Workgroup for Social Work Licensure Requirements

Date: November 13, 2024 **Time**: 10:00 am - 12:00 pm

Video call link: https://meet.google.com/rso-bhjm-uqe

Or dial: (US) +1 347-762-8966 PIN: 856 535 732#

Agenda

I. Administrative Updates -

- **A.** Roll Call
- **B.** Vote on Meeting Minutes
- **C.** Update on Meeting Cadence

I. Presentation -

Alternative Pathways Survey Results, Dr. Angela Gustus, CMAG & Associates

II. Discussion -

Workgroup discussion on Alternative Pathways Survey Results

III. Public Comment -

IV. Closing and Next Steps -

Vote on Alternative Pathways Recommendations at the November 20th meeting

V. Upcoming Meetings -

- **A.** November 20, 2024
- **B.** December 18, 2024

ALTERNATIVE PATHWAYS SURVEY RESPONSES REPORT

On October 30, 2024, The CMAG Team presented to the Workgroup the alternative pathways currently in use by various states. In addition, CMAG provided a survey for all Workgroup Members related to the Alternative Pathways and the recommendations provided during the presentation by the Maryland Board of Social Work Examiners.

The survey link was provided to all 22 Workgroup members. 20 Workgroup members participated in the survey. Below is a general analysis of the findings of the survey:

Data Analysis:

- 90% (18) of the participants said Yes to all 3 recommendations from the Maryland Board of Social Work Examiners
- 90% (18) of the participants who said Yes to at least 1 alternative pathway
- 85% (17) of the participants said Yes to either Illinois or Minnesota
- 80% (16) of the participants said Yes to 2 or more types of alternative pathways
- 10% (2) of the participants did not like any of the Alternative Pathways
- 85% (17) of the participants used one or more opportunities to comment throughout the survey.
- 50% (10) agree with the Illinois Alternative Pathway
- 65% (13) agree with the Minnesota Alternative Pathway
- 40% (8) agree with the Texas Alternative Pathway
- 60% (12) agree with the Oregan Alternative Pathway
- 55% (11) agree with the Michigan Alternative Pathway

General Comments (from the last question of the survey)

- Many individuals spoke of the importance that any alternative pathway should not be punitive or cost prohibitive to the individuals seeking licensure.
- Many individuals spoke of liking the idea of people having more that one option for licensure.
- Multiple individuals stated that they are concerned that there has not been enough discussion or a formal vote about the idea of establishing an alternative pathway for clinical licensure. In addition, an individual expressed concern about how the research on alternative pathways was conducted.
- Some individuals provided additional options or ideas for discussion:
    - Incentives for clinical supervisors
    - Free exam prep classes
    - Test taking skills classes
- Multiple individuals expressed their appreciation of the survey and looking forward to results providing an opportunity for further discussion.
- The topic of still needing to address the bias analysis in the final report was raised. In addition, others spoke of the need for state funded research to assess the demographics of those seeking licensure.
- Concerns about the removal of a competency exam was addressed, especially in comparison to other boards in the state.

DETAILED RESULTS FROM EACH ALTERNATIVE PATHWAYS

A brief summary of each Alternative Pathways, recommendations from the Maryland Board of Social Work Examiners, and the results of the Workgroup survey are provided in this next section.

IIIINOIS (50% Agree)

Alternative Pathway

Through the Illinois Department of Financial and Professional Regulation (IDFPR), Illinois has established an alternative pathway for individuals who have failed the ASWB exam and choose to take an alternative path. The alternative path details listed below are in addition to the clinical hours required to take the exam initially.

- If an individual fails the ASWB exam, they have the option of completing an additional 3,000 hours of clinical experience, which can be supervised by a Licensed Clinical Social Worker, Licensed Clinical Professional Counselor, Licensed Marriage and Family Therapist, Licensed Clinical Psychologist, Licensed Psychiatrist, or Licensed Advanced Practice Psychiatric Nurse.
- The exam attempt must have been made since 1/1/2019
- The exam alternative hours must not be more than 10 years old.

Workgroup Survey Results

Number of people who AGREE with this Alternative Pathway	Number Workgroup members who DISAGREE with this Alternative Pathway
10	10
Comments Summary:	
• Multipole individuals spoke of the importance of ensuring that other barriers are addressed whether this or another alternative pathway is chosen. • Determine the number of additional hours for this alternative pathway. Potentially less that the 3000 hours required in Illinois. • The ASWB exam still needs to be assessed even if an alternative pathway is put into place. • If additional supervision hours are required for an alternative pathway, the funding for those hours should be addressed to assist individuals who must pay for clinical supervision themselves. • Multiple people spoke of the importance of Clinical supervision requiring a more standardized approach including continuing education for supervisors.	

MINNESOTA (65% Agree)

Alternative Pathway

Minnesota has established a Provisional Licensed Independent Clinical Social Worker (LICSW). This process went into effect as of October 1, 2024. Individuals are not required to take the ASWB exam if they complete the process identified below.

- Academic Degree: Complete a master's degree in social work from a program accredited by the Council on Social Work Education (CSWE) or the Canadian Association of Schools of Social Work.
- 360 Clinical Clock Hours: Individuals must have completed courses from an institution of higher learning in the following areas (totaling 360 total hours of course work)
    - Differential Diagnosis and biopsychosocial assessment, including normative development and psychopathology across the life span (108 hours)
    - Assessment-based clinical treatment planning with measurable goals (36 hours)
    - Clinical intervention methods informed by research and current standards or practice (108 hours)
    - Evaluation Methodologies (18 hours)
    - Social work values and ethics, including cultural context, diversity, and social policy (72 hours)
    - Culturally specific clinical assessment and intervention (18 hours)
- Criminal Background Check
- Ethical Standards: Individuals must not have engaged in conduct in violation of the board's ethical standards of practice.
- Supervised practice: Individuals must submit documentation of the following
    - 200 hours of supervision over 4,000 to 8,000 hours of clinical practice
    - Hours must include 1,800 direct clinical contact hours
- Fees: Individuals must pay a total of $108.25 for the provisional application

Workgroup Survey Results

Number of people who AGREE with this Alternative Pathway	**Number Workgroup members who DISAGREE with this Alternative Pathway**
13	7
Comments Summary:	
• I am open to Minnesota's alternative pathway #2 option but I have concerns about the expense of paying for supervision. There should be waivers to cover the cost for those who demonstrate financial hardship. Access must be equitable. • Under this scenario, those who think their test taking skills are strong have access to a less time-consuming and likely less expensive pathway. • It seems like there could be additional barriers/challenges on this alternative pathway if an applicant does not yet have a job/is unemployed, unless they are offered it through their employer. • The bill to add the provisional path in MN was only effective several months ago. It's too soon to understand the unintended consequences for the public & profession. • I prefer this option, ASWB is harmful to those taking the exam and does not	

measure social work competency. • I believe that the additional hours need to equate what has already been achieved throughout Masters level school.

TEXAS (40% Agree)

Alternative Pathway

Texas is currently working to reinstate the statute, which provides an alternative pathway using the Alternative Method of Exam Competency (AMEC) Requirements. This alternative pathway was in place but removed in 2019 during a transition of the Texas Board of Social Worker Examiners to the Behavioral Health Executive Council. The AMEC process is in place for individuals who have failed the ASWB exam. This process includes the following:

- Complete professional portfolio
- Quarterly evaluations from a licensed supervisor
- 11 papers specific to core content within social work practice
- Case analysis of work with a client during this period
- Self-evaluation

Workgroup Survey Results

Number of people who AGREE with this Alternative Pathway	Number Workgroup members who DISAGREE with this Alternative Pathway
8	12
Comments Summary:	
• The overwhelming feedback on path that Texas has taken is that there is not enough information to chose this pathway. • Individuals who agree with this Alternative Pathway agree that an entirely new process should be developed; however, others have expressed concern that another process would still include some form of testing which may still be problematic. • Multiple people stated that whatever process is chosen, it should be well researched and should include more than just the exam. • While there is discussion about whether to re-instate the AMEC process in Texas, if this Alternative Pathway is to be considered, the workgroup should get a better understanding of why it was initially repealed. • Multiple individuals spoke about various education models including short 4-10 week courses,	

OREGON (60% Agree)

Alternative Pathway

In April of 2024, the Oregon Board of Licensed Social Workers (OBLSW) established the Oregon Alternative Pathways to Social Work Committee. The recommendations made to the OBLSW are as follows:

- Abolish the use of the ASWB exam for all licensure levels.

- Rather than establishing an "alternative pathway," they have recommended that a new path be established that does not involve the use of taking a standardized test at all.

No other publications have been found that identify any additional information about the status of the recommendations or the specific plans for the new pathway to licensure in Oregon.

Workgroup Survey Results

Number of people who AGREE with this Alternative Pathway	Number Workgroup members who DISAGREE with this Alternative Pathway
12	8
Comments Summary:	
• Many people stressed the importance of ensuring that the cost of the process to get licensed does not become an additional barrier for individuals who are financially disadvantaged. • Multiple people spoke of the additional burden that this method may place on the Maryland Board of Social Work Examiners. Individuals also stated that the needs of BSWE needs to be considered no matter which pathway is chosen. • Additional people spoke of the need for addressing the staff needs of the BSWE to fullfill the requirements of any of the pathways chosen. • Many individuals welcome the idea of developing a new, fair, and equitable process. Also individuals spoke of the importance of experience over the exam.	

MICHIGAN (55% Agree)

Alternative Pathway

There are 9 states throughout the country that use a Jurisprudence exam which focuses on las and ethics in addition to the ASWB exam. Michigan is discussing the possibility of replacing the ASWB exam with a Jurisprudence exam.

Workgroup Survey Results

Number of people who AGREE with this Alternative Pathway	Number Workgroup members who DISAGREE with this Alternative Pathway
11	9
Comments Summary:	
• Most of the comments related to this pathway were reiterating their agreement of this pathway. • Many individuals spoke of the importance that the jurisprudence exam should be focused on social work ethics and the laws here in Maryland. • Some individuals stated the importance of coupling a jurisprudence exam with additional supervision if chosen as an alternative pathway. • It was stated that a jurisprudence exam may remove the bias that can be found	

in other exams. • Individuals not in support of this Alternative Pathway are concerned that this type of exam does not assess evidence-based practice standards etc. In addition, the challenges that some individuals may face with standardized testing may still be present with a jurisprudence exam.

MARYLAND BOARD OF SOCIAL WORK EXAMINERS RECOMMENDED CHANGE IN TESTING PROCESS

Change #1:

Reduce the amount of time before an individual can re-take the exam. (the current wait time in Maryland is 90 days)

Workgroup Survey Results

Number of people who AGREE with this recommendation	Number Workgroup members who DISAGREE with this recommendation
18	2
Comments Summary:	
• Access to data that would allow a thorough assessment of the test's fairness would likely reveal that challenges posed by the exam may be more pervasive and impact a broader range of applicants. • An individual should be allowed to retake the exam (at no cost) as soon as they feel ready (and as many times as needed). Eliminate wait time. • The time frame to retake the exam should be reduced from 90 days to 30 days. • ASWB already administers a process to waive the 90-day wait period. • I also believe the retesting fee should be reduced for those who fail by 1-10 points. Since the ASWB exam discards 20 questions, it's possible some are effectively passing but lose needed points due to discarded questions.	

Change #2:

Wave fees for re-testing.

Workgroup Survey Results

Number of people who AGREE with this recommendation	Number Workgroup members who DISAGREE with this recommendation
19	1
Comments Summary:	
• Access to data that would allow a thorough assessment of the test's fairness would likely reveal that challenges posed by the exam may be more pervasive and impact a broader range of applicants. • There should be a one-time fee. There should also be a reduction in the fee for individuals who can demonstrate financial hardship. No retesting fees. • The Maryland licensing board first needs to guide this decision to understand	

impacts on operations from a fee waiver. • If alternative pathways are available, I do not agree with waiving fees. • There should be waived fees if the test taker failed between 1-10 points

Change #3:

Individuals unsuccessful in passing the ASWB exam will only have to re-take the section(s) they did not pass (similar to the Certified Public Accountant Exam)

Workgroup Survey Results

Number of people who AGREE with this recommendation	Number Workgroup members who DISAGREE with this recommendation
19	1
Comments Summary:	
• Access to data that would allow a thorough assessment of the test's fairness would likely reveal that challenges posed by the exam may be more pervasive and impact a broader range of applicants. • Free study materials to assist in retaking the exam should be provided and there should not be an additional cost. • If there is an exam requirement I agree with only retaking the section that was failed • ASWB is already working to modularize the exam. This is not a decision for the Workgroup to make, and it is not up to Maryland if they wanted to make the change. ASWB is committed to reducing barriers to licensure and helping to assure the process is fair and equitable for all. • The Board is concerned that a drastic change to how we assess minimal qualifications for licensing individuals will have an impact on both citizens and those Social Workers who are already licensed through the exam to practice.	

INVESTING IN MARYLAND'S BEHAVIORAL HEALTH TALENT

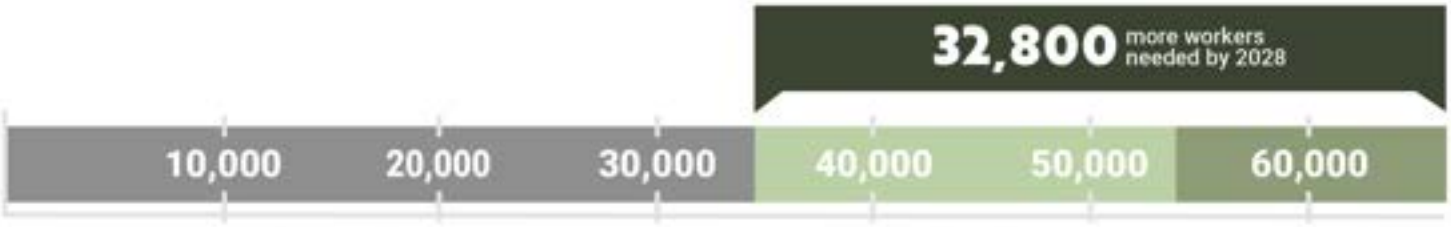
A needs assessment to inform the design of the *Behavioral Health Workforce Investment Fund* established by the Maryland legislature through Senate Bill 283

EXECUTIVE SUMMARY | OCTOBER 2024

MARYLAND Health Care Commission

TRAILHEAD STRATEGIES

HOW MANY MORE BEHAVIORAL HEALTH PROFESSIONALS DOES MARYLAND NEED?



34,600
behavioral health professionals in the current workforce

18,200
more workers needed to meet today's demand

14,600
to replace those leaving the field by 2028

OCCUPATION	ESTIMATED WORKERS IN BH (2023)	NET NEW POSITIONS NEEDED BY 2028	REPLACEMENT WORKERS NEEDED BY 2028	NEW NEEDED BY 2028
Social and Human Services Assistants*	7,583	4,029	4,000	**8,029**
Counselors and Therapists	8,732	5,784	3,748	**9,532**
Psychiatric Aides and Technicians	1,496	938	802	**1,740**
Social Workers in BH Settings	2,799	1,651	1,024	**2,675**
Psychologists (Clinical and Counseling)	1,266	745	315	**1,060**
Psychiatrists	1,196	105	164	**269**
Nursing Assistants	1,094	379	771	**1,150**
Licensed Practical Nurses	339	173	134	**307**
Registered Nurses (Inc. Adv. Practice)	2,126	1,002	590	**1,592**
Nurse Practitioners	313	260	78	**338**
Occupational Therapists	2,747	1,061	779	**1,840**
Rehabilitation Counselors	2,105	602	789	**1,391**
Community Health Workers	2,548	1,322	1,300	**2,622**
Physician's Assistants	269	171	71	**242**
Total	**34,613**	**18,222**	**14,565**	**32,786**

** This is a broad category that includes peer recovery specialists, outreach workers, unlicensed case managers, and other roles that are sometimes referred to as paraprofessionals.*

The **City of Baltimore** employs **more BH professionals** per capita than any Maryland county. **Prince George's, Carroll, Charles, Calvert, Worcester,** and **Queen Anne's** employ the **fewest** professionals per resident.

Most Behavioral Health workers are female, except for psychiatrists.

Black workers are underrepresented among higher paying BH professions including psychiatrists, nurse practitioners, and psychologists, but are **overrepresented among lower paying professions. Hispanic workers are underrepresented** across all professions.

Maryland colleges and universities awarded **fewer** master's degrees in **social work** (-9%), **clinical and counseling psychology** (-30%), and **counseling and therapy** (-10%) in 2022 compared to 2019.

70% masters of social work and clinical and counseling psychology graduates were either **working in other industries** outside of healthcare, **employed out of state,** or **not working** one year after degree completion.

Maryland's two psychiatry residency programs had 27 slots in 2024. While all matched, Maryland ranks **38th out of 50** states in psychiatry resident matches per capita.

HOW CAN A STATEWIDE BEHAVIORAL HEALTH WORKFORCE INVESTMENT FUND HELP?

> The purpose of the Behavioral Health Workforce Investment Fund is to provide reimbursement for costs associated with educating, training, certifying, recruiting, placing, and retaining behavioral health professionals and paraprofessionals.
>
> *Excerpt from Maryland Senate Bill 283*

SETTING OF FOCUS

- Community-based providers
- Federally Qualified Health Centers
- Certified Community Behavioral Health Clinics
- Providers in the crisis care continuum
- Education settings, especially primary and secondary public schools

INVESTMENTS FOR CONSIDERATION	RECOMMENDED AMOUNT	# WORKERS IMPACTED
Certified Peer Recovery Training and Placement Grants	$4.3M	579
Alcohol and Drug Counselor Registered Apprenticeship Program	$10.9M	1,090
Social Worker "Earn and Learn" Residency Program	$21M	750 – 1,250
Maryland Loan Repayment Programs for Social Workers and Professional Counselors	$10M	250
Community Behavioral Health Talent Attraction and Retention Grants*	$50M	2,500 - 5,000
Statewide BH Nursing Apprenticeship Pathway Program	$14.5M	965
Community Psychiatric Mental Health Nurse Practitioner Fellowships	$16.8M	168
Psychiatry Residency and Fellowship Program Expansion	$7.5M	50
Total Direct BH Workforce Program Investments	**$135M**	
Administration (10%)	**$13.5M**	
Total Over 5 Years	**$148.5M**	**6,352 – 9,352**

** Grants to employers in the settings of focus to provide paid internships, expand supervision opportunities, offer retention bonuses, provide scholarships and tuition assistance, implement flexible of hybrid schedules, or make other investments to increase retention.*

An investment of **$59.5M OVER FIVE YEARS** of new money and a commitment to align existing funding streams, state investments, and successful competitive federal grants could be used to reach the recommended amount.

HOW CAN THE FUND FIT INTO A COMPREHENSIVE WORKFORCE STRATEGY?

While the Fund is designed to support **STRATEGY 3** and **STRATEGY 5**, additional policy and practice change is needed to address the workforce crisis long term

1 PROVIDE COMPETITIVE COMPENSATION
More than half of paraprofessionals and many early career social workers and counselors do not make a living wage. After adjusting for cost of living, median salaries are lower in Maryland than in neighboring states for social workers, counselors, psychiatrists, and nurse practitioners. Paying a living wage and keeping pace with other settings and states is foundational.

2 INCREASE AWARENESS OF BEHAVIORAL HEALTH CAREERS
Expand partnerships with public schools to explose more students to behavioral health career pathways through coursework, certification, and apprenticeship programs under the *Blueprint for Maryland's Future*.

3 SUPPORT PAID EDUCATION AND TRAINING
The traditional education model is not working. Expanded opportunities to reduce the financial burden of education and training and help prospective and current BH professionals "Earn and Learn" on their way to certification or licensure is critical.

4 PROMOTE TIMELY AND EFFECTIVE LICENSING
Clear, efficient, and transparent processes to become a licensed social worker, counselor, therapist, and certified peer recovery specialist in Maryland is critical to the overall strategy.

5 INVEST IN JOB QUALITY
45% of BH professionals working today are expected to retire, leave Maryland, or leave the field or their occupation over the next five years. Supporting BH employers in community-based and school settings to offer paid-internships, flexible schedules, tuition assistance programs, and expanded mentorship and supervision are critical to increase retention.

6 EXPAND IMPACT OF CURRENT WORKFORCE
Expanding evidenced-based models, such as the Collaborative Care model (CoCM) where specialty BH providers partner with primary care providers, can help current healthcare workers serve more patients effectively.

Run back to college, if you want to make a livable income, ***don't*** become a social worker.

Licensed Clinical Social Worker

FUND FOCUS

If we don't focus on the staff we have now with the Fund, it will be like pouring water into a cup with leaks in the bottom. It won't work.

BH Policy and Advocacy Leader

ACKNOWLEDGEMENTS

Thank you to the **150 behavioral health frontline providers, employers, educators, and government leaders** *who shared their experiences and perspective during semi-structured interviews and regional input sessions.*

This report was completed by Trailhead Strategies for the Maryland Health Care Commission (MHCC), in coordination with the Maryland Department of Health, the Maryland Department of Labor, and the Maryland Higher Education Commission (MHEC) to help inform the design, financing, and administration of the Behavioral Health Workforce Investment Fund established by Senate Bill 283 (Chapter 287), House Bill 418 (Chapter 286) Mental Health - Workforce Development - Fund Established signed into law in May 2023.

Portions of the report were completed using data from the Maryland Longitudinal Data System (MLDS) Center. We are grateful for the data, technical, and research support provided by the MLDS Center and its agency partners. The views and opinions expressed are those of the authors and do not necessarily represent the views of the MLDS Center or its partner agencies.

