at the top of their license while expanding access and supporting career growth."
>
> – Jessica Lyons, co-founder and chief clinical officer of Helios Behavioral Health

Together, TAPM and Helios demonstrate how hybrid team staffing models that combine BHCMs with bachelor's- and master's-level training, whether through traditional supervision or cohort-driven workforce development, can expand the behavioral health workforce, strengthen clinical pipelines, and improve access. Employed BHCMs with bachelor's-level training at Helios and TAPM later pursue advanced degrees or additional training, underscoring the importance of deliberate educational pipelines and opportunities for career advancement. With clearly defined scopes of practice, organizations can safely broaden eligibility for BHCM roles while maintaining high-quality, patient-centered care.

Community-Based Workforce Pathways for High School and High School Equivalency Credential Graduates

Employing staff with a high school diploma or high school equivalency (HSE), as well as non-licensed team members, expands the workforce by attracting people with strong community ties, cultural insights, and lived experience. The following examples illustrate how organizations are training and deploying this workforce within integrated behavioral health care and CoCM settings through clearly defined roles, robust supervision, and structured training pathways.

In rural Nebraska, limited access to behavioral health providers, long wait times, and cultural differences between out-of-state clinicians and local residents prompted Dignity in Healing Collective founders to develop a model that trains and employs adults with a high school diploma or HSE credentials. Dignity in Healing Collective training includes foundational competencies such as self-care, emotional resilience, and healthy boundary-setting, as well as advanced skills in trauma-informed assessment, risk evaluation, cultural humility, and patient-centered approaches. Enrollees are trained in motivational interviewing, brief cognitive behavioral interventions, mindfulness-based stress reduction, and practical problem-solving supports, all grounded in trauma competence and cultural humility. Ongoing

> "Our mission is to train and support a new generation of behavioral health workers from within the communities we serve, expanding access to care while ensuring that the care reflects local culture, lived experience, and language."
>
> – Johnathan Giles, executive director of Dignity in Healing

supervision with licensed providers, access to psychiatric consultants, and collaboration with clinical and community healers further strengthen workforce capacity.

Accompany Health, a value-based care organization working in Michigan, Colorado, and Massachusetts, provides in-home, virtual, and 24/7 services employing CHWs and licensed clinicians to address the need for patient support with social drivers of health. Its tiered care model includes utilizing CHWs (adults 18 and older with a high school diploma or HSE credentials) alongside clinically licensed BHCMs. CHWs focus on social needs, care coordination, and resource navigation, while licensed BHCMs provide therapeutic interventions. This model extends care team capacity while directly addressing social drivers of health, allowing BHCMs to expand their scope of care for more complex patients within the CoCM framework.

> "By addressing behavioral health concerns and underlying social drivers of health in tandem, this model strengthens patient engagement and improves care outcomes, while also lowering the overall cost of service for these interventions."
>
> – Stephen Warnick Jr., national director of integrated behavioral health at Accompany Health

In Baltimore, Maryland, Partnering with Parents of Adolescent Latines on Mental Health Assistance (PALOMA) is an education program that focuses on adolescent suicide prevention. Families are referred to the program by the child's pediatrician. Over the course of two months, parents receive five education sessions with a CHW over the telephone. The PALOMA education program demonstrates how CHWs can deliver integrated, non-clinical behavioral health support in primary care settings. In Maryland, CHWs must be at least 18 years old, hold a high school diploma or HSE credentials, and complete a state-approved training and certification program. Within the PALOMA model, bilingual CHWs work closely with Spanish-speaking families of youth at risk of suicidal behaviors, providing culturally responsive safety planning, psychoeducation, and support in addressing social drivers of health. Leveraging trusted community relationships, this approach improves family engagement, strengthens care continuity, and bridges linguistic and cultural gaps that often limit access to care.