Maryland DEPARTMENT OF HEALTH

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Maryland DEPARTMENT OF LABOR

INVESTING IN MARYLAND'S BEHAVIORAL HEALTH TALENT

A needs assessment to inform the design of the *Behavioral Health Workforce Investment Fund* established by the Maryland legislature through Senate Bill 283

FULL REPORT | OCTOBER 2024

MARYLAND Health Care Commission

TRAILHEAD STRATEGIES

ACKNOWLEDGMENTS

Authored by **Andy Hall, Aaron Korn, Kweilin Waller,** and **Josh Shapiro, PhD,** with Trailhead Strategies, a workforce research and consulting firm.

*Thank you to the **150 behavioral health frontline providers, employers, educators, and government leaders** who shared their experiences and perspective during semi-structured interviews and regional input sessions.*

The research team would also like to thank the *Maryland Assembly on School-Based Health Care*, the *Maryland Association of School Health Nurses*, the *Maryland Occupational Therapy Association*, and the *Maryland School Counselor Association* for submitting letters with additional input and information. These letters are included in the appendix.

This report was completed by Trailhead Strategies for the Maryland Health Care Commission (MHCC), in coordination with the Maryland Department of Health, the Maryland Department of Labor, and the Maryland Higher Education Commission (MHEC) to help inform the design, financing, and administration of the Behavioral Health Workforce Investment Fund established by Senate Bill 283 (Chapter 287), House Bill 418 (Chapter 286) *Mental Health - Workforce Development - Fund Established* signed into law in May 2023. This legislation is referred to as Senate Bill 283 or SB 283 throughout the report.

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Maryland DEPARTMENT OF HEALTH

MARYLAND Health Care Commission

Maryland DEPARTMENT OF LABOR

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EXECUTIVE SUMMARY

Maryland is facing a significant behavioral health (BH) workforce shortage. Historical underinvestment in the behavioral health system, increasing rates of mental illness and substance use, and high rates of burnout and attrition has led to a national shortage of peer recovery specialists, addiction counselors, professional counselors, social workers, therapists, nurses and nurse practitioners and psychiatrists.

The workforce shortage is impacting access to care; in 2021, the US Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health estimated that fewer than half of people with a mental illness were able to get timely care.[1] As of December 2023, more than half of the U.S. population lives in a Mental Health Shortage Area (MHPSA), with significant shortages of addiction counselors, therapists, mental health counselors, psychologists, and psychiatrists projected for decades to come.[2] In 2018, more than half of U.S. counties did not have a practicing psychiatrist.[3]

In Maryland, every county except two are designated by the federal government as either a partial or countywide MHPSA.[4] According to the National Alliance on Mental Illness (NAMI), 31% of adults in Maryland that reported symptoms of anxiety or depression did not get the counseling or therapy they needed in 2021. That same year, half of youth aged 12-17 with depression did not receive care.[5] Amidst the worker shortage, the need for mental health and substance use disorder services continues to increase. Unintentional substance use related deaths, for example, have increased steadily since 2009, with a significant jump at the onset of the Covid-19 pandemic.[6]

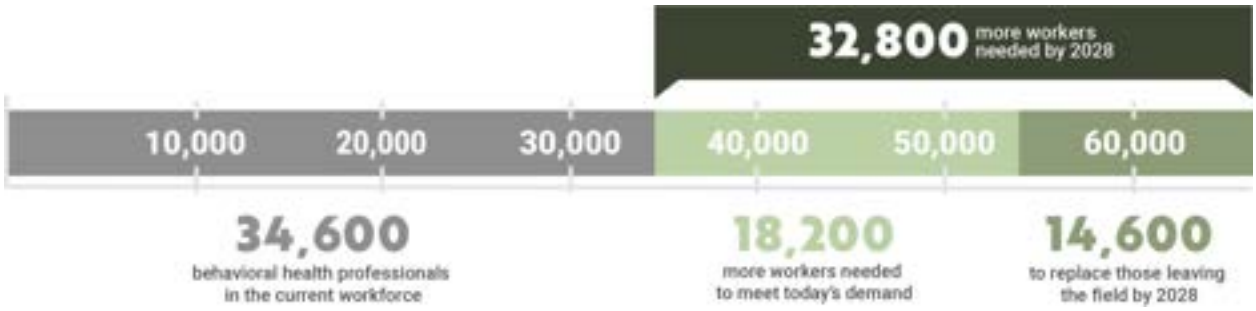
In response, the Maryland legislature passed Senate Bill 283 (SB 283)[7] establishing the Behavioral Health Workforce Investment Fund (the Fund), signed into law in May 2023.

[1] Substance Abuse and Mental Health Services Administration. 2021 NSDUH detailed tables. January 4, 2023. SAMHSA.gov. https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables
[2] National Center for Health Workforce Analysis. Behavioral Health Workforce 2023 Brief. December, 2023. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Brief-2023.pdf
[3] University of Michigan Behavioral Health Workforce Research Center. Estimating the Distribution of the U.S. Psychiatric Subspecialist Workforce. Ann Arbor, MI: UMSPH; 2018
[4] Health Professional Shortage Areas: Mental Health, by County, July 2024-Marland. Rural Health Information Hub. https://www.ruralhealthinfo.org/charts/7?state=MD
[5] Mental Health in Maryland Fact Sheet, 2021. National Alliance on Mental Illness (NAMI). https://www.nami.org/NAMI/media/NAMI-Media/StateFactSheets/MarylandStateFactSheet.pdf
[6] Unintentional Drug-and Alcohol-Related Intoxication Deaths in Maryland, 2022. Preliminary 2022 Data. Maryland Vital Statistics. Maryland Department of Health. https://health.maryland.gov/vsa/Documents/Overdose/Preliminarys/2022_PrelimIntoxReport_20231027.pdf
[7] Senate Bill 283's full citation is SB0283/CH0287, HB0418/CH0286, 2023 - Mental Health - Workforce Development - Fund Established. https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/sb0283/?ys=2023rs

> The purpose of the Behavioral Health Workforce Investment Fund is to provide reimbursement for costs associated with educating, training, certifying, recruiting, placing, and retaining behavioral health professionals and paraprofessionals.
>
> *Excerpt from Maryland Senate Bill 283*

This report was done to inform the establishment of the Fund. Section 1 provides a landscape analysis of the current BH workforce in Maryland, Section 2 estimates the extent of the workforce shortage, and Section 3 examines the supply of BH talent produced by Maryland colleges and universities since 2014. Key findings include:

- In 2023, there were an estimated 34,613 BH professionals across 16 core, nursing, and adjacent BH occupations employed in Maryland, nearly 50% short of the workers needed to meet the BH needs of Maryland's population.
- Maryland BH professionals are not evenly distributed by place, gender, or race and ethnicity.
  - While there are shortages in communities and neighborhoods across the state, the City of Baltimore employs significantly more BH workers per capita than any Maryland county. Counties with the fewest professionals per capita range from highly populated areas (e.g., Prince George's), midsize counties (Carroll, Charles, and Calvert), to less populated counties (Worcester and Queen Anne's).
  - Hispanic or Latinos, who make up 12% of Maryland's population, are underrepresented in the BH workforce overall, every BH occupation statewide, and in every county except Calvert.
  - Black or African American workers make up a higher share of BH professionals in lower paying professions (e.g., peer support professionals, outreach workers, case aides, and psychiatric technicians) compared to the population overall, and are underrepresented in higher paying professions (e.g., psychiatrists, psychologists, and nurse practitioners).
  - Maryland's BH workforce is overwhelmingly female, except for psychiatrists.
- Current trends suggest the workforce shortage will get worse without investments, policy, or practice changes in the State of Maryland.
  - Based on current trends, 45% of BH professionals working today are expected to retire, leave Maryland, or leave the field or their occupation over the next five years. If this attrition rate persists, Maryland will need to attract 30,000 new BH workers to meet unmet need and replace workers leaving the field, roughly the same number currently employed.



- Most of the additional professionals are needed in six core BH occupations, including social and human service assistant roles, counseling and therapy, psychiatric aides and technicians, social workers, psychologists, and psychiatrists.

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**This is a broad category that includes peer recovery specialists, outreach workers, unlicensed case managers, and other roles that are sometimes referred to as paraprofessionals*

- Graduation trends from Maryland colleges and universities suggest the existing education system is struggling to keep pace with the growing demand for BH professionals. Since the onset of the Covid-19 pandemic, degree completions from Maryland master's programs that lead to licensed clinicians have all declined from their 2019 peaks, including social work (-9%), clinical and counseling psychology (-30%), and counseling and therapy (-10%). Addiction studies certificate and associate degrees awarded by community colleges are well below the average

annual job openings for alcohol and drug counselors, and Maryland ranked 37th out of 50 states in psychiatry resident matches per capita in 2024.

- A much smaller number of graduates from BH-related and nursing education programs actually work in jobs in Maryland providing BH services to residents. For example, 70% Masters of Social Work and Clinical and Counseling Psychology graduates from Maryland universities since 2014 were either working in other industries in Maryland, were employed out of state, or not working one year after degree completion.

The second half of the report draws on the findings from quantitative research and input from over 150 frontline professionals, employers, policy leaders, and educators through semi-structured interviews and regional input sessions to recommend a framework for statewide action. Section 4 includes suggested core values – equity, collaborative, and outcomes - and six recommended strategies to address the workforce shortage. Section 5 lays out the recommended size, funding structure, and initial programs of the Behavioral Health Workforce Investment Fund, while Section 6 reviews key implementation considerations for setting up and administering the Fund. The six recommended strategies for an overarching BH workforce initiative in Maryland include:

- STRATEGY 1 – PROVIDE COMPETITIVE COMPENSATION: More than half of paraprofessionals and many early career social workers and counselors do not make a living wage for a single adult in Maryland. After adjusting for cost of living, median salaries are lower than neighboring states in key occupations, including social workers, counselors, psychiatrists, and nurse practitioners. Paying a living wage and keeping pace with other settings and states is foundational.

- STRATEGY 2 – INCREASE AWARENESS OF BEHAVIORAL HEALTH CAREERS: A person cannot aspire to a career they do not know exists. State and local government can expand partnerships with public schools and their career coaches to incorporate career exposure, awareness of career paths, coursework, certification, and apprenticeship opportunities under the *Blueprint for Maryland's Future*.

- STRATEGY 3 – SUPPORT PAID EDUCATION AND TRAINING: The traditional education model is not working. Expanded opportunities to reduce the financial burden and help prospective and current BH professionals "*Earn and Learn*" through apprenticeships, stipends, fellowships, and residency programs on their way to certification or licensure is critical to expanding the size and diversity of the talent pipeline, both for new entrants into BH careers and for existing professionals to advance.

- STRATEGY 4 – PROMOTE TIMELY AND EFFECTIVE LICENSING: Clear, efficient, and transparent processes to become a licensed social worker, counselor, therapist, and certified peer recovery specialist in Maryland is critical to the overall strategy. For example, interviewees shared it can take 6 – 24 months to receive a score on an exam and get a license to practice as a counselor or therapist.

- STRATEGY 5 – INVEST IN JOB QUALITY: 45% of BH professionals working today are expected to retire, leave Maryland, or leave the field or their occupation over the next five years. Supporting BH employers in community-based and school settings to offer paid-internships, flexible schedules, apprenticeships, tuition assistance programs, and expanded mentorship and supervision are critical to increase retention.

> If we don't focus on the staff we have now with the Fund, it will be like pouring water into a cup with leaks in the bottom. It won't work.
>
> *BH Policy and Advocacy Leader*

- STRATEGY 6 – EXPAND IMPACT OF CURRENT WORKFORCE: Expanding evidenced-based models, such as the Collaborative Care model (CoCM) where specialty BH providers partner with primary care providers and exploring how new technologies can help current healthcare workers serve patients more efficiently is critical to meeting population need long-term.

We recommend the Behavioral Health Workforce Investment Fund invest $148.5M over five years to address STRATEGY 3 and STRATEGY 5 of the statewide framework to attract and retain the additional workers needed to close the BH talent gap in eight target occupations. This report outlines eight initial programs for consideration. These programs were identified because they address the major challenges to increasing training enrollment, completion, and employment in BH settings, there is evidence these workforce interventions are working in other states, and/or some form of the program model is currently operating in Maryland and can be expanded.

INVESTMENT FOR CONSIDERATION IMPACT OVER 5-YEAR PERIOD	RECOMMENDED AMOUNT	# WORKERS IMPACTED
Certified Peer Recovery Training and Placement Grants	$4.3M	579
Alcohol and Drug Counselor Registered Apprenticeship Program	$10.9M	1,090
Social Worker "Earn and Learn" Residency Program	$21M	750 – 1,250
Maryland Loan Repayment Programs for Social Workers and Professional Counselors	$10M	250
Community Behavioral Health Talent Attraction and Retention Grants*	$50M	2,500 -5,000 [8]
Statewide BH Nursing Apprenticeship Pathway Program	$14.5M	965
Community Psychiatric Mental Health Nurse Practitioner Fellowships	$16.8M	168
Psychiatry Residency and Fellowship Program Expansion	$7.5M	50
Total Direct BH Workforce Program Investments	**$135M**	
Administration (10%)	**$13.5M**	
Total Over 5 Years	**$148.5M**	6,352 - 9352

** Grants to employers in the settings of focus to provide paid internships, expand supervision opportunities, offer retention bonuses, provide scholarships and tuition assistance, implement flexible of hybrid schedules, or make other investments to increase retention.*

Not all funds need to be "new" money. A downpayment of approximately $59.5M over 5 years of flexible state funds and a commitment to align existing state and federal workforce funding, federal grants, private sources, and recycled revenue from billable patient encounters could get to the full amount recommended. Section 5 details how this could work by program.

This report provides a broad overview of the current state of Maryland's BH workforce, estimates of the shortage, and a recommended framework for a long-term statewide initiative to address the BH workforce shortage. Central to the strategy is a recommendation for a catalytic investment of $60M over five years that attracts a total of $149M through other public and private sources – to expand effective talent development, attraction, and retention models across the State. The goal of these recommendations is to produce and retain sufficient skilled, qualified, diverse, and culturally competent BH professionals available to meet the BH needs of Maryland residents, regardless of their ability to pay.

[8] This investment would result in direct grants to non-profit providers and other employers in high priority settings, including schools, to make talent attraction and retention investments, such as paid internships, high quality supervision and mentorship, retention bonus, or the implementation of flexible or hybrid work schedules, aimed at reducing the time to hire for key roles and increasing retention rates. Depending on the size of the employers and the nature of the investments, we expect the range of BH professionals impacted would be between 5,000 and 10,000 over five years.

HOW MANY MORE BEHAVIORAL HEALTH PROFESSIONALS DOES MARYLAND NEED?

34,600
behavioral health professionals in the current workforce

18,200
more workers needed to meet today's demand

14,600
to replace those leaving the field by 2028

OCCUPATION	ESTIMATED WORKERS IN BH (2023)	NET NEW POSITIONS NEEDED BY 2028	REPLACEMENT WORKERS NEEDED BY 2028	NEW NEEDED BY 2028
Social and Human Services Assistants*	7,583	4,029	4,000	**8,029**
Counselors and Therapists	8,732	5,784	3,748	**9,532**
Psychiatric Aides and Technicians	1,496	938	802	**1,740**
Social Workers in BH Settings	2,799	1,651	1,024	**2,675**
Psychologists (Clinical and Counseling)	1,266	745	315	**1,060**
Psychiatrists	1,196	105	164	**269**
Nursing Assistants	1,094	379	771	**1,150**
Licensed Practical Nurses	339	173	134	**307**
Registered Nurses (Inc. Adv. Practice)	2,126	1,002	590	**1,592**
Nurse Practitioners	313	260	78	**338**
Occupational Therapists	2,747	1,061	779	**1,840**
Rehabilitation Counselors	2,105	602	789	**1,391**
Community Health Workers	2,548	1,322	1,300	**2,622**
Physician's Assistants	269	171	71	**242**
Total	**34,613**	**18,222**	**14,565**	**32,786**

** This is a broad category that includes peer recovery specialists, outreach workers, unlicensed case managers, and other roles that are sometimes referred to as paraprofessionals.*

The **City of Baltimore** employs **more BH professionals** per capita than any Maryland county. **Prince George's, Carroll, Charles, Calvert, Worcester,** and **Queen Anne's** employ the **fewest** professionals per resident.

Most Behavioral Health workers are female, except for psychiatrists.

Black workers are underrepresented among higher paying BH professions including psychiatrists, nurse practitioners, and psychologists, but are **overrepresented among lower paying professions. Hispanic workers are underrepresented** across all professions.

Maryland colleges and universities awarded **fewer** master's degrees in **social work** (-9%), **clinical and counseling psychology** (-30%), and **counseling and therapy** (-10%) in 2022 compared to 2019.

70% masters of social work and clinical and counseling psychology graduates were either **working in other industries** outside of healthcare, **employed out of state,** or **not working** one year after degree completion.

Maryland's two psychiatry residency programs had 27 slots in 2024. While all matched, Maryland ranks **38th out of 50** states in psychiatry resident matches per capita.

HOW CAN A STATEWIDE BEHAVIORAL HEALTH WORKFORCE INVESTMENT FUND HELP?

> The purpose of the Behavioral Health Workforce Investment Fund is to provide reimbursement for costs associated with educating, training, certifying, recruiting, placing, and retaining behavioral health professionals and paraprofessionals.
>
> *Excerpt from Maryland Senate Bill 283*

SETTING OF FOCUS

- Community-based providers
- Federally Qualified Health Centers
- Certified Community Behavioral Health Clinics
- Providers in the crisis care continuum
- Education settings, especially primary and secondary public schools

INVESTMENTS FOR CONSIDERATION	RECOMMENDED AMOUNT	# WORKERS IMPACTED
Certified Peer Recovery Training and Placement Grants	$4.3M	579
Alcohol and Drug Counselor Registered Apprenticeship Program	$10.9M	1,090
Social Worker "Earn and Learn" Residency Program	$21M	750 – 1,250
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Total Direct BH Workforce Program Investments	**$135M**	
Administration (10%)	**$13.5M**	
Total Over 5 Years	**$148.5M**	**6,352 – 9,352**

** Grants to employers in the settings of focus to provide paid internships, expand supervision opportunities, offer retention bonuses, provide scholarships and tuition assistance, implement flexible of hybrid schedules, or make other investments to increase retention.*

An investment of **$59.5M OVER FIVE YEARS** of new money and a commitment to align existing funding streams, state investments, and successful competitive federal grants could be used to reach the recommended amount.

HOW CAN THE FUND FIT INTO A COMPREHENSIVE WORKFORCE STRATEGY?

While the Fund is designed to support **STRATEGY 3** and **STRATEGY 5**, additional policy and practice change is needed to address the workforce crisis long term

1 PROVIDE COMPETITIVE COMPENSATION
More than half of paraprofessionals and many early career social workers and counselors do not make a living wage. After adjusting for cost of living, median salaries are lower in Maryland than in neighboring states for social workers, counselors, psychiatrists, and nurse practitioners. Paying a living wage and keeping pace with other settings and states is foundational.

2 INCREASE AWARENESS OF BEHAVIORAL HEALTH CAREERS
Expand partnerships with public schools to explose more students to behavioral health career pathways through coursework, certification, and apprenticeship programs under the *Blueprint for Maryland's Future*.

3 SUPPORT PAID EDUCATION AND TRAINING
The traditional education model is not working. Expanded opportunities to reduce the financial burden of education and training and help prospective and current BH professionals "Earn and Learn" on their way to certification or licensure is critical.

4 PROMOTE TIMELY AND EFFECTIVE LICENSING
Clear, efficient, and transparent processes to become a licensed social worker, counselor, therapist, and certified peer recovery specialist in Maryland is critical to the overall strategy.

5 INVEST IN JOB QUALITY
45% of BH professionals working today are expected to retire, leave Maryland, or leave the field or their occupation over the next five years. Supporting BH employers in community-based and school settings to offer paid-internships, flexible schedules, tuition assistance programs, and expanded mentorship and supervision are critical to increase retention.

6 EXPAND IMPACT OF CURRENT WORKFORCE
Expanding evidenced-based models, such as the Collaborative Care model (CoCM) where specialty BH providers partner with primary care providers, can help current healthcare workers serve more patients effectively.

Run back to college, if you want to make a livable income, ***don't*** become a social worker.

Licensed Clinical Social Worker

FUND FOCUS

If we don't focus on the staff we have now with the Fund, it will be like pouring water into a cup with leaks in the bottom. It won't work.

BH Policy and Advocacy Leader

ACKNOWLEDGEMENTS

Thank you to the **150 behavioral health frontline providers, employers, educators, and government leaders** *who shared their experiences and perspective during semi-structured interviews and regional input sessions.*

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Portions of the report were completed using data from the Maryland Longitudinal Data System (MLDS) Center. We are grateful for the data, technical, and research support provided by the MLDS Center and its agency partners. The views and opinions expressed are those of the authors and do not necessarily represent the views of the MLDS Center or its partner agencies.

Maryland DEPARTMENT OF HEALTH

MARYLAND Health Care Commission

Maryland DEPARTMENT OF LABOR

SECTION 1: OVERVIEW OF MARYLAND'S BEHAVIORAL HEALTH WORKFORCE

The growing need for behavioral health (BH) services in the United States – that is, treatment and care related to mental health, substance use disorders, or co-occurring illnesses – has been well documented. Nationally, two out of five adults report symptoms of anxiety or depression, alcohol and drug induced deaths are at record highs and 90% of American adults believe the country is facing a mental health crisis.[9] While 18% of US adults reported a substance use disorder in the past year, most did not receive treatment.[10]

Maryland, like the US, has a growing need for BH treatment. According to the National Alliance on Mental Illness, 781,000 adults had a mental health condition in 2022, and nearly half of Maryland residents aged 12-17 who had depression did not receive care.[11] Unintentional substance use related deaths have also increased steadily since 2009, with a significant jump at the onset of the Covid-19 pandemic.[12]

A shortage of available BH professionals, both nationally and in the State of Maryland, is one of several challenges public leaders face in addressing this pressing public health issue. In Maryland, Senate Bill 283 was signed into law in May 2023 to help address the workforce shortage by establishing a Behavioral Health Workforce Investment Fund (the Fund).

> *The goal of the fund, as described in the legislation, is to* ***"provide reimbursement for costs associated with educating, training, certifying, recruiting, placing, and retaining behavioral health professionals and paraprofessionals."***

The first step in designing such a fund is to establish a foundational understanding of the current professionals in Maryland who are working to meet the BH needs of Maryland residents. This section provides an overview of the occupations, employment estimates, and demographics of Maryland's current BH workforce. The data in this section will serve as a baseline for the estimates of the workforce shortage and the size and focus areas of the Fund found in later sections. Key findings and insights include:

[9] Panchal et al. The Implications of Covid-19 for Menal Health and Substance Use. Kaiser Family Foundation. March 20, 2023. https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/
[10] Reinert, M, Fritze, D & Nguyen, T. The State of Mental Health in America 2024. Mental Health America, Alexandria VA. July 2024
[11] National Alliance on Mental Illness, Maryland State Fact Sheet. National Alliance on Mental Illness. https://www.nami.org/NAMI/media/NAMI-Media/StateFactSheets/MarylandStateFactSheet.pdf
[12] Unintentional Drug-and Alcohol-Related Intoxication Deaths in Maryland, 2022: Preliminary 2022 Data. Maryland Vital Statistics. Maryland Department of Health. November 2023. https://health.maryland.gov/vsa/Documents/Overdose/Preliminarys/2022_PrelimIntoxReport_20231027.pdf

- In 2023, there were an estimated 34,613 BH professionals across 16 frontline occupations employed in Maryland.
- The largest occupations by number of workers were counselors and therapists (8,732), social and human service assistants which include peer recovery specialists, outreach workers, unlicensed case workers, and a range of other paraprofessional job titles (7,583) and social workers employed in BH settings (2,799).
- Top growing occupations include nurse practitioners, counselors and therapists, and psychiatric technicians.
- Nearly 10% of the total BH workforce needs to be replaced each year due to retirements, those leaving the field, and professionals leaving the state, with significant variation by occupation.
- The City of Baltimore has the largest concentration of BH professionals overall and per capita. Talbot, Dorchester, Kent, and Allegany also rank highly in workers per 30,000 residents, although not in every occupation.
- The counties of Queen Anne's, Calvert, Charles, Worcester, Carroll, and Prince George's have the fewest professionals per resident.
- Most BH workers are female, except for psychiatrists (38.5%).
- Hispanic or Latino workers are underrepresented relative to the population in every BH occupation statewide, every county except one, and the City of Baltimore.
- Black or African American workers were overrepresented in lower paying BH occupations and underrepresented in higher paying occupations relative to the population of Maryland overall.
- Most psychiatrists, nurse practitioners, and psychologists are White or Asian.

1.1: Employment Estimates Approach and Methodology

Sections one and two of this report examine 16 frontline BH occupations critical to delivering substance use disorder and mental health services and treatment. Estimates and analysis are focused on professionals providing clinical services, not necessarily the number of people with a specific license. For example, if an individual has an active license to practice clinical social work (e.g., a Licensed Clinical Social Worker) but the individual is at a university and their primary job functions do not include providing clinical services, that person would not be included in our estimates.

Employment estimates are based on the number of people providing direct patient care employed in Maryland. Because of this, estimates may differ from the number of active licenses in some professions.

This report used Standard Occupational Classification (SOC) codes and corresponding occupation titles and descriptions to generate estimates of employment figures, wages, demographics, replacement rates, and growth rates based on US Census, US Bureau of Labor Statistics, Maryland job posting data analyzed by Lightcast[13], a labor market analytics company, and the American Medical Association Physician Masterfile.

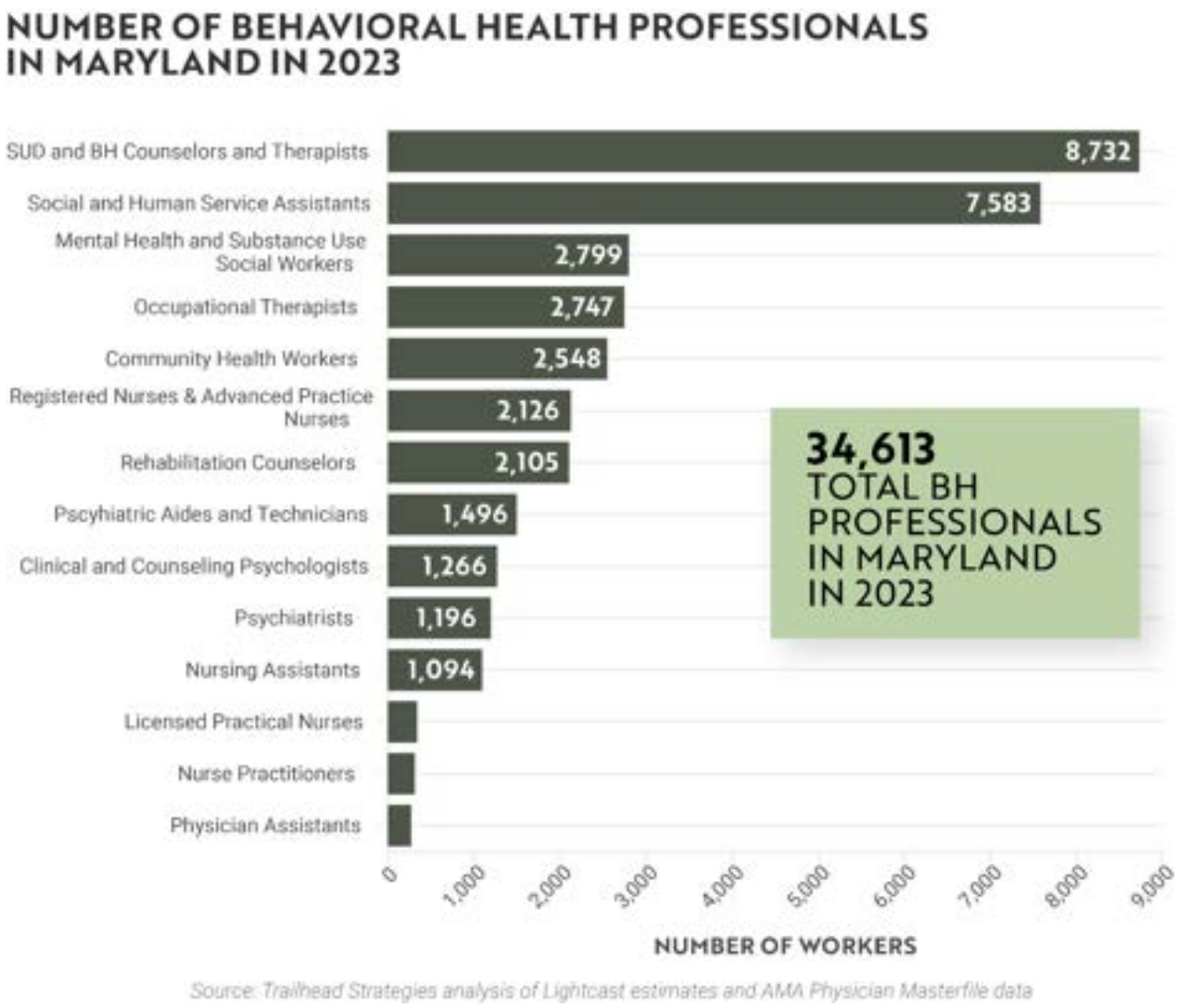
Figure 1: Data Sources Used to Produce Employment Estimates

Some occupations included have commonly understood boundaries (e.g., *psychiatrists*). Other occupational categories cover a broad range of jobs titles and responsibilities (e.g., *Social and Human Service Assistants)* is a broad category that includes case aides, outreach workers, crisis line specialists, and peer recovery specialists.

Other occupations may or may not work in BH settings (e.g., *registered nurses*) and separate estimates to isolate professionals in these occupations that are working in BH settings in Maryland are not available in the data sources used. In these cases, this report uses national level estimates of the number of these professionals working in BH settings. Specifically, this report assumes that 4% of registered nurses work in BH settings[14], and 6.8% of nurse practitioners (NPs) and physician's assistants (PAs)[15] work in BH settings.

Figure 2: Maryland BH Employment Estimates by Occupation, 2023

[13] Job Posting Analytics (JPA) Methodology, Lightcast. July 2024, https://kb.lightcast.io/en/articles/6957446-job-posting-analytics-jpa-methodology
[14] Phoenix BJ. The Current Psychiatric Mental Health Registered Nurse Workforce. Journal of the American Psychiatric Nurses Association. 2019;25(1):38-48. Doi: https://doi.org/10.1177/1078390318810417
[15] Spetz, J., Hailer, L., Gay, C., Tierney, M., Schmidt, L. A., Phoenix, B., & Chapman, S. A. (2022). Buprenorphine treatment: Advanced practice nurses add capacity. Health Affairs, 41(9), 1231-1237. Doi: https://doi.org/10.1377/hlthaff.2022.00310



Occupations included in this workforce assessment are grouped into three categories: core BH occupations, nurses working in BH, and adjacent roles. The table below also includes common job titles from Maryland employers based on public job posting data for less commonly understood categories.

Figure 3: BH Occupations and Common Job Titles

	SOC CODE(S)	**TITLE** (COMMON JOB TITLES)	**ESTIMATED WORKERS (2023)**
Core	21-1093	Social and Human Services Assistants Community Support Specialist, Peer Support Specialist, Outreach Worker, Social Service Coordinator, Case Aide, Case Worker	7,583
	21-1011	Counselors and Therapists in BH settings	8,732[16]

[16] While data limitations make it difficult to estimate the specific number of Professional Counselors, Alcohol and Drug Counselors, and Marriage and Family Therapists employed in Maryland, the most recent active licensure data from 2021 from the Maryland State Board of Professional Counselors and Therapists show 8,793 total active licenses. This total includes Professional Counselors (6,081), Alcohol and

	21-1013	Addiction Counselor, Substance Use Disorder Counselor, Behavioral Health Counselor, Mental Health Counselor, Professional Counselor, Licensed Counselor, Behavioral Therapist, Clinical Therapists	
	31-1133 29-2053	Psychiatric Aides and Technicians Behavioral Health Technician, Autism Behavior Technician, Psychiatric Technician, Registered Behavioral Technician / ABA	1,496
	21-1023	Social Workers in BH Settings Case Manager, Clinical Social Worker, Licensed Clinical Social Worker, Clinician	2,799
	19-3033	Psychologists (Clinical and Counseling)	1,266
	29-1223	Psychiatrists	1,196[17]
Nursing in BH	31-1131	Nursing Assistants	1,094
	29-2061	Licensed Practical Nurses	339
	29-1141	Registered Nurses (Including Advanced Practice Nurses)	2,126
	29-1171	Nurse Practitioners	313
Adjacent	29-1122	Occupational Therapists	2,747
	21-1015	Rehabilitation Counselors	2,105
	21-1094	Community Health Workers	2,548
	29-1071	Physician's Assistants	269
Total			34,613

1.2: Growth and Replacement Rates

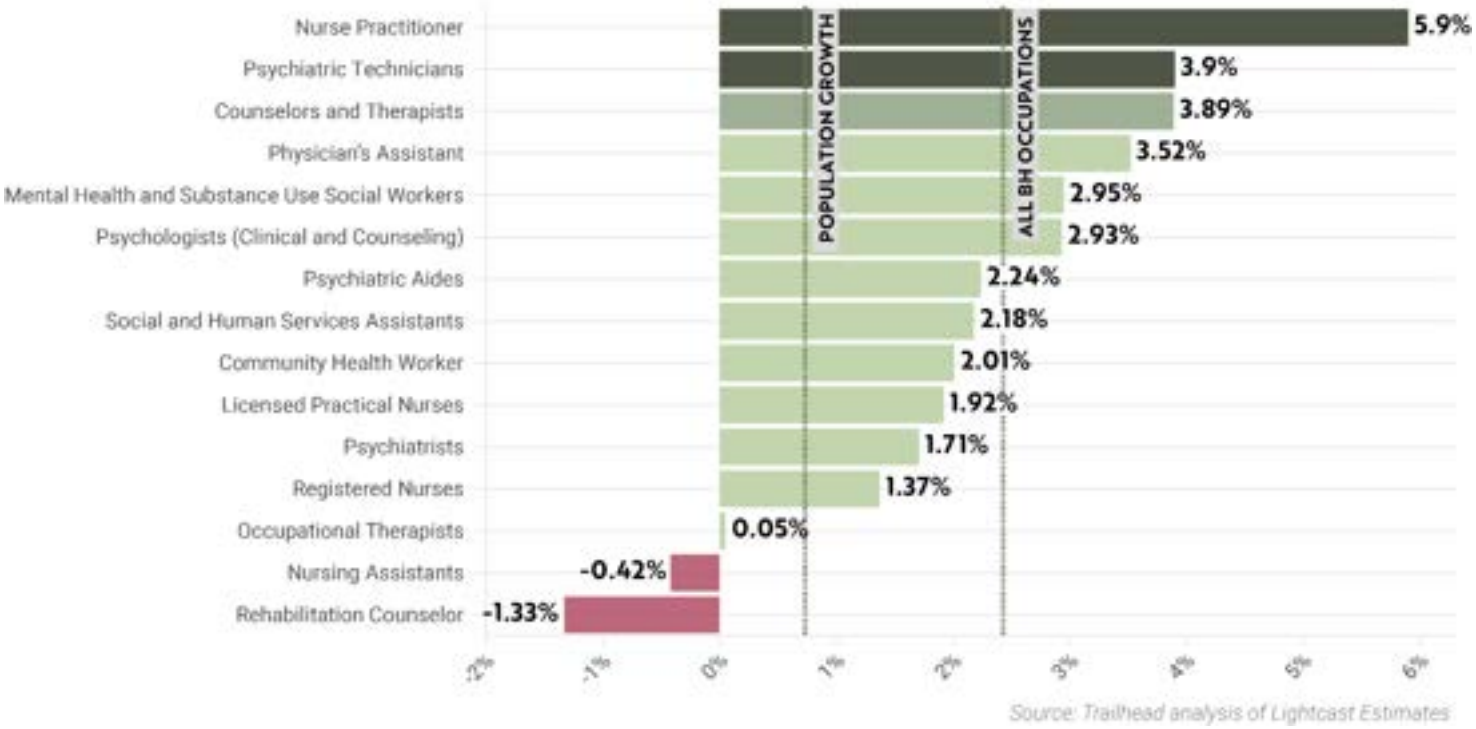
This section provides estimates of the annual growth and replacement rates (e.g., how many professionals retire, leave the occupation, or leave Maryland) every year for each occupation of interest in the State of Maryland. This is useful to understand how staffing patterns are changing in the BH workforce and how many annual openings are expected in the years ahead.

The fastest growing occupations from 2022 to 2023 were nurse practitioners (+6%), psychiatric technicians (+4%), and counselors and therapists (+4). Nursing assistants (-0.42%) and rehabilitation counselors (-1.33%) were the only occupations that had fewer workers employed in Maryland in 2023 compared to 2022.

Drug Counselors (2,348) and Marriage and Family Therapists (354). 2021 active license data is based on most recent available data from the Maryland State Board of Professional Counselors and Therapists accessed on May 15, 2024 https://health.maryland.gov/bopc/pdfs/bopct22annualreport.pdf.

[17] The HRSA Area Health Resource File (AHRF) shows 1,196 Psychiatrists are working in the State of Maryland in 2022 – 2023, based on the AMA Physician Masterfile using 2021 data, the most recent available. The research team opted to use the AMA Physician Masterfile count for psychiatrists. Lightcast estimated 685 psychiatrists employed in Maryland as of January 2024 based on the BLS and analysis of Maryland job posting data. This difference is likely related Lightcast's data sources undercounting self-employment psychiatrists. Lightcast also does not include psychiatrists who do not provide clinical services as their primary job function (e.g., a psychiatrist working in healthcare administration is not included). For a full methodology, please see https://kb.lightcast.io/en/articles/7198481-us-united-states-methodology.

Figure 4: Annual BH Employment Growth in Maryland, 2022 to 2023



In addition to occupational growth rates, Figure 5 shows occupational replacement rates in Maryland – the annual percentage of the workforce that is expected to retire, leave their occupation, or leave the state each year. Replacement rates are lower than turnover rates because they do not include workers who move from one employer to another while staying in the same occupation. In general, lower paid professions with fewer education and licensure requirements have higher replacement rates, as workers in these occupations are more likely to transition to other jobs in health and human services or to other industries (e.g., retail, food service) that pay similar wages.

Using employment and annual growth estimates with replacement rates, Figure 5 provides an estimated number of annual job openings for each occupation of interest.

Figure 5: Estimated Annual Openings for BH Professions in Maryland, 2023

OCCUPATION	2023 JOBS	ANNUAL GROWTH RATE	NEW JOBS	REPLACEMENT RATE	REPLACEMENT JOBS	ANNUAL JOB OPENINGS
Counselors and Therapists	8,732	3.9%	341	8.2%	716	1,057
Social and Human Services Assistants	7,583	2.2%	165	10.1%	766	931
Community Health Worker	2,548	2.0%	51	9.8%	250	301
Social Workers (in BH settings)	2,799	3.0%	83	6.9%	193	276
Occupational Therapists	2,747	0.05%	2	5.39%	148	150
Rehabilitation Counselor	2,105	-1.3%	-28	7.7%	162	134
Nursing Assistants (in BH settings)	1,094	-0.4%	-5	14.2%	155	151
Psychiatric Technicians	1,051	3.9%	41	8.1%	85	126
Registered Nurses (in BH settings)	2,126	1.4%	29	5.4%	115	144
Psychologists (Clinical and Counseling)	1,266	2.9%	37	4.7%	60	97
Psychiatric Aides	445	2.2%	10	14.7%	65	75
Nurse Practitioner (in BH settings)	313	5.9%	18	4.4%	14	32
Psychiatrists	1,196	1.7%	20	2.6%	31	51
Licensed Practical Nurses (in BH settings)	339	1.9%	7	7.6%	26	32
Physician's Assistant (in BH settings)	269	3.5%	9	4.9%	13	23
Total	34,613		780		2,799	3,580

Overall, there were an estimated 3,580 annual job openings for BH professionals in 2023, with the majority of job openings replacing professionals leaving the field or retiring (2,799 of 3,580 openings). The most annual job openings in Maryland's BH workforce are for counselors and therapists (1,057), followed by social and human services assistance positions (931), a broad category that includes unlicensed case workers, outreach workers, crisis line workers, and peer support specialists.

1.3: Counties and City of Baltimore Employment Estimates

BH professionals working across Maryland are not evenly distributed geographically. The City of Baltimore – home to The John Hopkins Hospital, other hospitals that serve the entire state, and a network of providers and related outpatient services – has the highest density of BH professionals per population by a wide margin. Other highly ranked counties when considering all BH core, adjacent, and nursing occupations include the rural counties of Talbot, Dorchester, Kent, and Allegany, and densely populated Baltimore and Montgomery counties. The midsize counties of Wicomico, Washington, and Howard round out the top 10 local jurisdictions of total BH professionals per 30,000 residents.