FamilyWell Health is a Massachusetts-based startup focused on perinatal behavioral health, demonstrating another pathway for unlicensed professionals to support CoCM. FamilyWell employs behavioral health coaches—including parents, doulas, lactation consultants, social workers, and birth workers – trained through the organization's Perinatal Behavioral Health Certification. Coaches learn evidence-based strategies to identify and intervene early in perinatal mood and anxiety disorders, provide brief interventions, and coordinate community support services. This structured training equips unlicensed professionals to deliver targeted behavioral health coaching while expanding workforce capacity in perinatal care.

Era Supports operates across two multi-site FQHCs in Washington, D.C., illustrating how peer support specialists can be effectively integrated into CoCM teams to engage populations with complex needs, particularly people with substance use disorders and multiple comorbid conditions. Its model pairs BHCMs with a clinical license and peer specialists who bring their lived experience to enhance trust-building, harm reduction, and in-person warm connections for patients who often distrust traditional health care systems. Peer specialists lead engagement and outreach efforts, co-conducting intake assessments with BHCMs, participate in weekly systematic case review, and support skill-based interventions such as motivational interviewing, while licensed clinicians retain responsibility for diagnosis and clinical treatment planning. As Julian Mitton, the head of clinical operations for Era Supports, explained, "Integrating peer specialists with our licensed BHCMs allows us to expand access to care for patients who are often hard to reach. With clear role delineation and robust supervision, our teams can manage complex cases effectively while maintaining high-quality, patient-centered care." Robust supervision is embedded through daily huddles and weekly systematic case reviews, enabling BHCM-peer teams to manage large caseloads while maintaining care quality. By pairing robust onboarding, supervision, and ongoing training with a hiring strategy that prioritizes lived experience over formal educational credentials, this model demonstrates the effectiveness of peer-led staffing in expanding CoCM capacity for hard-to-engage populations.

> "By creating opportunities for local residents to join the behavioral health workforce, we not only expand capacity, we ensure that care is delivered by people who truly understand the community's culture and needs."
>
> – Julie Luzarraga, co-founder of Dignity in Healing

Across these examples, employing staff with a high school diploma or HSE, as non-licensed team members emerges as a scalable solution for expanding access to behavioral health services, when paired with clear role delineation, robust training, and a strong supervision structure. Dignity in Healing Collective strengthens cultural and linguistic representation in rural communities. Accompany Health provides CoCM services for patients with more severe mental illness, while addressing social drivers of health. PALOMA improves family engagement and care continuity for Spanish-speaking youth at risk of suicide by embedding trusted CHWs in primary care. FamilyWell Health broadens the perinatal behavioral health workforce by equipping unlicensed professionals with specialized, evidence-informed skills, while Era Supports demonstrates how peer-led models grounded in lived experience and supported by robust supervision can sustain engagement among hard-to-reach populations with complex needs. Together, these approaches illustrate how diversifying entry points into behavioral health roles strengthens patient engagement, particularly among communities historically underserved by traditional care models, while meaningfully expanding CoCM capacity through team-based, community-centered workforce design.

Internship and Earn-While-You-Learn Models

Some organizations are addressing workforce shortages by building structured internship programs and practicum experiences for varied levels of unlicensed providers that create early exposure to integrated behavioral health care, expand short-term workforce capacity, and strengthen long-term hiring pipelines for recruiting trained staff into permanent BHCM roles.

Dignity in Healing Collective launched a training clinic in Nebraska in direct response to a shrinking local workforce. With many long-standing licensed providers nearing retirement, the pool of educators capable of training future clinicians is limited. In Nebraska, establishing a local training clinic for providers without clinical licensure offers a more sustainable solution. To enroll, students must have a minimum of a high school diploma or HSE credentials. The training clinic mirrors models long used in nursing education, providing a structured environment where students can develop core BHCM skills. Training at the Dignity in Healing Collective clinic occurs in two phases. The first six weeks emphasize practical clinical skills, including motivational interviewing (MI), somatic and mindfulness-based stress reduction techniques, brief cognitive-behavioral therapy, problem-solving therapy, and the use of Internal Family Systems language, which complement MI's focus on ambivalence. The second phase focuses on interprofessional practice, including how to collaborate as a team, present cases effectively, and conduct safety assessments. Students learn how to work within a primary care setting, interact with primary care clinicians, and present cases to psychiatric consultants. Cohorts typically include six to seven students, supported through stipends funded by Nebraska Blue Foundation, with plans to expand to as many as 12 students per cohort.