Figure 6: Maryland BH Professionals Per Capita by County, 2023

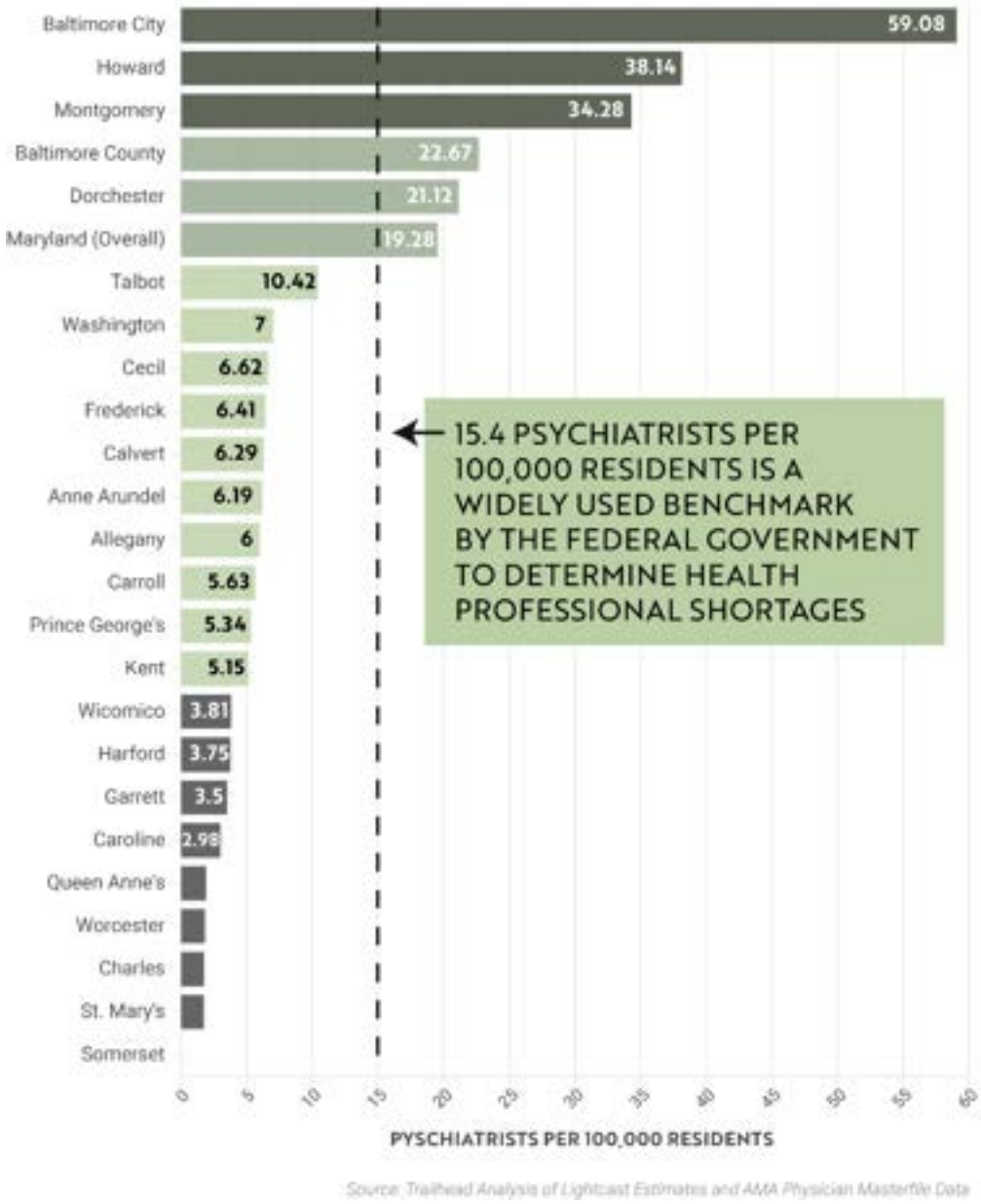
BHA REGION	JURISDICTION	2023 POPULATION	BH PROVIDERS PER 30,000 PEOPLE	RANK
Central	Baltimore City	563,687	363.4	1
Eastern	Talbot	38,402	292.1	2
Western	Allegany	66,676	247.7	3
Eastern	Dorchester	33,137	234.6	4
Eastern	Kent	19,428	227.8	5
Eastern	Wicomico	105,090	225.6	6
Western	Washington	157,205	219.5	7
Central	Baltimore County	851,159	193.0	8
Southern	Montgomery	1,053,094	167.9	9
Central	Howard	338,242	158.6	10
Central	Anne Arundel	598,201	148.4	11
Southern	St. Mary's	115,538	143.9	12
Eastern	Somerset	24,448	140.6	13
Western	Garrett	28,558	124.2	14
Eastern	Cecil	105,793	119.2	15
Central	Harford	266,656	110.8	16
Eastern	Caroline	33,564	110.4	17
Western	Frederick	296,364	110.3	18
Southern	Prince George's	954,320	104.8	19
Western	Carroll	177,618	101.7	20
Eastern	Worcester	54,622	96.3	21
Southern	Charles	172,319	85.4	22
Southern	Calvert	95,449	78.2	23
Eastern	Queen Anne's	52,323	76.0	24

In 1980, a Department of Health and Human Services (DHHS) report estimated 15.4 psychiatrists were needed for every 100,000 residents in a given jurisdiction based on prevalence of mental illness and the estimated annual provider time required per patient.[18] While other studies have suggested a higher ratio may be needed, including a 2009 report that used National Comorbidity Survey Replication data estimating 25.9 psychiatrists are needed per 100,000 adults[19], the 15.4 metric is widely used and referenced across the US.

[18] Marshall EC. Report of the Graduate Medical Education National Advisory Committee to the secretary. J Am Optom Assoc. 1982 Aug;53(8):623-6. PMID: 7130602.
[19] Thomas KC, Ellis AR, Konrad TR, Holzer CE, Morrissey JP. County-level estimates of mental health professional shortage in the United States. Psychiatry Serv. 2009 Oct;60(10):1323-8. doi: 10.1176/ps.2009.60.10.1323. PMID: 19797371.

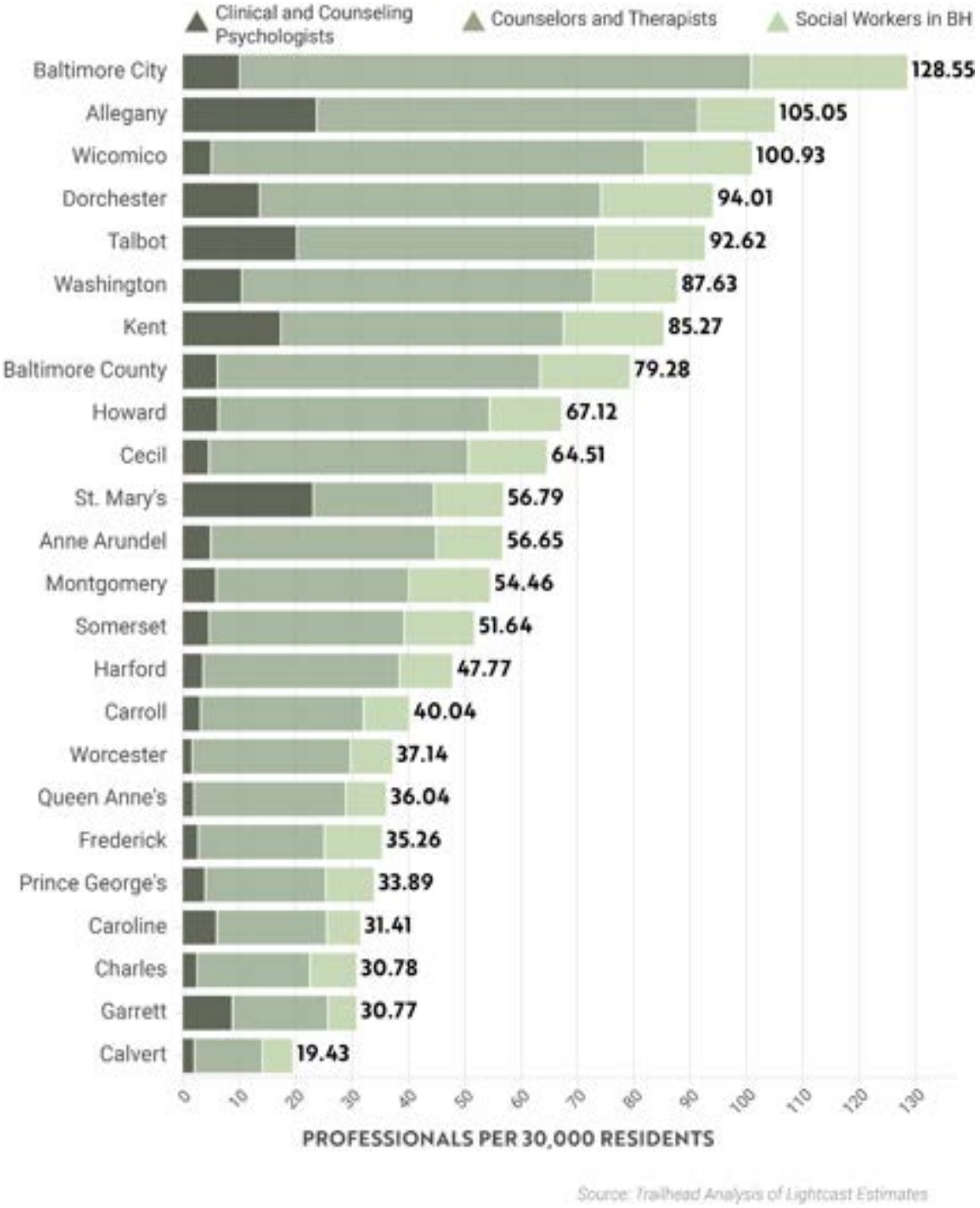
In Maryland, there are currently 1,196 psychiatrists, or 19.3 per 100,000 residents. This is higher than the 15.4 benchmark used by the Department of Health and Human Services (DHHS). However, only Baltimore City, Montgomery County, Howard County, Baltimore County, and Dorchester County are above this benchmark at the local level. Somerset has no psychiatrists, while Charles, St. Mary's Worcester, and Queen Anne's counties have less than two per 100,000 residents.

Figure 7: Psychiatrists Per 100,000 Residents, 2023



Like every BH profession, the City of Baltimore has the most social workers, and counselors and therapists employed in BH settings per resident. Rural counties including Allegany, Wicomico, Dorchester, and Talbot also rank in the top five counties in per capita clinical and counseling psychologists, counselors and therapists, and social workers combined. Counties in the bottom five for these professionals include large population centers (Prince George's County), midsize counties (Charles and Calvert), and rural counties in both eastern (Caroline County) and western (Garret County) Maryland. Each occupation's employment estimates by county can be found in *Appendix A*.

Figure 8: Counselors, Therapists, Psychologists, and Social Workers Employment Estimates By County, 2023



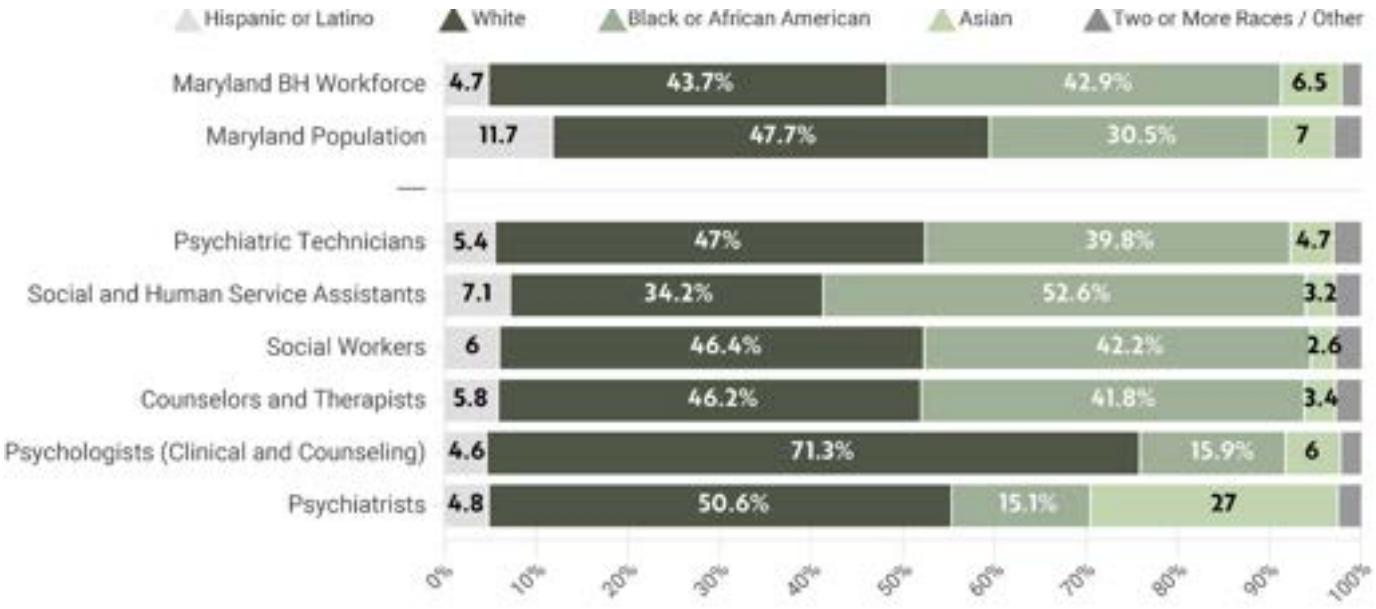
1.4: Race and Ethnicity of Maryland's Behavioral Health Workforce

When healthcare providers lack cultural competency or do not represent the diversity of a given patient population, there can be negative impacts on patient outcomes, access to care, and patient trust. For example, a significant number of White medical students and residents reported biased views and false beliefs about race-based pain perceptions, which were shown to affect their treatment recommendations[20]. For many decades, large health-systems, government, and patient advocacy groups have been calling for greater cultural competency of healthcare providers – sometimes broken down into cultural awareness, cultural knowledge, and cultural skills[21]. This section provides an overview of the BH workforce by race/ethnicity in 2023. Key findings include:

- Hispanic or Latino workers are underrepresented in the BH workforce in Maryland overall and within every individual occupation. Hispanic/Latinos make up 11.7% of the Maryland population overall, but only 4.7% of the BH workforce.
- Statewide, Black or African American workers are overrepresented in lower paying jobs, most notably social and human service assistants (52.6%) and underrepresented in higher paying jobs, including psychologists and psychiatrists.
- White and Asian workers represent a much larger share of the workers employed as psychiatrists (78%) and psychologists (77%) than their share of the BH workforce (50%) and Maryland population overall (55%).

[20] Hoffman KM, Trawalter S, Axt JR, Oliver MN. Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. Proc Natl Acad Sci U S A. 2016 Apr 19;113(16):4296-301. doi: 10.1073/pnas.1516047113. Epub 2016 Apr 4. PMID: 27044069; PMCID: PMC4843483.
[21] Anand R. & Lahiri I. (2009) Intercultural competence in healthcare developing skills for interculturally competent care. In: D.K. Deardoff (Ed.) The Handbook of Intercultural Competence, pp. 387–402. Sage, Newbury Park.

Figure 9: Race/Ethnicity of Maryland BH Workforce, 2023



Source: Trailhead Analysis of Census Bureau and BLS Occupational Estimates Accessed through Lightcast

When looking at the race/ethnicity at the local level, the following insights stand out:

- Hispanic or Latino workers represent a smaller percentage of the BH workforce than the population overall in every jurisdiction, except for Calvert County. Montgomery and Prince George's counties, the two most populated local jurisdictions, have the highest underrepresentation of Hispanic or Latino workers. 10% of the BH workforce is Hispanic or Latino in Montgomery County, compared to 21% of the population overall. Prince George's County BH workforce is 7% Hispanic or Latino, compared to 21% of its residents.
- Black or African American BH professionals are overrepresented in the BH workforce overall in every jurisdiction except the City of Baltimore, Charles County and Prince George's County, mostly driven by overrepresentation in social and human service assistant occupations that include peers, outreach workers, navigators, case aides, and other unlicensed paraprofessional roles that make up a significant portion of the BH workforce. Black or African American professionals represent a smaller share of psychiatrists than the population overall in every jurisdiction.
- White workers represent a smaller share of the BH workforce than the population overall in every jurisdiction except Baltimore City, Charles County, Prince George's County, and Hartford County, mostly driven by smaller share of White workers employed in lower paying social and human service assistance occupations, nursing assistant and practical nursing roles, and psychiatric aid and technician occupations.

- Asian BH professionals represent a higher share of psychiatrists than the population overall in every jurisdiction. In Montgomery County where Asian residents make up 16% of the population, Asians are significantly underrepresented in social work, counseling, and therapy occupations.

Race and ethnicity of the workforce for each occupation by county and the City of Baltimore can be found in Appendix C.

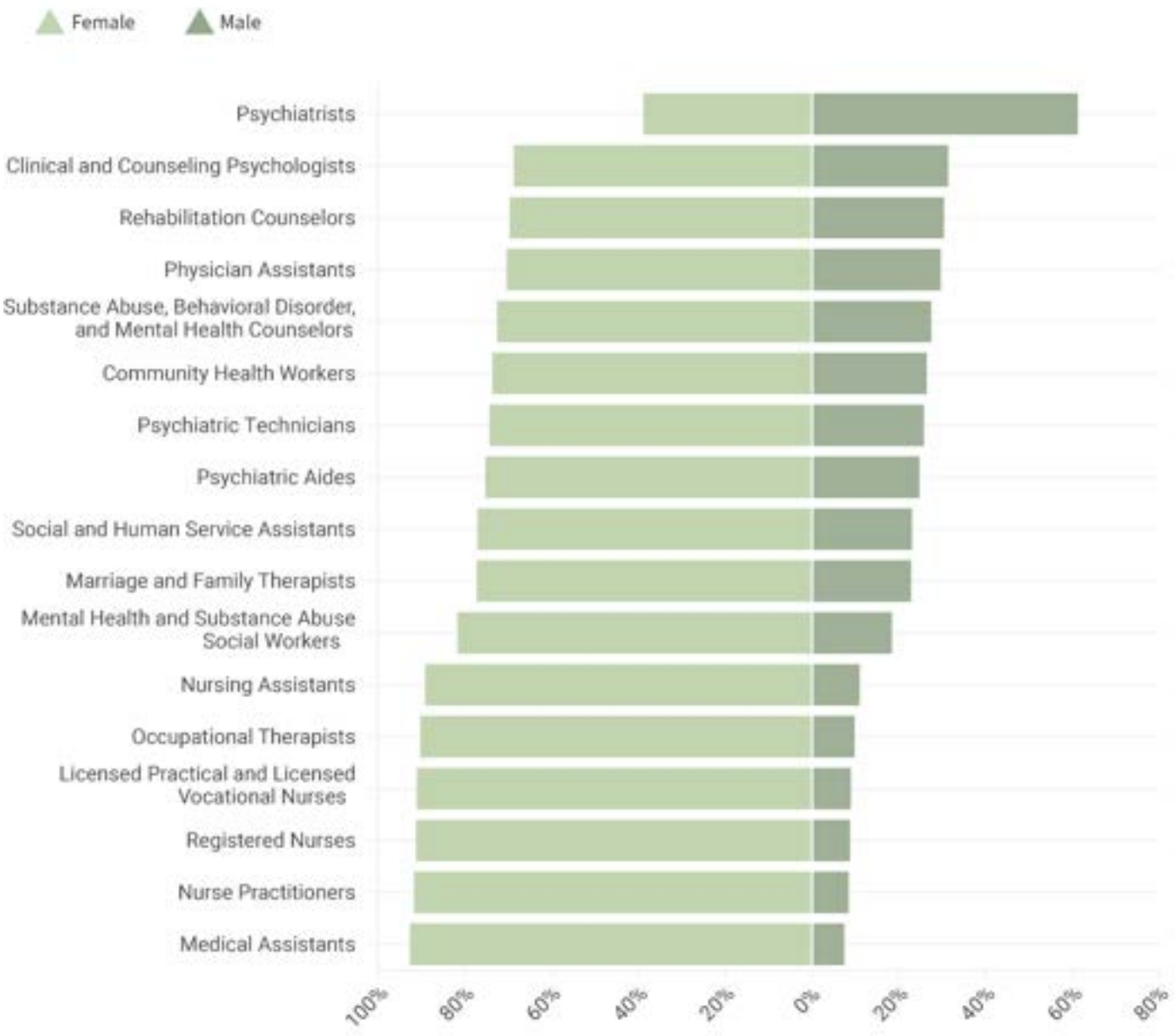
1.5: Gender of Maryland's Behavioral Health Workforce

The Maryland BH workforce is overwhelmingly female, except for psychiatrists. These trends mirror the healthcare workforce nationally: the National Institutes of Health estimates that 76% of the healthcare workforce is female[22], while a John Hopkins study published in the National Library of Medicine estimates 38.5% of practicing psychiatrists are female[23]. There were no noticeable differences across regions (not shown).

[22] U.S. Department of Health and Human Services. Health Resources and Services Administration. National Center for Health Workforce Analysis. Sex, Race, and Ethnic Diversity of U.S. Health Occupations (2011–2015) 2017. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/diversity-us-health-occupations.pdf.

[23] Wyse R, Hwang WT, Ahmed AA, Richards E, Deville C Jr. Diversity by Race, Ethnicity, and Sex within the US Psychiatry Physician Workforce. Acad Psychiatry. 2020 Oct;44(5):523-530. doi: 10.1007/s40596-020-01276-z. Epub 2020 Jul 23. PMID: 32705570.

Figure 10: 2023 Maryland BH Workforce by Gender



Source: Trailhead Analysis of Lightcast Estimates

There is evidence of occupational segregation – the systemic overrepresentation or underrepresentation of a demographic group in a particular occupation or field of employment – in Maryland's BH workforce. Like national trends in the workforce more generally, women of color in Maryland's BH workforce are disproportionately working in jobs that often do not pay family-sustaining wages, offer fewer benefits, and are often viewed as lower quality jobs compared to other BH professions in the region.

SECTION 2: ESTIMATING THE WORKFORCE SHORTAGE IN THE STATE OF MARYLAND

Historical underinvestment in BH by public insurance programs, private insurers and employers, increasing rates of mental illness and substance use in the US, and high rates of attrition in key BH jobs has led to a national shortage of BH workers. The workforce shortage is impacting access to timely care. In 2021, Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH) estimated that fewer than half of people experiencing a mental illness were able to get timely care[24]. As of December 2023, more than half of the US population lives in a Mental Health Professional Shortage Area, with significant shortages of addiction counselors, therapists, mental health counselors, psychologists, and psychiatrists projected[25]. The shortage has been impacting care well before the Covid-19 pandemic magnified the challenge. In 2018, more than half of US counties did not have a practicing psychiatrist[26].

In Maryland, every county except Montgomery and Howard is designated as either a partial or countywide Mental Health Professional Shortage area, with significant shortages in western Maryland, the Eastern Shore, and Calvert, Charles, and St. Mary's counties[27]. According to the National Alliance on Mental Illness (NAMI) Maryland, 31% of adults in Maryland that reported symptoms of anxiety or depression did not get the counseling or therapy they needed in 2021. That same year, nearly half of youth aged 12-17 who experienced depression did not receive care.[28]

While *Section 1* estimated 34,613 BH professionals were working with patients in Maryland in private and public clinical settings in 2023, this section estimates the extent of the shortage in Maryland, both today and over the next five years. Key findings include:

- In 2023, the Maryland workforce was 17,161 workers short of what is needed to meet unmet need for BH services, more than 50% of the size of the current workforce.
- By the end of 2028, 14,565 BH professionals are expected to leave Maryland, retire, or leave their occupation and will need to be replaced.