In New York State, Primary Care Independent Physician Association (PCIPA) has developed a highly structured, immersive internship program that pairs pre-licensure first- and second-year Master's in Social Work (MSW) students from nearby institutions with licensed MSW supervisors. First-year interns begin with a two-week orientation, then focus on coordinating referrals and addressing social drivers of health and higher-level care needs, while providing follow-up feedback to the care team. Second-year interns complete a six-week onboarding process that includes two weeks of online CoCM instruction through the AIMS Center at the University of Washington, along with instruction in HIPAA compliance, mandated reporting, safety protocols, and use of the EHR and patient communication platforms. During weeks three and four, interns shadow full-time BHCMs in pediatric and adult primary care clinics. By weeks five and six, they transition to assigned clinic sites, where they participate in monthly training webinars, manage a supervised caseload of eight to 15 patients, and receive weekly one-hour individual clinical supervision. Through partnerships with Daemen University and the University at Buffalo, PCIPA has created a sustainable pipeline for recruiting well-trained BHCMs directly from internship into full-time roles.

"A key component of this training model is structured skill transfer. The integration of interns at Primary Care IPA allows Daemen students to gain hands-on clinical experience in integrated primary care settings, building real-world competencies in assessment, brief interventions, collaboration, and documentation."

– Maggie Dreyer, director of practicum education at Daemen University

Concert Health, a technology-enabled behavioral health services organization working across 19 states, offers remote clinical practicum placements for counseling students and second-year MSW students, while also offering policy internships for public health and macro MSW students. At Concert, clinical interns carry their own prorated caseloads and are supported by intensive wrap-around supervision, case consultation with the psychiatric consultant, and structured training that mirrors full BHCM onboarding. Onboarding includes training on suicidal risk assessment, motivational interviewing, registry and electronic medical record workflows, and ongoing scheduled and ad-hoc clinical supervision.

"At Concert, we've seen that with the right training and supervision, social work interns can safely manage real-world caseloads while gaining invaluable clinical experience, strengthening both their skills and our pipeline of future behavioral health professionals."

– Virna Little, co-founder of Concert Health

Despite clear benefits, internship programs face ongoing challenges. Aligning program structures with university practicum requirements can be difficult, as can developing clear role definitions for students at varying skill levels. As internship participation grows, organizations must also ensure adequate supervisory capacity to provide structured, high-quality oversight. These challenges can be addressed by strengthening educational partnerships and prioritizing workforce expansion as a state policy investment.

Higher Education Partnerships

Washington state provides an excellent example of how state agencies, employers, and higher education institutions can jointly build a scalable behavioral health workforce through coordinated policy, credentialing, and training alignment. After state leaders identified the need for statutory authority to support reimbursement and formal recognition of a new bachelor's-level role, the Washington State Legislature passed Substitute Senate Bill 5189 in 2023, directing the Department of Health to establish a Behavioral Health Support Specialist (BHSS) certification and requiring the Health Care Authority to ensure Medicaid coverage of BHSS services. This legislation created the policy and reimbursement foundation necessary for

employers to hire BHSSs and for training programs to align around a common, statewide role definition.[25]

With this policy framework in place, the University of Washington (UW) and other higher education institutions operationalized the workforce pathway. The UW Department of Psychiatry and Behavioral Sciences, long a national leader in behavioral health integration, led the development of the BHSS competency framework and clinical training model, defining a standardized role for behavioral health support staff with bachelor's-level training capable of delivering brief interventions, care coordination, and measurement-informed care. In response to state requirements, 10 colleges and universities in Washington initiated the process of aligning their curricula to these competencies, incorporating supervised practicum experiences designed to prepare graduates for team-based practices in primary care and community settings.[26]

Employers play a complementary role by serving as training sites, supervisors, and early adopters of the BHSS role. Health systems, community health centers, and other integrated care settings provide the supervised practice environments required by BHSS programs and create demand for graduates by embedding the role into care teams. State policy requiring Medicaid and commercial coverage of BHSS services further incentivizes employer uptake by making the role financially viable within existing delivery systems.

> "Washington State shows how states can move beyond isolated training programs to build a coordinated workforce pipeline, one in which state agencies set standards and reimbursement policy, universities deliver aligned, competency frameworks, and employers integrate and sustain the role in practice."
>
> – Bill O'Connell, director of the BHSS Workforce Development Project at the University of Washington

The University of Washington has also developed materials to support national dissemination, with the long-term goal of establishing a standardized taxonomy for behavioral health roles requiring bachelor's-level training that can be adapted across states.

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[25] O'Connell, W. P., Renn, B. N., Areán, P. A., Raue, P. J., & Ratzliff, A. (2024). Behavioral health workforce development in Washington State: Addition of a behavioral health support specialist. *Psychiatric Services*, *75*(10), 1042-1044. https://doi.org/10.1176/appi.ps.20230312

[26] O'Connell, W., & Salisbury, J. (2025). Competency framework for bachelor-level social workers to deliver psychosocial interventions within integrated care. *Journal of Evidence-Based Social Work*, 1-22. https://doi.org/10.1080/26408066.2025.2553011

Universities are not, however, the only way to expand the behavioral health workforce. Non-degree, skills-focused training programs such as California's Lay Counselor Academy (LCA) demonstrate how employer-anchored models can expand access to mental health care by enhancing the scope of community health workers, case managers, legal aides, school personnel, and others to deliver mental health counseling. Employers such as schools, clinics, and community-based organizations partner with the LCA to identify current staff or community members for training, creating a clear and supported on-ramp into behavioral health roles. This employer-led recruitment model reduces barriers to entry, aligns training with real-world job needs, and enables rapid deployment of lay counselors equipped with evidence-based mental health counseling skills. As Alli Moreno, co-creator of the LCA, noted, "In their current roles, participants who come to the LCA are *already* hearing community members' mental health disclosures because they have the skills and aptitudes that convey trustworthiness and care. Our program aims to enhance those folks' skill and confidence to provide meaningful, supportive mental health counseling in exchanges that are already happening. Many feel very supported by their employers to do the work they're already engaged in."

> "At the Lay Counselor Academy, our approach allows people who are already embedded in the community to step into behavioral health roles with structured training and employer support, making the workforce both more accessible and more effective."
>
> – Elizabeth Morrison, co-creator of the Lay Counselor Academy

Together, both degree and non-degree training pathways can support multiple complementary entry points into the behavioral health workforce, meeting people where they are while maintaining competency and quality standards.

Future Directions

The programs highlighted in this paper demonstrate that staff without clinical licensure can be embedded into behavioral health delivery when training, scope of practice, supervision, and reimbursement are intentionally aligned. Funders, policymakers, and training institutions seeking to address the national behavioral health workforce crisis need not start from scratch. Instead, they can accelerate progress by adapting and scaling these existing models. To support this effort, we identify four key areas of opportunity.

Develop and Standardize Competency-based Training

Consistent, widely available competency-based training is essential to ensuring that the incoming behavioral health workforce is prepared for real-world practice. Competency-based approaches prioritize applied skills such as behavioral activation, motivational interviewing, psychoeducation, trauma-informed care, harm reduction and safety planning, de-escalation, and addressing social drivers of health, skills that are immediately deployable in primary care

and community-based settings. Given the variation in certification and training requirements across states, clearly defining BHCM roles, responsibilities, and competencies can facilitate more streamlined integration of unlicensed behavioral health staff into care teams.