[24] Substance Abuse and Mental Health Services Administration. 2021 NSDUH detailed tables. January 4, 2023. SAMHSA.gov. https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables
[25] National Center for Health Workforce Analysis. Behavioral Health Workforce 2023 Brief. December, 2023. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Brief-2023.pdf
[26] University of Michigan Behavioral Health Workforce Research Center. Estimating the Distribution of the U.S. Psychiatric Subspecialist Workforce. Ann Arbor, MI: UMSPH. 2018
[27] Health Professional Shortage Areas: Mental Health, by County, July 2024-Marland. Rural Health Information Hub. https://www.ruralhealthinfo.org/charts/7?state=MD
[28] Mental Health in Maryland Fact Sheet, 2021. National Alliance on Mental Illness (NAMI). https://www.nami.org/NAMI/media/NAMI-Media/StateFactSheets/MarylandStateFactSheet.pdf

- Over the next five years, Maryland needs to attract and/or retain 32,786 BH workers to meet unmet need in the state, roughly the same number currently employed.
- This includes 23,467 workers in core BH occupations, including paraprofessionals (8,029), therapists and counselors (9,532), social workers in BH settings (2,675), psychiatric aides and technicians (1,740), psychologists (1,060), and psychiatrists (431).

2.1: Approach to Estimating the Shortage

We estimate the shortage by occupation through three major research questions.

Figure 11: Research questions to estimate the BH workforce shortage in Maryland

STEP 1: HOW MANY WORKERS ARE EMPLOYED TODAY?

The first step in estimating the number of professionals needed is to establish how many workers are employed today in relevant occupations. As described in Section 1, there were an estimated 34,613 behavioral health professionals working in core, nursing, and adjacent occupations in BH settings in 2023.

Figure 12: BH Professionals Working in Maryland, 2023

	TITLE	ESTIMATED WORKERS (2023)
Core	Social and Human Services Assistants	7,583
	Counselors and Therapists in BH settings	8,732
	Psychiatric Aides and Technicians	1,496
	Social Workers in BH Settings	2,799
	Psychologists (Clinical and Counseling)	1,266
	Psychiatrists	1,196
Nursing Pathway	Nursing Assistants	1,094
	Licensed Practical Nurses	339
	Registered Nurses (Including Advanced Practice Nurses)	2,126
	Nurse Practitioners	313
Adjacent	Occupational Therapists	2,747
	Rehabilitation Counselors	2,105
	Community Health Workers	2,548
	Physician's Assistants	269
	Total	34,613

STEP 2: WHAT IS THE WORKER SHORTAGE TODAY?

The next step is to estimate how many workers are required to meet population needs for mental health and substance use treatment. To do this, data was analyzed from the National Survey on Drug Use and Health (NSDUH), conducted annually by the SAMHSA, which provides nationally representative data on the use of tobacco, alcohol, and drugs; substance use disorders; mental health issues; and receipt of substance use and mental health treatment among the civilian, noninstitutionalized population aged 12 or older in the United States.

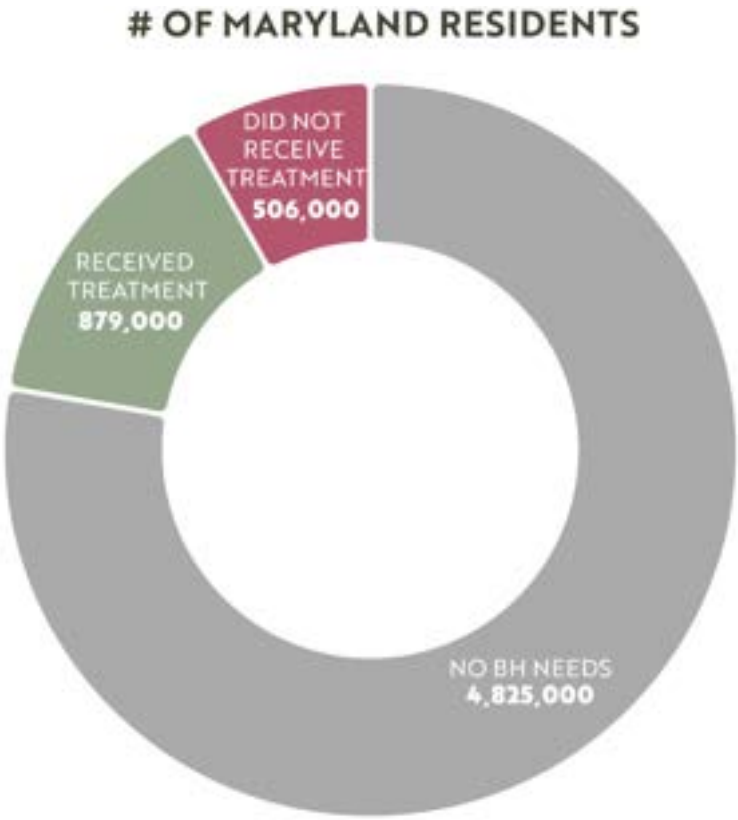
Data for five biannual cross-sections were available from SAMHSA's NSDUH on incidence of mental health illness, substance use, and mental health services received (2008-2010, 2010-2012, 2012-2014, 2014-2016, and 2016-2018).

Due to changes in data collection and methodology beginning in 2019 because of the Covid-19 pandemic, SAMHSA cautions that estimates from 2020-2022 are not comparable to prior years. The research team opted to use the older data to calculate a growth rate and then project a rate of mental health illness, substance use disorder, and BH services received for Maryland residents over the next five, ten, and twenty years. The SAMHSA NSDUH estimates used were based on Maryland resident responses to the following survey questions:

- Did you experience mental illness in the past year (adults aged 18 or older)?
- Did you receive any mental health treatment in the past year?
- Are you needing, but did not receive treatment at a specialty facility for substance use in the past year (ages 12 years and older)?

After controlling estimates of comorbidity, an estimated 22%, or 1.385M of the estimated 6.297M Maryland residents needed BH services in 2023. Based on projections of NSDUH estimates, 63% of those residents' received treatment or service in the last year, and 37% (or 506,000 residents) did not.

Figure 13: Maryland Met and Unmet Need for Behavioral Services (2023 Estimates)

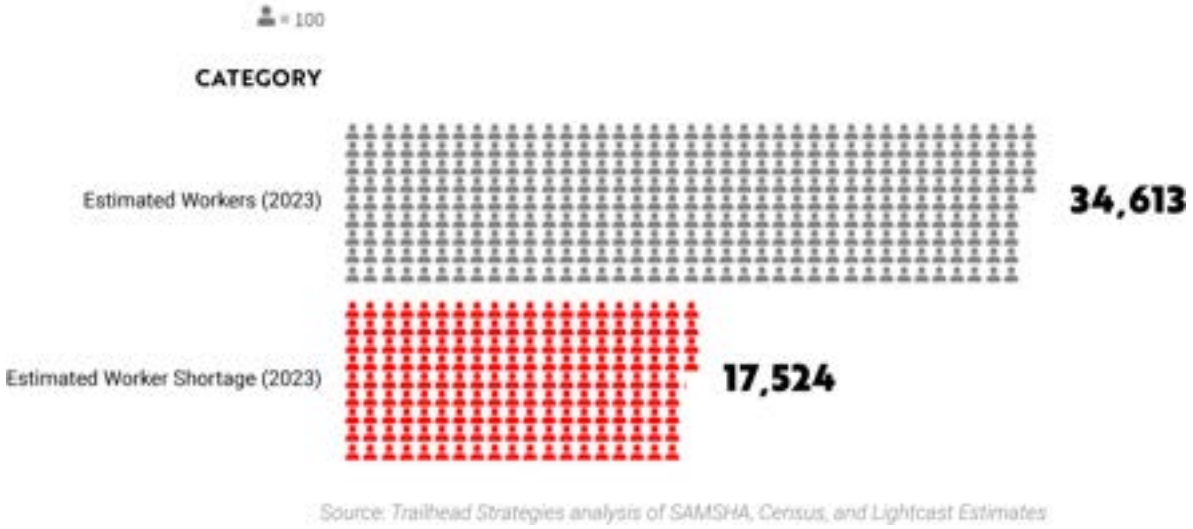


Source: Trailhead analysis of SAM HSA NSDUH Estimates based on 2012-2014, 2014-2016, and 2016- 2018 trends.

Based on these metrics, the met and unmet need was determined, a service ratio of workers to patients was calculated, and an estimate of the expected total labor force needed to provide a service or treatment to the additional 506,000 Maryland residents that needed a BH service or treatment was developed. Based on these methods, we estimate the workforce needs to increase by ~50% to serve population need in 2023, assuming there are no changes in level of collaborative care with primary care

professionals, uses of telehealth from out-of-state professionals, staffing models, or dramatic changes in the number of residents the average BH professional can serve.

Figure 14: Maryland Behavioral Health Workforce Shortage, 2023



STEP 3: HOW MANY WORKERS WILL BE NEEDED IN THE FUTURE?

To estimate the number of workers needed over the next five years, we used the current number of workers employed in 2023, the proportion of the workforce each occupation represented in 2023, the extent of the shortage today, population growth estimates, and individual occupational growth and replacement rates shown in *Section 1*. This method provides us with the following estimates:

- Net new positions needed by 2028 to address the workforce shortage
- Replacement workers needed by 2028 to replace those leaving the field
- Total additional workers needed by 2028 (the sum of the previous two bullets)

Figure 15: Maryland's Behavioral Health Workforce Shortage by 2028

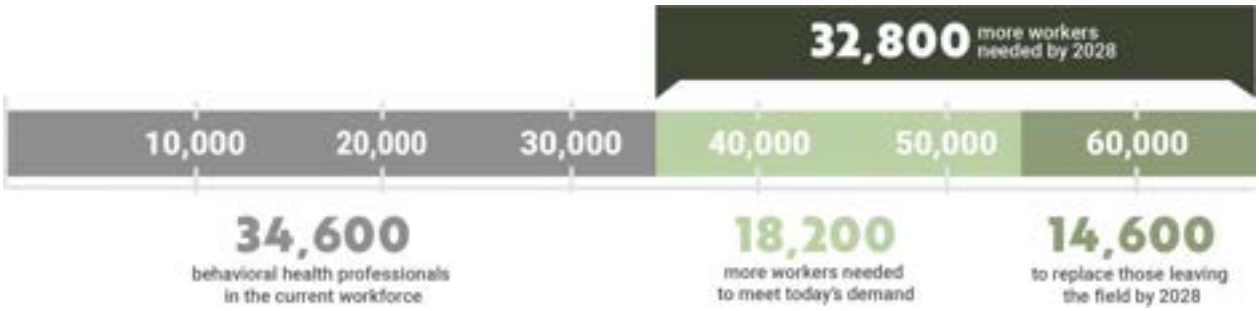


Figure 16: Shortage of BH Workers in Maryland, 2023-2028

OCCUPATION	ESTIMATED WORKERS IN BH (2023)	NET NEW POSITIONS NEEDED BY 2028	REPLACEMENT WORKERS NEEDED BY 2028	NEW NEEDED BY 2028
Social and Human Services Assistants*	7,583	4,029	4,000	8,029
Counselors and Therapists	8,732	5,784	3,748	9,532
Psychiatric Aides and Technicians	1,496	938	802	1,740
Social Workers in BH Settings	2,799	1,651	1,024	2,675
Psychologists (Clinical and Counseling)	1,266	745	315	1,060
Psychiatrists	1,196	105	164	269
Nursing Assistants	1,094	379	771	1,150
Licensed Practical Nurses	339	173	134	307
Registered Nurses (Inc. Adv. Practice)	2,126	1,002	590	1,592
Nurse Practitioners	313	260	78	338
Occupational Therapists	2,747	1,061	779	1,840
Rehabilitation Counselors	2,105	602	789	1,391
Community Health Workers	2,548	1,322	1,300	2,622
Physician's Assistants	269	171	71	242
Total	34,613	18,222	14,565	32,786

**This is a broad category that includes peer recovery specialists, outreach workers, unlicensed case managers, and other roles that are sometimes referred to as paraprofessionals*

By 2028, Maryland needs to attract, retain, and/or upskill over 32,000 workers if the state Is going to address the worker shortage and replace professionals expected to leave the field over the next 5 years. This is roughly the same number of professionals currently employed in Maryland today.

Estimates for the number of new positions, replacement workers needed, and total additional workers needed by occupation by 2033 and 2043 can be found in Appendix D.

2.2: Limitations

We believe we have developed the best possible estimates with the data available, however, this analysis has several limitations and weaknesses.

First, the Bureau of Labor Statistics' SOC are broad and do not change often. Several occupations in our analysis (for example, registered nurses, nurse practitioners, and physician's assistants) are employed throughout the health system; behavioral health is only one of several specialties or work settings. To include them in our analysis, we used national estimates for the number of these professionals employed in BH settings, as explained above.

The validity of those estimates rests on the following assumptions: 1) Maryland has a similar proportion of each of these professions working in behavioral health as the US at large and 2) key features, like turnover and replacement rates, are similar across specialties.

Additionally, a handful of high-priority occupations for Maryland, such as peer support specialists, do not have a designated SOC code and their job titles are included in the SOC code for social and human service assistants, making it difficult to estimate how many peer support specialists are currently employed and how many are needed in the future.

Second, our analysis rests primarily (and necessarily) on historical data, but recent and anticipated changes impact the reliability of our estimates. For example, the Covid-19 pandemic has changed the demand and supply for behavioral health services. SAMHSA urges caution in interpreting and comparing NSDUH estimates post-Covid; our research team opted to use pre-Covid estimates for reasons explained above, which is likely an underestimate of unmet need for BH services given national trends in substance use and mental health need increasing during and after the pandemic. We cannot predict what long-term impacts these, and other large investments and policy changes will have on these estimates.

Third, available data do not allow us to estimate the number of providers that take patients regardless of their ability to pay. For example, we know a large percentage of licensed clinicians and psychiatrists

are employed in “cash only” private practices, further exacerbating the provider shortage for individuals on publicly funded health plans and the uninsured.

Fourth, available data is limited on race/ethnicity, language competency, and specific zip code of practice for each occupation, making it difficult to draw conclusions related to the shortage of providers in specific neighborhoods or with specific language or cultural competency.

Finally, our analysis does not include workforce optimization efforts, including technology innovations such as using Artificial Intelligence (AI) to expand the number of patients a provider can serve, using remote or telehealth to meet community need through providers that live outside of Maryland, or other efforts to expand services through the existing workforce. Similarly, the model does not account for out-of-state professionals serving Maryland residents. These are all areas for further research and inquiry.

SECTION 3: POST-SECONDARY EDUCATION DEGREE COMPLETION TRENDS

Maryland's education and training system is working to keep pace with the demand for BH talent. Colleges, universities, certificate programs, apprenticeship programs, and on-the-job training collectively make up the talent development system charged with training and upskilling the BH workforce. This section examines graduation and employment outcome data from the Maryland Longitudinal Data System (MLDS)[29] that contains student education and employment outcome data from Maryland schools, colleges, and universities. Key takeaways include:

- Since the onset of the Covid-19 pandemic, there has been a steady decline in master's degree graduates in BH related fields from Maryland colleges and universities. In 2022, 1,673 master's degrees were awarded in social work, clinical and counseling, psychology, and counseling and therapy programs, down 14% from the 2019 peak.
- While the total number of nursing degrees awarded in 2022 (4,007) is approximately unchanged from 2014 (3,994), there is a much larger share of master's and doctorate nursing degree awards today than there were in 2014.
- Maryland ranked 38th out of the 50 states, Washington DC and Puerto Rico in psychiatry resident matches per capita in 2024.
- 70% Masters of Social Work and Clinical and Counseling Psychology graduates from Maryland universities were either working in other industries in Maryland, were employed out of state, or not working one year after degree completion.
- Only 2% of nursing graduates from associate, bachelor's, master's, and doctorate programs were employed in BH settings in Maryland one year after graduation. More than half were not visible in the wage file, suggesting they were working out of state or not employed.
- Maryland community colleges have an opportunity to increase the number of addiction studies and related associate degree and certificate programs. While there are relatively few graduates of these programs relative to the need, 40% of graduates were likely or possibly employed in BH settings in Maryland one year and five years after graduation.

[29] The research in this section was supported by the Maryland Longitudinal Data System (MLDS) Center. The authors are grateful for the assistance provided by the MLDS Center. All opinions are the authors' and do not represent the opinion of the MLDS Center or its partner agencies.

3.1: Methodology

To conduct this analysis, the research team examined certificate, associate, bachelor's, master's, doctorate, and post-graduate certificate programs in relevant fields, identified through the Higher Education General Information Survey (HEGIS) codes used by the Maryland Higher Education Commission (MHEC). Figure 17 shows the programs that were selected for analysis from the available data.

Figure 17: Education and Training HEGIS Codes and Descriptions Selected for Analysis

HEGIS	DESCRIPTION	HEGIS	DESCRIPTION	HEGIS	DESCRIPTION
210400	Social Work and Helping Services	491021	Clinical Mental Health Counseling, Addiction Counseling, Mental Health Services, Behavioral Health Counseling and Related Counseling	120300	Nursing
210401		499953		120301	
200300	Clinical Psychology	082601		120302	
200900	Developmental Psychology	521600		120303	
082200	Educational Psychology	521602		120305	
200100	Psychology, General	521603		120307	
200101	Educational Psychology	521605		120309	
200102	Psychology, General	521606		120313	
200121		121400		520801	Nursing, RN
200400		129900		520802	
200401				520901	Nursing, Practical
200402	Psychology for Counseling	491008	Public Health / Public Service / Human Services / Community Services	520101	Health Services Assistance
200403		080810		210101	Adult / Human Development
200405		121412			
		210101			
		050613			
		550101			
		499911			

3.2: Related Degree and Certificate Award Trends

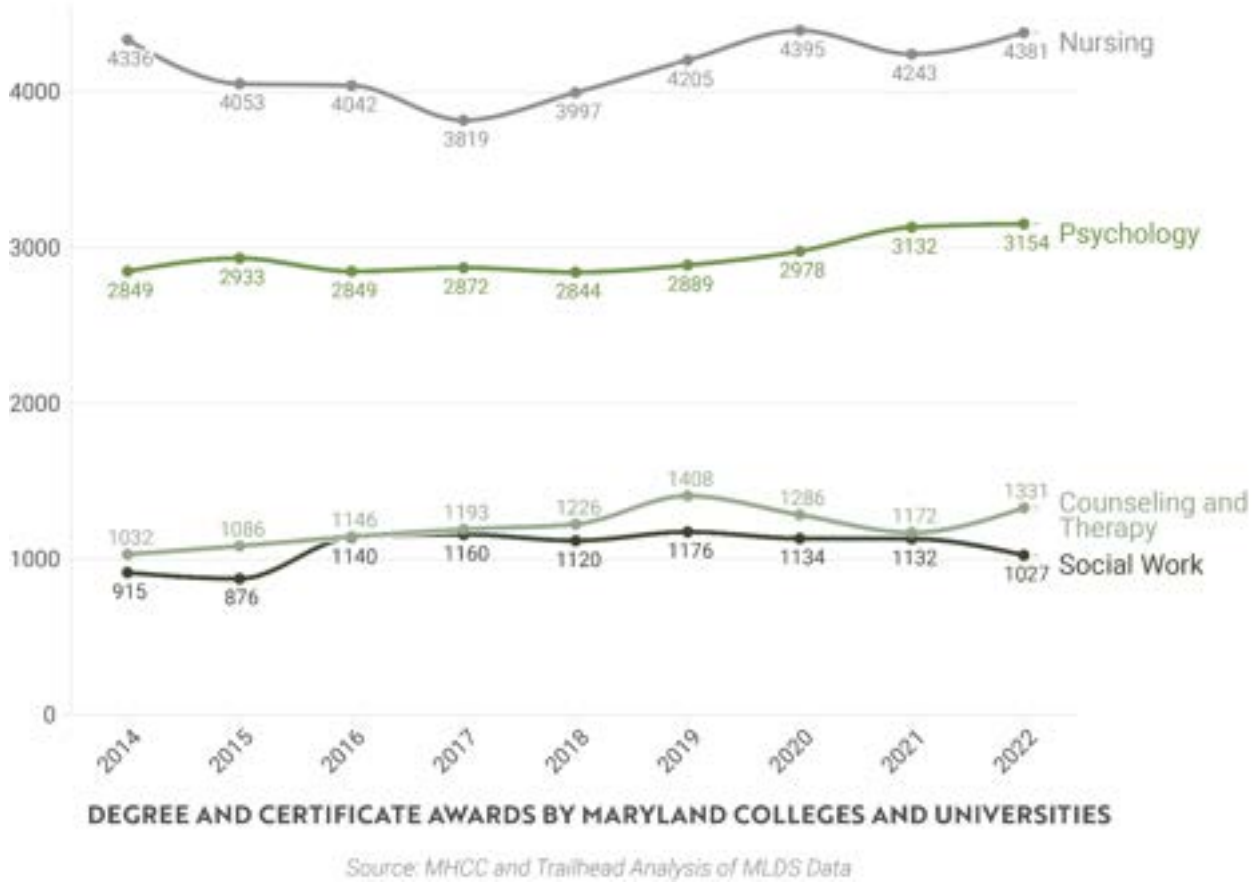
Maryland colleges and universities with programs related to nursing, psychology, counseling and therapy, and social work awarded a total of 9,933 certificates and degrees in 2022, the most recent full year of available data[30]. Most awards were in Nursing (44%) and Psychology (32%). Counseling and Therapy program graduates and Social Work program graduates made up a much smaller share at 13% and 10%, respectively (Figure 18).

Overall, Maryland's colleges and universities awarded more degrees and certificates in these four categories in 2022 compared to 2014. The largest percentage change was in Counseling and Therapy

[30] 2023 education completion data is not yet available through MLDS from awards conferred between July through December 2023. There were 6,141 completions from January to June 2023, consistent with prior six month trends.

programs (29%), followed by Social Work programs (12%) and Psychology programs (11%). Overall, Nursing degrees awarded were relatively unchanged from 2014 to 2022.