Align State Level Requirements and Scope

Variation in state-specific requirements, particularly where expectations for unlicensed behavioral health roles are unclear or inconsistently defined, can affect workforce entry and implementation. As states continue to operationalize behavioral health workforce strategies, clearer alignment among training and supervision requirements, scope-of-practice definitions, and CMS guidance can reduce ambiguity for employers and trainees. Emphasizing demonstrated competency, through training, supervised experience, and skills-based assessment, rather than credential attainment alone can support broader participation in BHCM roles while maintaining appropriate distinctions between licensed clinicians and other clinical support roles including CHWs, Certified Mental Health Professionals (CMHP) as recognized in Florida or Qualified Mental Health Professionals (QMHP) as recognized in Texas, peer support specialists, and coaches. This competency-forward approach allows states to align education and training requirements with the needed skills of the behavioral work force, rather than relying solely on formal credentialing as a proxy for readiness. This clarity is essential for safe, effective, and sustainable workforce integration. Additional research examining outcomesassociated with unlicensed behavioral health roles within different training and supervision models would guide state policymakers in strengthening scope of practice definitions and workforce models that ensure all staff are practicing at the top of their training and capability.

Advance Sustainable Reimbursement Structures

Reimbursement for CoCM services remains inconsistent across states and payers. Although at the time of writing, 37 states reimburse CoCM codes to varying degrees, rates often fall short of supporting financial sustainability for health systems.[?] Widespread adoption of CoCM, and the long-term viability of BHCM roles staffed by unlicensed providers will depend on reimbursement structures that adequately support staffing, supervision, and care delivery.

In addition to CoCM-specific codes, sustainable workforce expansion requires reimbursement models that recognize the essential role of other clinical support staff, including CHWs and peer support specialists. These roles contribute directly to patient engagement, care coordination, and continuity of care, functions that are critical to patient care but are often unsupported or inconsistently reimbursed. Aligning reimbursement with team-based care delivery not only supports workforce sustainability, but also reinforces the engagement, trust, and rapport that staff without a clinical license such as CHWs and peer support specialists uniquely provide. Sustainable payment models are therefore a prerequisite not only for workforce growth and

program longevity, but for realizing the full clinical and equity benefits of integrated, community-centered behavioral health care.

One model worth examining is the Certified Community Behavioral Health Clinic (CCBHC), which shares CoCM's emphasis on integrated, team-based care and is also designed to serve individuals with serious mental illness and co-occurring substance use and chronic health conditions. CCBHCs are required to serve anyone who requests care regardless of diagnosis, insurance status, or ability to pay. Critical to workforce sustainability, the model empowers all staff levels, particularly peer specialists, recovery coaches, and counselors, to play a larger role in client care, enhancing care coordination and person-centered care. A federal evaluation of the CCBHC demonstration found that associate's-degree-level and non-degree counselors, peer specialists, and recovery coaches, case management staff, and community health workers showed stable rates of employment across demonstration years, even as the proportion of clinics employing psychiatrists declined, suggesting that CCBHCs are identifying ways to use staff at all credential levels more efficiently to meet demand.[27] A recent evaluation also observed high levels of retention of behavioral health workers after five years of operation across eight states.[28] As reimbursement reform efforts advance, the CCBHC model offers a concrete example of how prospective, cost-based payment structures can support the kind of diverse, community-centered workforce that is desperately needed.

Invest in Education Partnerships

Community colleges are uniquely positioned as critical partners in scaling the behavioral health workforce, drawing from student populations that reflect the demographics, lived experience, and deep community investment of the neighborhoods they serve. Students who live and work in their communities bring authenticity and relational trust that are essential to effective behavioral health support roles. Through stackable credentials, certificate programs, associate degrees, and clearly articulated pathways to four-year institutions, community colleges can support both workforce entry and long-term career advancement. The demonstrated demand for skills- and competency-based training, defined scopes of practice, and applied learning opportunities underscores the importance of these partnerships in creating durable community-rooted pathways to employment.

[27] Office of the Assistant Secretary for Planning and Evaluation and Office of Behavioral Health, Disability, and Aging Policy. (2019). Certified community behavioral health clinics demonstration program: Report to congress, 2019. U.S. Department of Health and Human Services. https://aspe.hhs.gov/system/files/pdf/263966/CCBHCRptCong19.pdf

[28] National Council for Mental Wellbeing. (2025). Transforming state behavioral health systems: Findings from states on the impact of CCBHC implementation. https://www.thenationalcouncil.org/wp-content/uploads/2025/02/Transforming-State-Behavioral-Health-Systems.pdf

Conclusion

The urgent need to expand the behavioral health workforce cannot be overstated. Demand for behavioral health services continues to outpace the supply of licensed clinicians, placing sustained strain on health systems and communities. At the same time, promising solutions are already emerging. Across the country, organizations are implementing structured supervision models, competency-based training, and practicum pathways that prepare individuals from diverse educational and professional backgrounds for behavioral health support roles. Importantly, the talent pool for these roles already exists. Community-facing professionals including CHWs, CMHPs, QMHPs, peer support specialists, case managers, substance use counselors, teacher aides, medical assistants, legal advocates, and customer service professionals bring relational, cultural, and communication skills that are foundational to effective behavioral health care. With appropriate training and supervision, these individuals can demonstrate the competencies needed to meaningfully expand access to care in integrated and community-based settings.

The long-term implications of these promising practices are substantial and include a larger and more representative workforce, faster access to care, lower system costs, and more equitable outcomes for patients and communities. The opportunity to redesign the behavioral health workforce is already within reach. Strategic investments in competency-based training, regulatory alignment, reimbursement reform, and education partnerships can transform promising models into scalable solutions to ensure that individuals with behavioral health needs can access timely, high-quality care when and where they need it.

Suggested citation:

The Meadows Mental Health Policy Institute. (2026, March). *Scalable strategies to expand the behavioral health workforce*.

Appendix A: Key Informant Interviews

Table 1A. Key Informant Interviews

Name(s)	Organization	Website
Stephen Warnick, MD, Jenny Hubbard, LCSW	Accompany Health	https://accompanyhealth.com
Virna Little, PsyD	Concert Health	https://concerthealth.com
Jonathan Giles, LCMHC, Julie Luzarraga, LICSW, DSCW	Dignity in Healing Collective	https://dignityinhealing.org
Julian Mitton, MD, MPH Yona Remer, MBA	Era Supports	https://www.erasupports.com/
Jessica Gaulton, MD, MPH	FamilyWell Health	https://www.familywellhealth.com
Jessica Lyons, LMFT	Helios Behavioral Health	https://www.heliosbehavioralhealth.org
Elizabeth Morisson, PhD, Alli Moreno	Lay Counselor Academy	https://www.emorrisonconsulting.com/services/lay-counselor-training-academy/
Jill Donelan, PsyD, Tyrena Lester, LICSW	Mirah	https://www.mirah.com
Kiara Alvarez, PhD, Ellen Molino, BBA	PALOMA Partnering with Parents	https://jhcentrosol.org/research/paloma-suicide-prevention-family-clinic/
Larry Zielinski, MBA, Heidi Sansbury, MBA, LMSW, Mallory Tominich, LMSW	Primary Care IPA	https://primarycareipa.org
Maggie Dreyer, LCSWR	Daemon University Department of Social Work & Sociology	https://www.daemen.edu/academics/college-health-human-sciences-business/social-work/master-social-work-msw
Jaclyn Lipscomb–Noble, Meaghan Whitson, LCSW	Triad Adult & Pediatric Medicine	https://tapmedicine.com
Anna Ratzliff, MD, PhD, Bill O'Connell, PhD	University of Washington Department of Psychiatry and Behavioral Sciences	https://bhss-wa.psychiatry.uw.edu