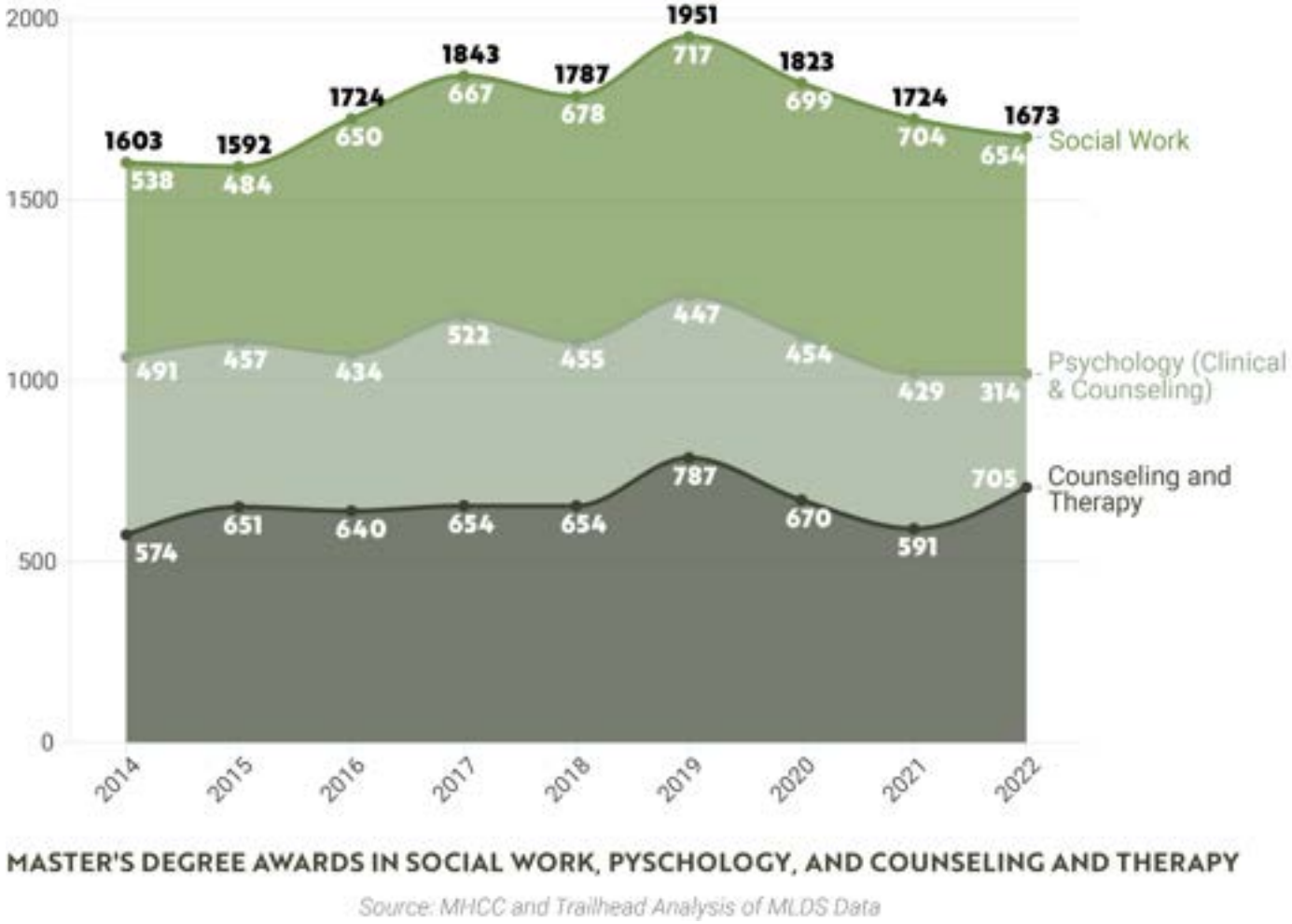
Figure 18: Maryland Colleges and University Academic Awards in Programs Relevant to BH Careers, 2014 - 2022



While the above graph shows increasing awards in the four broad categories listed above, there are important trends by type of award and discipline.

Master's degree awards in social work, counseling and therapy, and clinical and counseling psychology programs saw a steady increase from 1,603 awards combined in 2014 to a peak of 1,951 awards in 2019, growing nearly 4% year-over-year. However, since the onset of the Covid-19 pandemic, there has been a steady decline in master's degree graduates from Maryland colleges and universities. In 2022, 1,673 master's degrees combined will be awarded in social work, clinical and counseling psychology, and counseling and therapy programs, down 14% from the 2019 peak, although there was a significant uptick in counseling and therapy master's level graduates in 2022 compared to the prior year (Figure 19).

Figure 19: Master's Degree Awards in Social Work, Psychology, and Counseling/Therapy, 2014 – 2022



There have also been noticeable changes over time in the nursing pathway. While the majority of nurses work in healthcare settings outside of in-patient psychiatric units, in-patient crisis respite centers, substance use disorder programs, or other specialized BH settings, licensed practical nurses, registered nurses, and psychiatric mental health nurse practitioners are a critical part of the BH workforce.

In 2022, Maryland colleges and universities awarded a total of 4,007 nursing degrees – 1,623 bachelor's degrees, 1,477 associate degrees, 639 master's degrees, and 268 Doctors of Nursing practice. While the total number of nursing degrees awarded in 2022 (4,007) is approximately unchanged from 2014 (3,994), there is a much larger share of master's and doctorate degree awards today than there were in 2014.

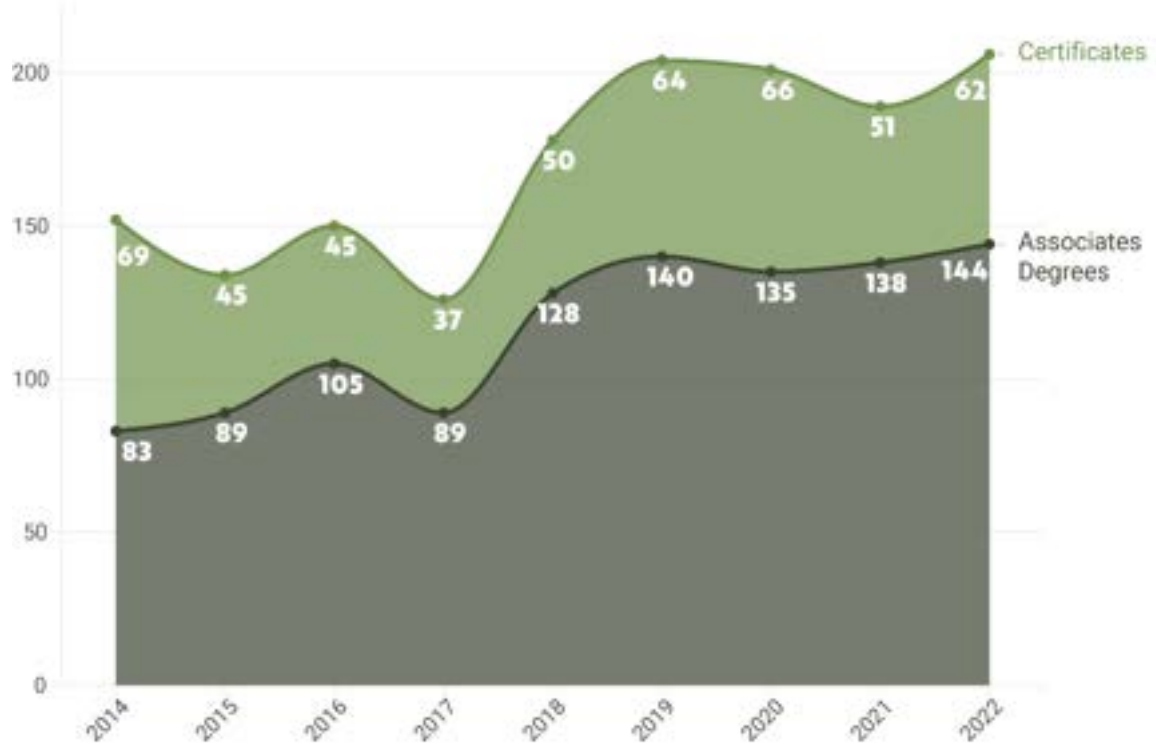
Figure 20: Nursing Degree Awards from Maryland Colleges and Universities, 2014-2022

NURSING DEGREE TYPE	2014	2015	2016	2017	2018	2019	2020	2021	2022	2014 -2022 CHANGE
Associate degree	1,709	1,526	1,575	1,383	1,354	1,464	1,570	1,385	1,477	-13.58%
Bachelor's Degree	1,638	1,638	1,640	1,474	1,552	1,617	1,710	1,664	1,623	-0.92%
Master's Degree	604	544	525	652	675	642	629	624	639	5.79%
Doctorate Degree	43	43	53	75	120	167	166	244	268	+523.26%
Total	3,994	3,751	3,793	3,584	3,701	3,890	4,075	3,917	4007	0.33%

Source: MHCC and Trailhead Analysis of MLDS Data

Certificate and associate degree addiction counseling programs are important pathways for individuals to enter the BH workforce, working toward certification as an alcohol and drug counselor, peer recovery specialist, or working in an unlicensed role such as an outreach worker or case manager. While many individuals take private and/or online training programs that are not represented in the MLDS data, there has been an increase in associate degree awards conferred in addiction studies by Maryland community colleges from 2014, though the overall number remains small.

Figure 21: Addiction Studies Certificate and Associate Degree Awards from Maryland Colleges, 2014 – 2022.



ADDICTION STUDIES CERTIFICATES AND AA AWARDS

Source: MHCC and Trailhead Analysis of MLDS Data

3.3: Inventory of BH Degree Awards by Institution and Program

In 2022, the most recent calendar year with a full year of available data for degree awards, 40 different colleges and universities awarded certificates and degrees in relevant programs related to BH, with John Hopkins University, the University of Maryland (various campuses), Towson University, and Salisbury University awarding the most degrees (figure 22).

Figure 22: Maryland Post-Secondary Education Institutions with Degree Awards in Relevant BH Programs, 2022

SCHOOL	AWARDS	SCHOOL	AWARDS
Johns Hopkins University	1,242	Harford Community College	117
University of Maryland, Baltimore	1,149	Washington Adventist University	116
Towson University	874	Baltimore City Community College	112
University of Maryland Global Campus	795	College of Southern Maryland	105
Univ. of Maryland University College	578	McDaniel College	102
Salisbury University	518	University of Baltimore	93
University of Maryland, Baltimore County	458	Prince George's Community College	90
Stevenson University	314	Goucher College	88
Community College of Balt County	295	Hagerstown Community College	88
Frostburg State University	260	Frederick Community College	77
Morgan State University	233	Hood College	75
Bowie State University	214	Cecil College	68
Anne Arundel Community College	207	Saint Mary's College of Maryland	64
Loyola University Maryland	193	Carroll Community College	40
Notre Dame of Maryland University	193	Naval Academy	36
Coppin State University	156	Chesapeake College	34
Howard Community College	153	Washington College	31
Allegany College of Maryland	143	Mount St. Mary's University	18
Montgomery College-All Campuses	140	Univ. of Maryland Eastern Shore	10
Wor-Wic Community College	138	Garrett College	5

Two colleges, Johns Hopkins University and the University of Maryland Baltimore, are producing more than half of the total master's degree graduates with the education required to become licensed clinicians (e.g., licensed social workers, licensed professional counselors, clinical psychologists) or advanced practice nurses or nurse practitioners. Other universities producing a high numbers of master's level graduates include Salisbury University, the University of Maryland University College, Towson University, Morgan State University, Loyola University, and Bowie State University.

Figure 23: Master's Degree Completions by School and Discipline

PROGRAM	SOCIAL WORK	COUNSELING AND THERAPY	PSYCHOLOGY	NURSING	TOTAL
Johns Hopkins University		465	5	318	788
University of Maryland, Baltimore	381			207	588
Salisbury University	193			5	198
Univ. of Maryland University College		116	21		137
Towson University			89	5	94
Morgan State University	80	13			93
Loyola University Maryland		48	40		88
Bowie State University		16	52	5	73
Stevenson University				48	48
McDaniel College		35	5		40
Frostburg State University			5	32	37
University of Baltimore			33		33
Washington Adventist University		5	15	5	25
Hood College			23		23
Coppin State University			10	5	15
Notre Dame of Maryland University				15	15
Naval Academy		5			5
Univ. of Maryland Eastern Shore		5			5
University of Maryland, Baltimore County			5		5
Total	654	708	303	645	2,310

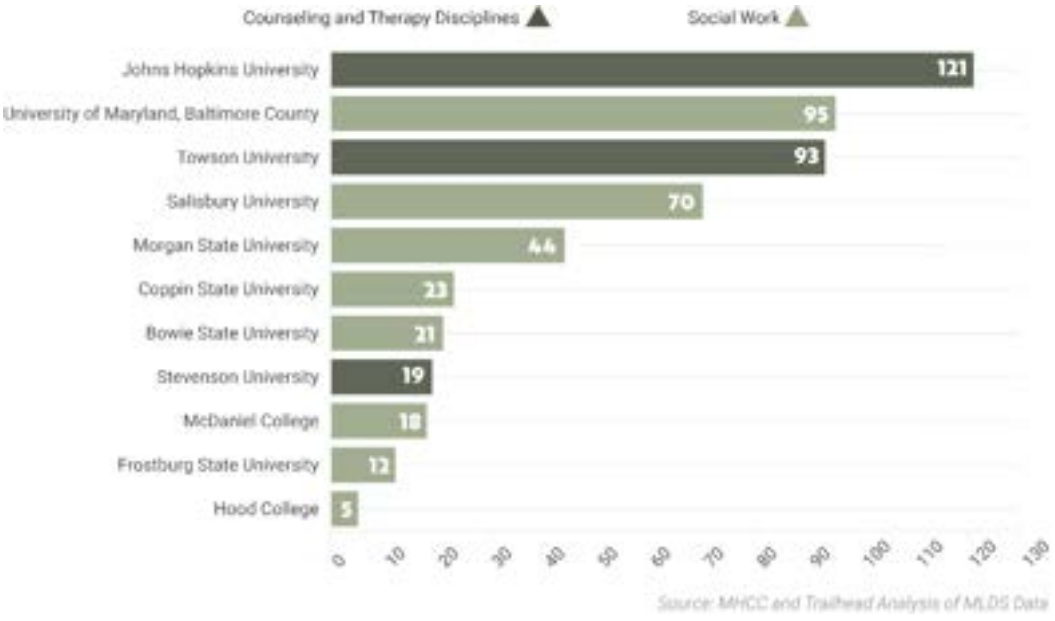
While every community college in Maryland awarded associate degrees in nursing, not all colleges awarded associate degrees in counseling and therapy, social work, and psychology. The majority of the 142 awards in counseling, therapy, social work, and psychology program codes came from the Community College of Baltimore County, Wor-Wic Community College, Anne Arundel Community College, Cecil College, and Prince George's Community College.

Figure 24: Associate degree Completions by School and Discipline

PROGRAM	COUNSELING AND THERAPY, SOCIAL WORK, AND PSYCHOLOGY	NURSING	TOTAL
Community College of Baltimore County	44	157	201
Anne Arundel Community College	29	152	181
Montgomery College-All Campuses	5	135	140
Howard Community College	5	134	139
Allegany College of Maryland		121	121
Harford Community College		117	117
Wor-Wic Community College	31	74	105
College of Southern Maryland		95	95
Prince George's Community College	13	72	85
Frederick Community College	5	67	72
Hagerstown Community College	5	54	59
Baltimore City Community College	5	53	58
Cecil College	22	31	53
Carroll Community College		35	35
Chesapeake College		29	29
Garrett College	5		5
Total	142	1,326	1,495

Top universities awarding bachelor's degrees in social work and counseling and therapy disciplines include John Hopkins University, the University of Maryland Baltimore County, Towson University, and Salisbury University.

Figure 25: Maryland Bachelor's Awards in Counseling, Therapy, and Social Work, 2022



3.4: Psychiatry Residency Programs

Maryland is home to two psychiatry residency programs. Based on data from the National Resident Matching Program on 2024 residency matches across the country, the John Hopkins University program had 11 resident matches, and the University of Maryland / Sheppard Pratt program had 16 matches, for a total of 27 matches in 2024[31]. Both residencies are 4-years long, resulting in a total of 104 resident slots available across all four years in Maryland.

Maryland ranked 38th out of the 50 states, Washington DC and Puerto Rico in psychiatry resident matches per capita in 2024. Neighboring jurisdictions rank very high on this metric, including the District of Columbia (ranked 1st), West Virginia (ranked 3rd) and Pennsylvania (ranked 11th).

Figure 26: Matched Psychiatry Residents Per Capita, 2024

STATE	2024 MATCHES	CITIZENS PER MATCHED RESIDENT	RANK	STATE	2024 MATCHES	CITIZENS PER MATCHED RESIDENT	RANK
District of Columbia	26	26,114	1	Delaware	6	171,982	27
New York	297	65,896	2	Illinois	71	176,756	28
Massachusetts	100	70,014	3	Hawaii	8	179,392	29
West Virginia	24	73,753	4	Kansas	16	183,784	30
Rhode Island	13	84,305	5	Texas	159	191,845	31
Connecticut	39	92,748	6	Virginia	44	198,084	32
New Hampshire	15	93,470	7	Georgia	55	200,531	33
Louisiana	44	103,949	8	Tennessee	35	203,614	34
Nevada	30	106,473	9	Minnesota	27	212,515	35
Michigan	85	118,085	10	Vermont	3	215,821	36
Pennsylvania	109	118,915	11	Wisconsin	27	218,924	37
New Jersey	75	123,878	12	Maryland	27	228,898	38
Maine	11	126,884	13	Utah	14	244,124	39
North Dakota	6	130,654	14	Mississippi	12	244,974	40
South Dakota	7	131,331	15	Idaho	8	245,591	41
New Mexico	16	132,148	16	Alabama	20	255,423	42
North Carolina	81	133,771	17	Colorado	23	255,548	43
Missouri	46	134,699	18	Indiana	26	263,931	44
South Carolina	38	141,409	19	Kentucky	17	266,244	45
Oklahoma	27	150,142	20	Puerto Rico	12	267,141	46
Florida	150	150,738	21	Arizona	25	297,254	47
Nebraska	13	152,183	22	Washington	23	339,690	48
Iowa	21	152,714	23	Oregon	12	352,780	49
Ohio	75	157,146	24	Montana	3	377,604	50

[31] Results and Data, 2024 Main Residency Match ®. National Resident Matching Program®. June 2024.

STATE	2024 MATCHES	CITIZENS PER MATCHED RESIDENT	RANK	STATE	2024 MATCHES	CITIZENS PER MATCHED RESIDENT	RANK
Arkansas	19	161,460	25	Wyoming	0	n/a	51
California	228	170,900	26	Alaska	0	n/a	52

3.5: Demographics of Graduates in Relevant Fields

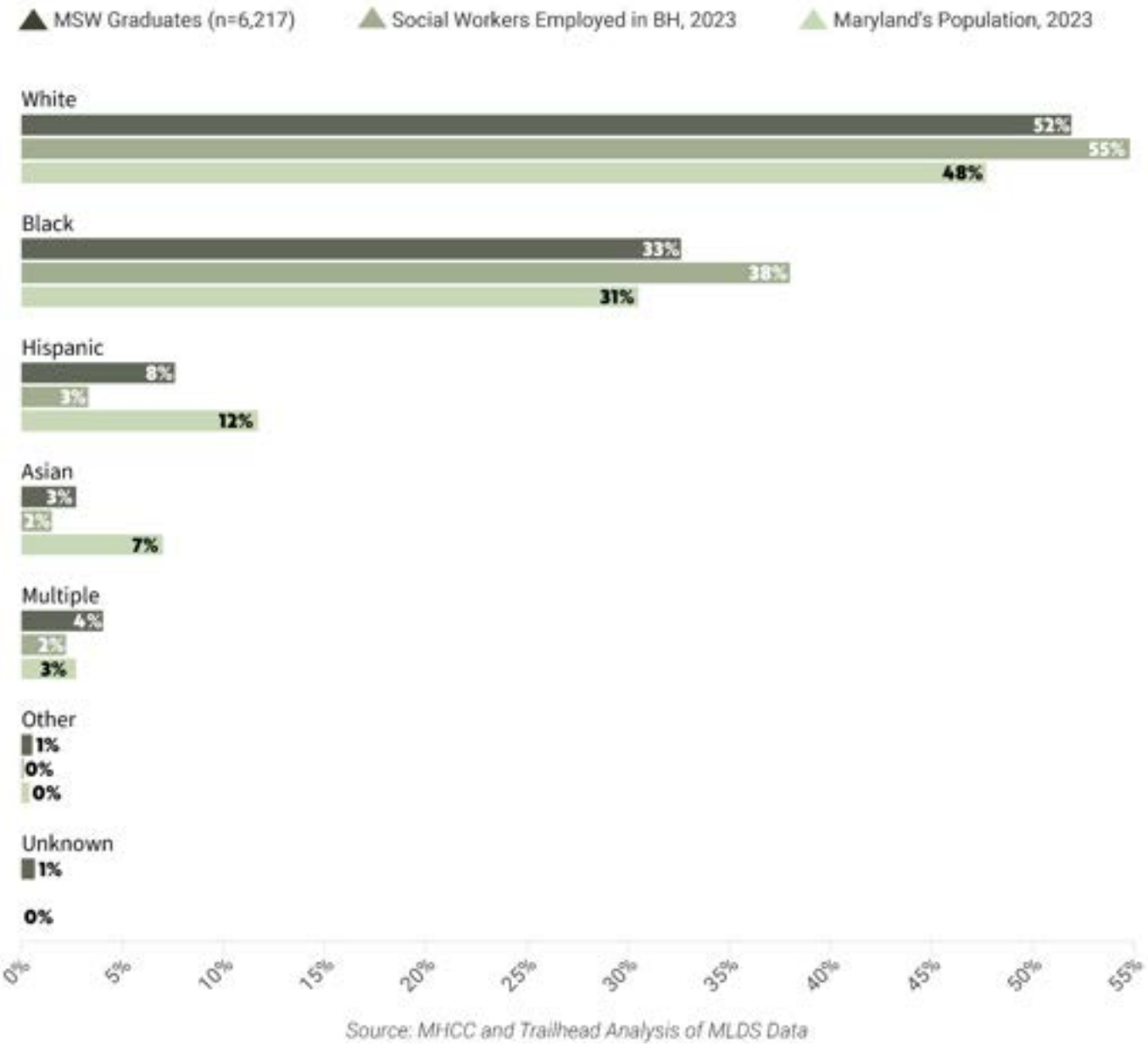
While deeper investigation is needed into demographic trends in post-secondary enrollment and graduation, this section provides a high-level snapshot of the race and ethnicity of individuals graduating from BH programs in Maryland from 2014 to 2023 in relevant academic programs. During this time, a total of 78,847 individuals received at least one certificate or degree in social work, counseling and therapy, psychology, and/or nursing from Maryland colleges or universities. 51% of those graduates were White, 27% were Black, 9% were Asian, and 8% were Hispanic.

Figure 27: Race and Ethnicity of Maryland Post-Secondary Education Certificate and Degree Programs in Relevant BH Fields, 2014-2023

	BLACK		HISPANIC		WHITE		ASIAN		MULTI-RACIAL		OTHER		UNKNOWN		TOTAL	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Counseling & Therapy	2,178	21%	734	7%	4,597	44%	1,836	18%	481	5%	98	0.9%	462	4%	10,386	100%
Social Work	3,242	37%	750	9%	4,106	47%	245	3%	338	4%	61	0.7%	70	1%	8,812	100%
Psychology	6,805	26%	2,424	9%	12,895	50%	2,109	8%	1,196	5%	232	0.9%	303	1%	25,964	100%
Nursing	8,942	27%	2,107	6%	18,513	55%	2,725	8%	949	3%	242	0.7%	207	1%	33,685	100%
Total	21,167	27%	6,015	8%	40,111	51%	6,915	9%	2,964	4%	633	0.8%	1,042	1%	78,847	100%

The majority (52%) of the 6,217 graduates of Master of Social Work programs in Maryland from 2014 to 2023 were White, just below the share of White professionals employed as social workers in BH settings in 2023 (55%). Black students represented 33% of MSW program graduates during this time, 5 percentage points below the share of social workers that were Black in 2023. Hispanic and Asian students represented 8% and 3% of MSW graduates in Maryland since 2014, respectively (Figure 28).

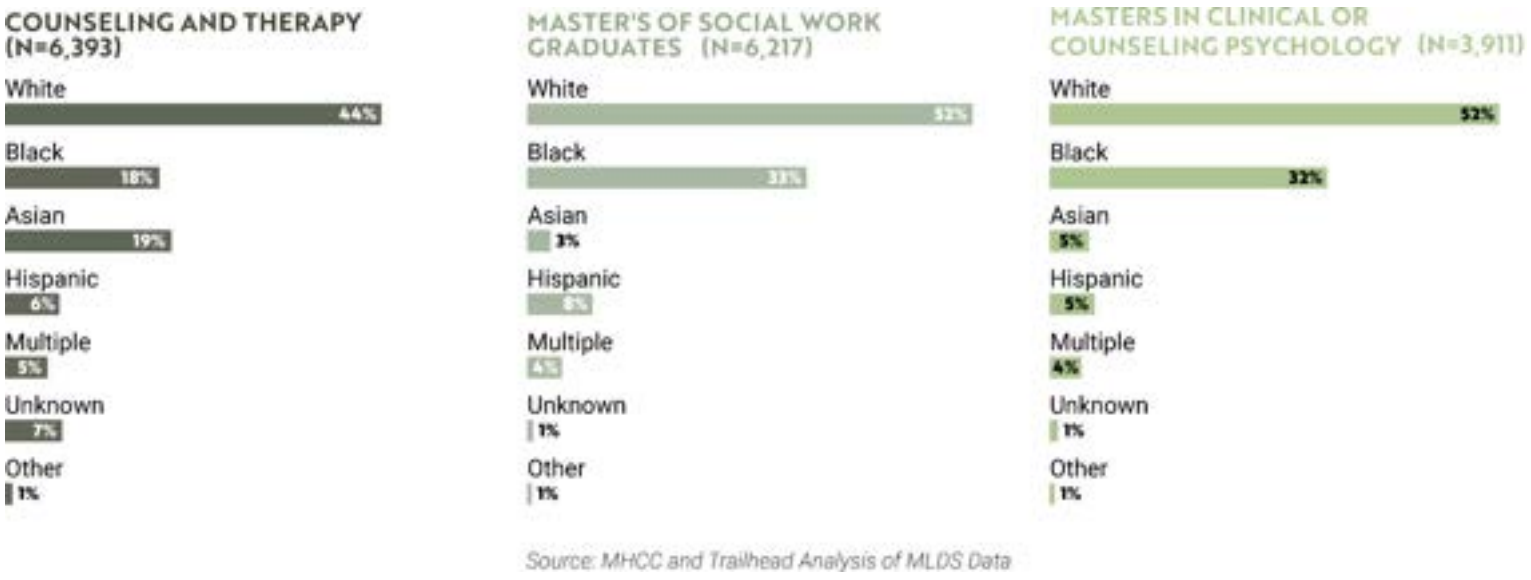
Figure 28: Race and Ethnicity of Master of Social Work Program Graduates in Maryland, 2014-2023



Source: MHCC and Trailhead Analysis of MLDS Data

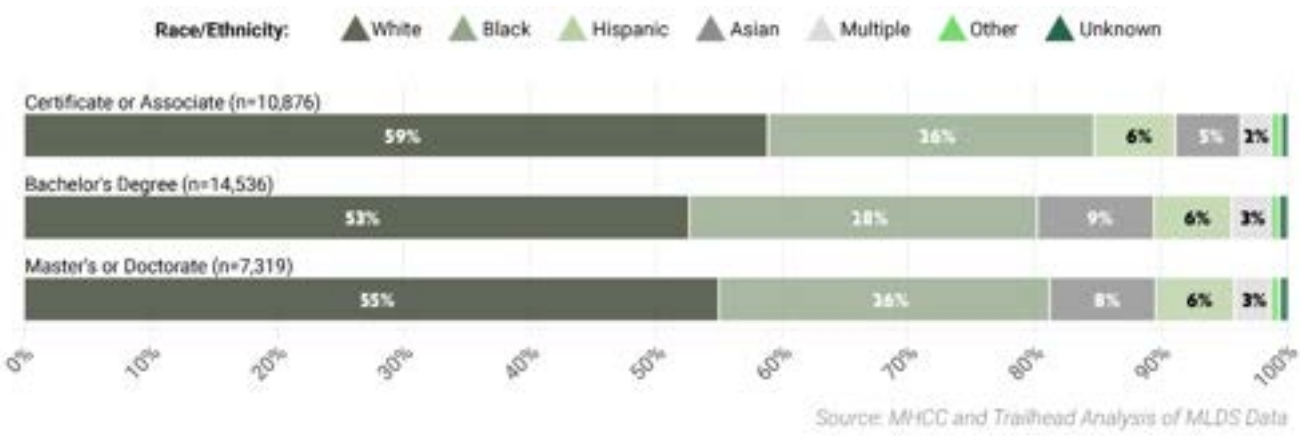
The demographics of graduates of master's level clinical and counseling psychology programs were similar to MSW programs. Master's level counseling and therapy programs, however, showed a much higher share of Asian graduates (19%) from 2014-2023 than the other disciplines that lead to licensed clinician roles including licensed professional clinical counselor, licensed clinical social work, and licensed clinical psychologists.

Figure 29: Race and Ethnicity of Licensed Clinician Feeder Program Graduates, 2014-2023



Most nursing program graduates from 2014 – 2023 were White or Black, with no significant differences in each group share of graduates by certificate or degree level. Asian students had a slightly higher share of nursing graduates at the Bachelor's and Master's level, while the share of Hispanic nursing graduates was 6% across each certificate or degree award examined.

Figure 30: Race and Ethnicity of Graduates from Nursing Programs in Maryland, 2014-2023



3.6: Workforce Outcomes for Graduates of Behavioral Health Related Programs

The number of graduates from relevant BH programs in Maryland is only part of the workforce challenge; attracting and retaining these professionals to careers working in Maryland's BH system is critical to keeping pace with community needs for mental health and substance use treatment. In this section we explore two major questions:

- How many graduates from relevant programs work in Maryland's behavioral health system on year after degree completion?
- What about five years after degree completion?

To better understand the share of graduates from Maryland colleges and universities that found employment in Maryland's healthcare and BH system, we matched wage records with individual graduation data from 2014-2023 from the relevant programs through the MLDS, which provides quarterly wages and the industry of the employer for Maryland employees.

We then looked for individuals with wages reported at two single points in time:

- the second quarter one year after degree or certificate completion
- the second quarter five years after degree or certificate completion.

For those with wages reported, we used the North American Industry Classification System (NAICS) codes of the employer for each individual with a wage record in one of both quarters of interest to classify each record graduate based on the likelihood of employment in a BH setting. We used four categories, "Likely", "Possible", "Unlikely", and "Not Visible". Individuals who graduated from a relevant program, but did not yet reach one or five years post degree completion were not included. Figure 31 below provides a description of each category with an example NAICS code. A full list of all "Likely" or "Possible" NAICS codes can be found in *Appendix D*.

Figure 31: BH Employment Outcomes Categories

CLASSIFICATION	LIKELY	POSSIBLE	UNLIKELY	NOT VISIBLE
Description	Received wages from an employer in the quarter of interest (Q2 one or five years after completion) in an industry that suggests a high likelihood the individual is providing BH services in Maryland.	Received wages from an employer in the quarter of interest (Q2 one or five years after completion) may be providing BH services in Maryland.	Received wages from an employer in the quarter of interest (Q2 one or five years after completion) that is not likely providing BH services in Maryland.	Individual did not show up in the wage file in the quarter of interest (Q2 one or five years after completion), suggesting this individual is not working in W-2 employment or employed outside of Maryland
Example NAICS Code	621420: Outpatient Mental Health and Substance Abuse Centers	611110: Elementary and Secondary Schools	522110: Commercial Banking	

From 2014-2022, there were a total of 19,081 graduates who completed a master's degree in counseling and therapy, psychology, or social work fields. 6% of these professionals were likely employed in Maryland BH settings and 21% were possibly employed in BH settings, such as a general hospital, nursing home, or school. 9% were employed in other fields unlikely to be related to BH, and 65% were not visible in the wage file that quarter. In all three disciplines, over half of these graduates were either working outside of Maryland, not employed, or self-employed.

The likelihood of these graduates working in Maryland's BH system was little changed five years after completion. Of the 11,461 individuals who completed a master's program in counseling or therapy, psychology, or social work from 2014-2018, the share of those likely employed in BH held steady at 6%, while the number possible employed in BH ticked up to 23%, led by increased in the number of social work graduates in the "possibly" category working in general healthcare of education settings.

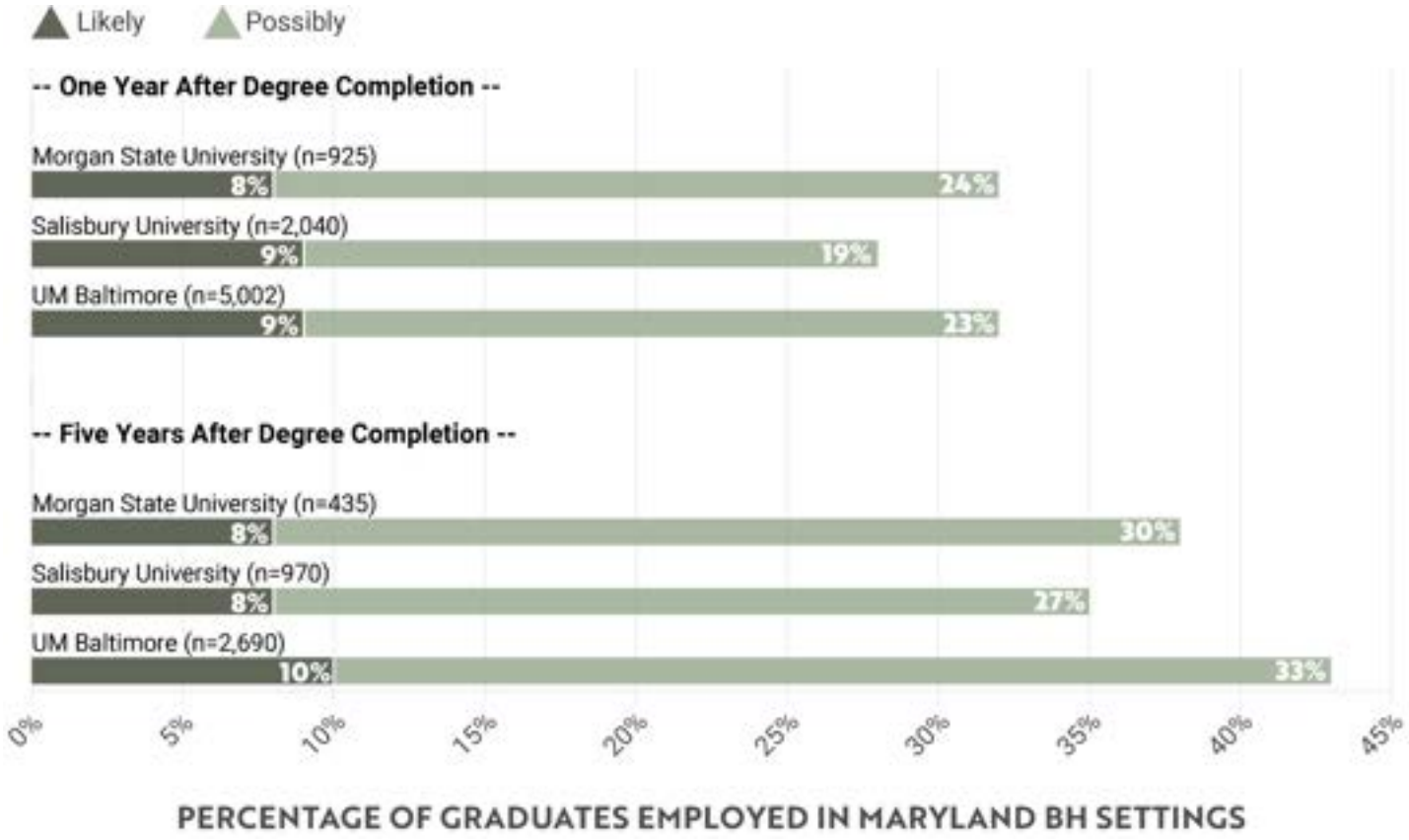
Figure 32: Likelihood of Employment in a BH Setting in Maryland After Master's Degree Completion, 2014 - 2022

	LIKELY		POSSIBLY		UNLIKELY		NOT VISIBLE		TOTAL	
ONE YEAR POST-COMPLETION	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Counseling and Therapy	132	2%	1,119	17%	271	4%	4,936	76%	6,458	100%
Psychology (Clinical and Counseling)	311	7%	1,069	23%	387	8%	2,889	62%	4,656	100%
Social Work	694	9%	1,788	22%	975	12%	4,510	57%	7,967	100%
One Year Totals	1,137	6%	3,976	21%	1,633	9%	12,335	65%	19,081	100%
	LIKELY		**POSSIBLY**		**UNLIKELY**		**NOT VISIBLE**		**TOTAL**	
FIVE YEARS POST-COMPLETION	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Counseling and Therapy	78	2%	724	15%	168	4%	3,704	79%	4,674	100%
Psychology (Clinical and Counseling)	194	7%	622	23%	280	10%	1,596	59%	2,692	100%
Social Work	379	9%	1,272	31%	669	16%	1,775	43%	4,095	100%
Five Year Totals	651	6%	2,618	23%	1,117	10%	7,075	62%	11,461	100%

70% Masters of Social Work and clinical and counseling psychology graduates from Maryland universities were either working in other industries in Maryland, were employed out of state, or not working one year after degree completion.

7,967 individuals in Maryland graduated from Master of Social Work programs between 2014 and 2023 with available data in Q2 the year following their graduation date. 4,095 graduates received their degree five years prior to MLDS wage data. The University of Maryland Baltimore's MSW program had the most graduates and also had the highest share of individuals likely (10%) or possibly (33%) employed in Maryland's BH system five years after graduation. 38% of Morgan State Universities MSW graduates were either likely or possibly employed in BH settings in Maryland five years later, up from 32% after one year. Of the 970 Salisbury University MSW graduates from 2014 to 2018, 35% were either likely (8%) or possibly (27%) working in BH settings (Figure 33).

Figure 33: Percent of MSW Graduates Likely or Possibly Employed in Maryland BH Settings Since 2014, One and Five Year After Degree Award



We also looked at employment outcomes for 19,578 students at Maryland colleges and universities that completed bachelor's in psychology programs, 16,984 that completed bachelor's in nursing, 2,381 that completed bachelor's in fields related to counseling and therapy, and 2,264 in social work. Overall, only 2% of students who completed a bachelor's degree program in these fields were likely employed in specialized BH settings one year after completing school. This number ticked up to 3% five years after graduation. However, a much larger share – 23% and 27% - worked in healthcare or school settings in which they possibly were delivering BH services to the public.

While a large number of Maryland students are earning bachelor's in psychology programs, the vast majority were not employed in BH, healthcare, or school settings where they are likely or possibly providing BH services. Of the over 19,500 students who completed psychology in bachelor's programs from 2014 to 2022, 79% were either employed in unrelated industries in Maryland (9%) or not visible in the Maryland wage file (70%). After five years, this jumped to 84%.

Figure 34: Likelihood of Employment in a BH Setting in Maryland After Bachelor's Degree Completion, 2014 - 2022

	LIKELY		POSSIBLE		UNLIKELY		NOT VISIBLE		TOTAL	
ONE YEAR AFTER DEGREE COMPLETION	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Counseling and Therapy	27	1%	346	15%	165	7%	1,843	77%	2,381	100%
Nursing	300	2%	6,834	40%	485	3%	9,365	55%	16,984	100%
Psychology	389	2%	1,814	9%	1,888	10%	15,487	79%	19,578	100%
Social Work	121	5%	353	16%	204	9%	1,586	70%	2,264	100%
One Year Totals	837	2%	9,347	23%	2,742	7%	28,281	69%	41,207	100%
	LIKELY		**POSSIBLE**		**UNLIKELY**		**NOT VISIBLE**		**TOTAL**	
FIVE YEARS AFTER DEGREE COMPLETION	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Counseling and Therapy	15	1%	228	14%	172	11%	1,211	74%	1,626	100%
Nursing	233	3%	4,054	48%	365	4%	3,781	45%	8,433	100%
Psychology	278	2%	1,697	14%	1,635	13%	8,746	71%	12,356	100%
Social Work	76	6%	330	26%	208	17%	636	51%	1,250	100%
Five Year Totals	602	3%	6,309	27%	2,380	10%	14,374	61%	23,665	100%

Students that completed counseling associate degree programs in addiction studies and related fields at Maryland's community colleges had higher rates of employment in BH settings than bachelor's and master's degree graduates. Overall, 23% of associate degree graduates in counseling and therapy related programs were employed in settings likely providing BH services to Maryland residents one year later. 18% were possibly employed in settings providing BH services in Maryland, with most graduates coming from the Community College of Baltimore County (555), Anne Arundel Community College (343), and Wor-Wic Community College (139) during the time period analyzed. Still, nearly half (49%) were not visible in the wage file one year later. At the five year mark, no significant differences were observed; 22% of graduates were likely employed in settings providing BH services, 17% were possibly employed in such settings, 11% were unlikely, and 49% were not visible in the wage file (not shown).

Figure 35: Counseling Associate Degree Graduates Likelihood of Employment in Maryland BH Settings One Year After Graduation, 2014 - 2022

COMMUNITY COLLEGE	LIKELY		POSSIBLE		UNLIKELY		NOT VISIBLE		TOTAL	
	#	%	#	%	#	%	#	%	#	%
CC of Baltimore County	132	24%	106	19%	47	8%	270	49%	555	100%
Anne Arundel CC	95	28%	47	14%	38	11%	163	48%	343	100%
Wor-Wic CC	25	18%	23	17%	18	13%	73	53%	139	100%
Baltimore City CC	18	24%	13	18%	5	7%	38	51%	74	100%
Prince George's CC	5	9%	15	27%	5	9%	31	55%	56	100%
Howard CC	5	14%	5	14%	5	14%	22	59%	37	100%
Cecil CC	5	20%	5	20%	5	20%	10	40%	25	100%
Frederick CC	5	33%	5	33%		0%	5	33%	15	100%
Montgomery College		0%		0%		0%	5	100%	5	100%
Grand Total	290	23%	219	18%	123	10%	617	49%	1,249	100%

Of the individuals that completed nursing programs in Maryland since 2014, those that completed certificate programs had the highest share likely working in BH settings in Maryland after one year (6%) and five years (11%). 40% of all nursing graduates were employed in Maryland in settings where they were possibly delivering BH services (e.g., general hospital, nursing home, school) a year after graduation.

55% of nursing graduates at all degree levels were not visible in the wage file, suggesting they took employment out of state or were not working one year after graduation. Overall, nursing graduates were very unlikely to be employed in an industry outside of a healthcare or school setting where they are unlikely providing nursing services – only 3% of nursing graduates were unlikely providing healthcare services after one year due to employment in non-healthcare, education, or social assistance industries (Figure 36).

Figure 36: Likelihood of Employment in a BH Setting in Maryland After Nursing or Certificate Degree Completion, 2014 - 2022

	LIKELY		POSSIBLE		UNLIKELY		NOT VISIBLE		TOTAL	
ONE YEAR AFTER DEGREE COMPLETION	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Certificate	56	6%	368	40%	58	6%	438	48%	920	100%
Associate Degree	233	2%	4,244	39%	365	3%	6,148	56%	10,990	100%
Bachelor's Degree	300	2%	6,834	40%	485	3%	9,365	55%	16,984	100%
Master's Degree	82	1%	2,766	44%	149	2%	3,335	53%	6,332	100%
Doctorate	28	2%	758	43%	39	2%	935	53%	1,760	100%
One Year Totals	699	2%	14,970	40%	1,096	3%	20,221	55%	36,986	100%
	LIKELY		**POSSIBLE**		**UNLIKELY**		**NOT VISIBLE**		**TOTAL**	
FIVE YEARS AFTER DEGREE COMPLETION	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Certificate	45	11%	106	27%	45	11%	202	51%	398	100%
Associate degree	184	3%	2,981	48%	310	5%	2,769	44%	6,244	100%
Bachelor's Degree	233	3%	4,054	48%	365	4%	3,781	45%	8,433	100%
Master's Degree	81	2%	1,463	38%	138	4%	2,196	57%	3,878	100%
Doctorate	20	3%	178	23%	15	2%	570	73%	783	100%
Grand Total	563	3%	8,782	44%	873	4%	9,518	48%	19,736	100%

SECTION 4: A FRAMEWORK FOR ADDRESSING MARYLAND'S BH WORKFORCE SHORTAGE

Informed by the data analysis shown in the previous sections, along with input and discussions with over 150 BH employers, frontline professionals, colleges and university leaders, and policy and advocacy groups, and regional presentations and public input sessions[32], this report recommends the BH Workforce Investment Fund be part of a larger framework the State of Maryland uses to address the workforce shortage. The recommended framework includes six strategies:

- **STRATEGY 1 – PROVIDE COMPETITIVE COMPENSATION:** Paying a living wage and keeping pace with other settings (e.g., hospitals, schools, telehealth providers, private practice) is foundational to addressing the shortage. Other strategies will have limited impact if professionals and students perceive current and expected future wages for careers in BH as inadequate.

- **STRATEGY 2 – INCREASE AWARENESS OF BH CAREERS:** Residents of Maryland cannot aspire to a career they do not know exists. Greater awareness of BH careers through the K-12 school system and post-secondary nursing, medical, social work and psychology programs is needed to expand the pipeline of future BH professionals interested and equipped to work in BH settings.

- **STRATEGY 3 – SUPPORT PAID EDUCATION AND TRAINING:** Expanded opportunities to reduce the financial burden and help prospective BH professionals "earn and learn" on their way to certification or licensure is critical to expanding the size and diversity of the MD BH workforce pipeline.

- **STRATEGY 4 – PROMOTE TIMELY AND EFFECTIVE LICENSING:** Clear, efficient, and transparent processes to become a licensed social worker, counselor, therapist, and peer recovery specialist in Maryland is needed to cut down wait times and reduce attrition as professionals are waiting for licensure or renewals.

- **STRATEGY 5 – INVEST IN JOB QUALITY:** Supporting BH providers – especially those working in community-based settings – to make job design changes, such as paid-internships, offering flexible schedules, tuition assistance programs, and expanded mentorship and supervision are needed to attract and retain talent.

- **STRATEGY 6 – EXPAND IMPACT OF CURRENT WORKFORCE:** Expanding evidenced-based models, supporting alternative staffing arrangements, and exploring how new technologies can help

[32] As a result of the regional public input sessions, the Maryland Health Care Commission received written input related to priority occupations and settings from the Maryland Assembly on School-Based Health Care, the Maryland Occupational Therapist Association, and the Maryland School Counselor Association. These letters have been included in the appendix.

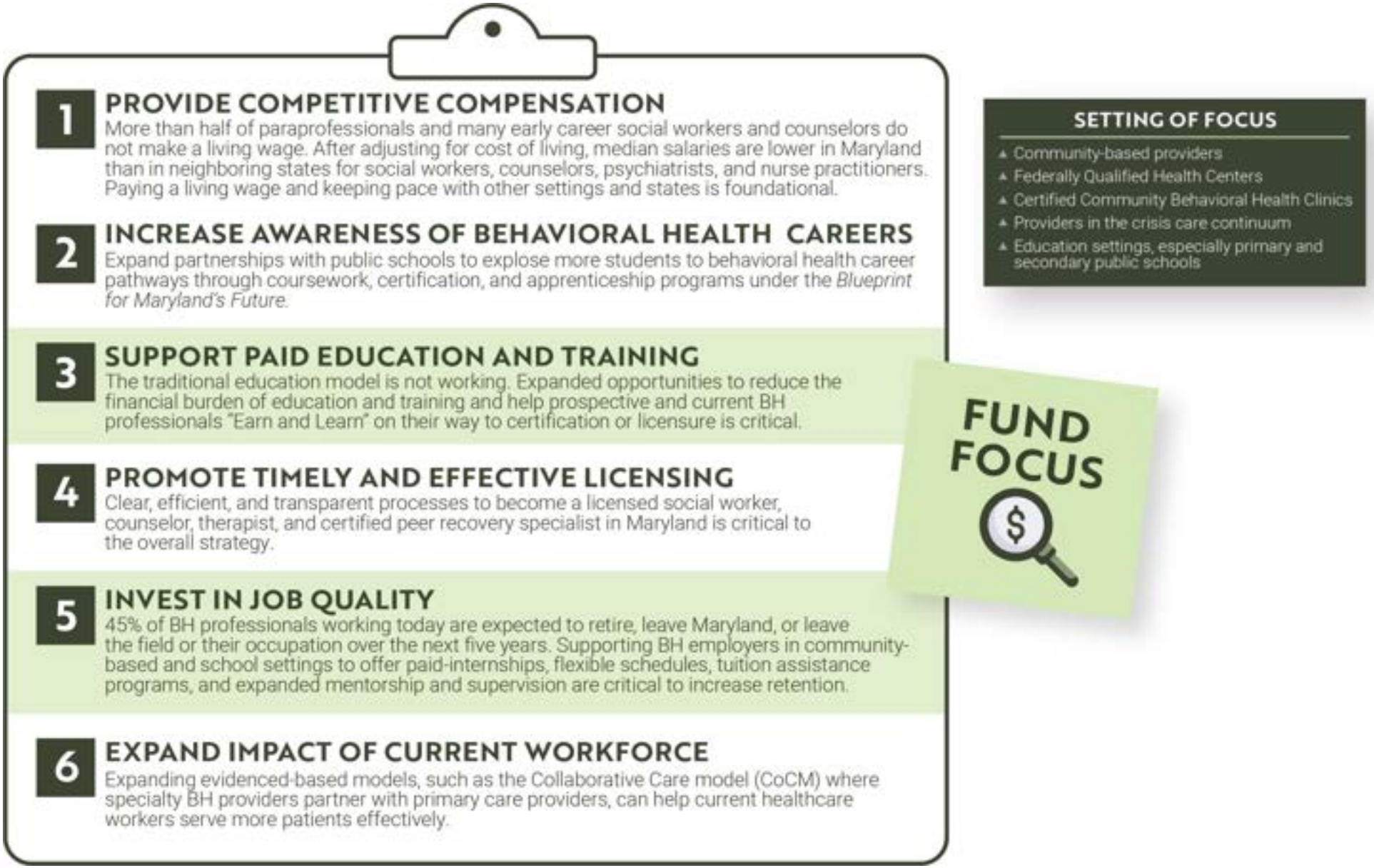
current healthcare workers serve patients more efficiently and effectively as a critical piece to meeting population needs long-term.

While we recommend the Behavioral Health Workforce Investment Fund established through SB 283 primarily focus on **STRATEGY #3 PROVIDE PAID EDUCATION AND TRAINING** *and* **STRATEGY #5 INVEST IN JOB QUALITY,** *the Fund will be most impactful if it is part of a coordinated effort across agencies to address the shortage that also includes Strategies 1, 2, 4, and 6.*

The design and execution of these strategies should be grounded in three core principles – Equity, Collaboration, and Outcomes – to expand the number of peer recovery specialists, addiction counselors, social workers, professional counselors, nursing professionals, nurse practitioners, and psychiatrists working in settings where care is delivered, regardless of an individual's ability to pay.

The focus of the recommendations is to increase the number of providers working in community-based programs, federally qualified health centers (FQHCs), the newly established certified community behavioral health clinics (CCBHCs), the crisis care continuum, and education settings, including primary and secondary schools. These settings were identified as having some of the biggest challenges attracting and retaining qualified BH professionals and are also where high levels of resident access care, especially those without privately funded health insurance.

Figure 37: Maryland Community BH Workforce Strategy



4.1: Strategy 1 – Provide Competitive Compensation

> Run back to college, if you want to make a livable income, ***don't*** become a social worker.
>
> *Licensed Clinical Social Worker*

Pay was the most important workforce issue identified by almost all employers and professionals we spoke with. Addressing this issue will likely require significant changes to how services are funded, such as increasing Medicaid reimbursement rates or developing new payment models. While there are many other interventions that improve workforce recruitment and retention, Maryland's BH system is likely to continue to experience a workforce shortage without increases in compensation to critical BH occupations, including peers, counselors, therapists, and social workers. Interviewees communicated that:

- *Low pay is a root cause of the shortage*, with interviewees identifying it as the most significant impediment to increasing new entrants into the field and retaining those already working in community BH settings. While benefits such as tuition assistance, loan forgiveness, and other incentives and support are important, most emphasized that they will have limited effect long-term if compensation for critical roles continues to lag behind the cost of living, other settings (e.g., schools or hospitals), and/or other states.
- *Different occupations use different reference points when assessing "fair" or "competitive" compensation.*

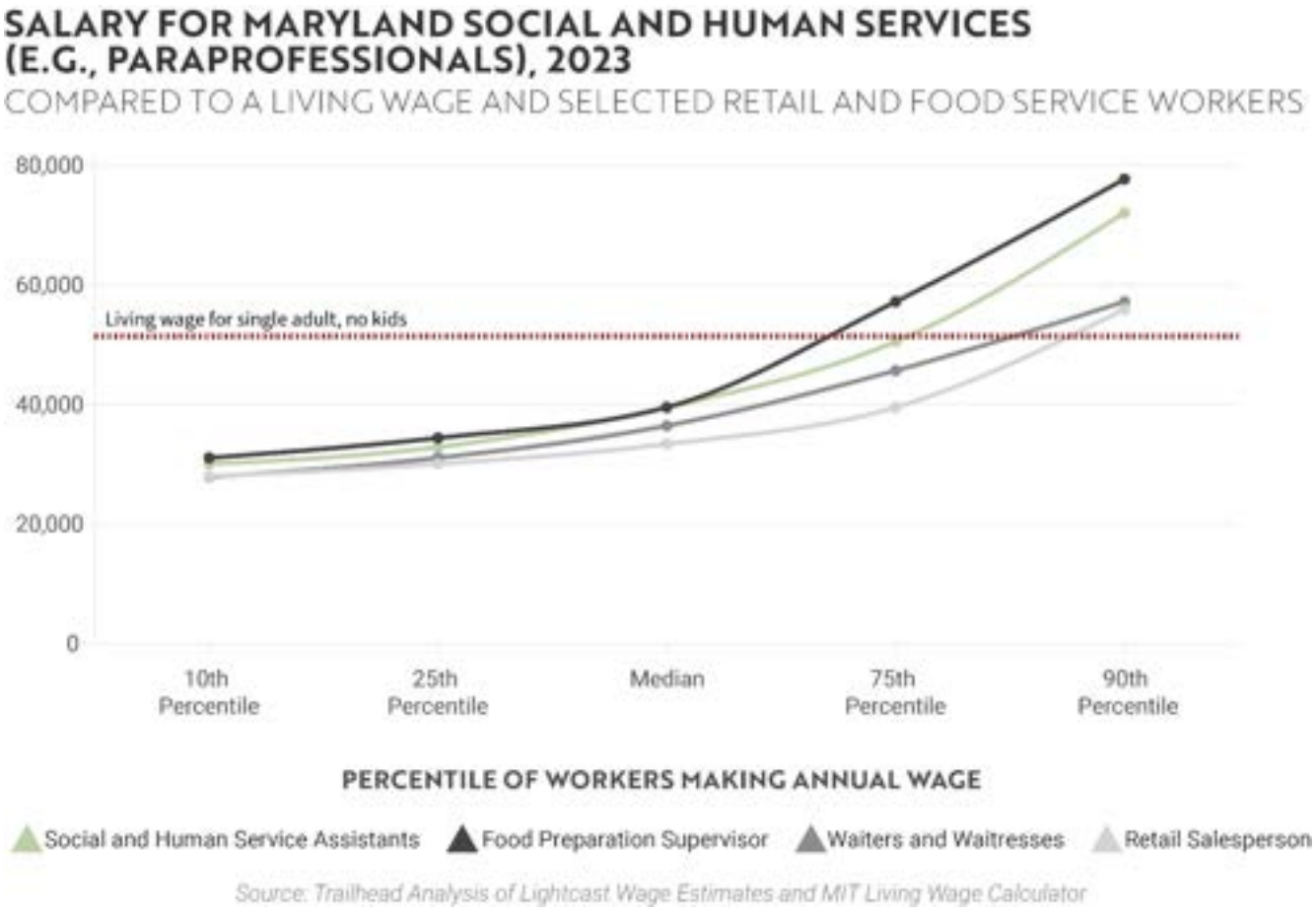
> What I am doing is not sustainable. I'm paycheck to paycheck, I cannot support a family.
>
> *Unlicensed Case Manager*

Peer recovery specialists, unlicensed professionals, and certified alcohol and drug (A&D) counselors often think about their pay in comparison to other, less stressful industries (e.g., retail, food service, hospitality) and/or whether they make a living wage/that can support their family and meet their basic necessities such as rent, food, child care, and transportation[33]. This sentiment tracks with available data on earnings and wages. Based on US Bureau of Labor Statistics estimates, we found that

[33] A living wage in Maryland for one adult, no children is $24.74 and a single parent with one child is $41.75 based on MIT's Living Wage Calculator (https://livingwage.mit.edu/states/24).

75% of social and human service assistants (e.g., paraprofessionals) make less than a living wage of $24.74 an hour (or $51,460 per year) for an adult with no dependents in the State of Maryland.

Figure 38: MD Wages of Social and Human Service Assistants, 2023



Licensed clinicians, including LCP/LCPCs and LSW/LCSWs often evaluate their wages by setting. The most common comparisons were made between community settings as compared to schools, FQHCs, hospitals, telehealth providers, and private practice, all recognizing they can make more outside of community or public BH. Additionally, these professionals who hold master's degrees often talk about their pay in relation to the years of education they completed, unpaid internships they participated in while delivering services, and the student debt they carry.

Many expressed views that if they had a better understanding of the financial burden of becoming a licensed clinician, they would not have gone down this career path. Some interviewees shared that they are cautioning others not to get a master's degree. Our analysis

suggests this sentiment of low pay is based in reality; available wage and employment data suggests ~25% of counselors and therapists, and social workers make less than a living wage ($51,460 per year) for a single adult in Maryland, and a much larger share do not make enough to support themselves and a dependent, estimated at $86,850[34].

> *As this sentiment of pay incommensurate with education requirements and costs continues to take hold, it will be difficult to overcome to attract new entrants into the field.*

Psychiatrists and nurse practitioners expressed less dissatisfaction with wages overall and focused more on the differences in pay between community-based BH and hospital settings or private practice. They also noted that pay in BH is significantly below other specialties. Psychiatrists in particular expressed satisfaction with the flexibility they have to craft a career with a high salary from multiple sources, including private practice, contract work at a hospital, and teaching or consulting.

> *Several community-based interviewees mentioned hiring a psychiatrist as a medical director is not considered an option or possibility because of the pay disparity.*

- *Pay at community-based providers lags behind other behavioral health settings.* While salaries are low across the BH field, community-based providers described consistent struggles competing with the pay offered by hospitals, schools, and private practices. Most social workers in BH settings did make significantly less in 2023 compared to social workers in child welfare, school, hospital, or other healthcare settings based on wages reported by employers and aggregated by the US Census.

  The median wage for social workers in BH was $55,475 compared to $67,074 in child, family, and school settings, $63,699 in healthcare settings (e.g., hospitals), and $66,236 in all other settings. However, job posting data from January 2021 through January 2024 shows a slightly different picture, with advertised salaries for social workers in healthcare settings at $85,376 and BH settings at $72,576, followed by child, family, and school social workers at $61,568. Note, wage estimates include fully licensed social workers and social workers still working to accrue hours.

Figure 39: MD Median Social Workers Wages by Setting*

34 ibid

	SUD/MH SOCIAL WORKERS	CHILD, FAMILY, AND SCHOOL SOCIAL WORKERS	HEALTHCARE SOCIAL WORKERS	SOCIAL WORKERS ALL OTHER
	21-1023	21-1021	21-1022	21-1029
Nominal Wages Reported (2023)	$55,475	$67,074	$63,699	$66,236
Maryland Job Postings (2021-2024)	$72,576	$61,568	$85,376	Insuf. Data

** Wage estimates include individuals who are not yet fully licensed.*

- *Pay needs to be addressed across the State of Maryland.* Many employers have made efforts to improve compensation, including significant pay increases, signing bonuses, and retention bonuses since the onset of the pandemic. However, they recognized that while this may improve staffing at one organization, other providers may not be able to afford to match the increased salaries. This results in professionals moving from organizations with lower resources to those with more funding but does not necessarily bring more people into the field. This was also mentioned in the context of public schools hiring and recruiting for more BH professionals.

As discussed earlier, perspectives and opinions on what is "fair" or "competitive" pay are often developed and communicated relative to what other workers are making in other markets or industries. When looking at salaries relative to neighboring states and Washington D.C., we see that for most occupations, Maryland, along with the DC metro area, pays higher than Pennsylvania, Virginia, and West Virginia. That is shown as the column labeled nominal salary in Figure 40, below. However, after adjusting for cost of living, Maryland median wages ranked either last or second to last in all but one occupation. Because of the cost of living in Maryland, salaries of BH workers offer less purchasing power than the salaries of BH workers living in neighboring states or the District of Columbia. These low cost of living adjusted wages may contribute to the sentiment from BH employers and professionals that the Maryland BH workforce is underpaid and that a statewide payment reform is required to close the gap.

Figure 40: Maryland BH Nominal and Cost of Living (COL) Adjusted Wages Compared to Other States, 2023

	MARYLAND		PENNSYLVANIA		VIRGINIA		WEST VIRGINIA		WASHINGTON, D.C.	
Green = MD in top 1 or 2 Red = MD in bottom 1 or 2	NOMINAL	COL ADJUSTED	NOMINAL	COL ADJUSTED	NOMINAL	COL ADJUSTED	NOMINAL	COL ADJUSTED	NOMINAL	COL ADJUSTED
Psychiatrists	50,376	197,769	262,682	257,279	239,292	234,141	Insuf. data	Insuf. data	230,121	195,515
Physician Assistants	127,775	100,928	119,178	116,727	121,984	119,358	120,809	126,501	124,742	105,983
Nurse Practitioners	127,633	100,816	125,873	123,284	123,772	121,108	108,752	113,877	126,601	107,563
Psychologists	102,853	81,243	74,520	72,987	90,667	88,715	66,168	69,286	101,927	86,599
Registered Nurses	89,247	70,495	82,741	81,039	84,035	82,227	78,700	82,409	92,677	78,740
Therapists	65,507	51,744	63,529	62,222	58,232	56,979	52,422	54,892	65,978	56,056
Licensed Practical Nurses	64,432	50,894	59,612	58,386	58,143	56,892	47,580	49,822	66,491	56,492
Social Workers	55,476	43,820	46,163	45,214	58,291	57,036	38,431	40,242	70,613	59,994
Counselors	54,373	42,949	50,583	49,543	54,605	53,430	44,568	46,668	60,853	51,701
Community Health Workers	47,764	37,728	47,207	46,236	49,240	48,180	35,808	37,496	57,298	48,682
Medical Assistants	43,979	34,738	39,450	38,639	40,197	39,332	34,332	35,949	45,907	39,003
Psychiatric Aides	41,529	32,804	44,921	43,997	34,651	33,905	28,184	29,512	41,088	34,909
Psychiatric Technicians	40,019	31,611	39,458	38,646	40,830	39,951	28,600	29,948	47,164	40,071
Social and Human Service Assistants	39,775	31,418	40,944	40,102	38,220	37,397	34,833	36,474	44,135	37,498
Occupational Therapists	99,244	78,516	92,208	90,400	97,733	95,536	86,023	90,265	102,065	86,864
Rehabilitation Counselors	38,647	30,527	47,115	46,146	43,950	43,004	40,709	42,628	43,805	37,218
Nursing Assistants	38,577	30,472	38,511	37,719	36,762	35,971	35,453	37,123	41,592	35,337

4.2: Strategy 2 – Increase Awareness of Behavioral Health Careers

Residents of Maryland cannot aspire to a career they do not know exists. Greater awareness of BH careers through the K-12 school system and post-secondary nursing, medical, social work and psychology programs is needed to expand the pipeline of future BH professionals.

- There is o*pportunity to increase awareness of community BH careers through the public K-12 school system*, including both the need for increased awareness of mental health and substance use disorders generally as part of overall health and well-being, and exposure to specific careers in the field. Several interviewees mentioned the lack of programming to school-age youth and the need for technical education pathways in high school like those provided for other occupations, including the building and construction trades, automotive careers, and nursing and allied health.

There may be an opportunity to align with the *Blueprint for Maryland's Future* to incorporate BH exposure through expanded investments in Career and Technical Education (CTE). This could include general awareness of career paths in BH, and specific coursework, certification, and apprenticeship opportunities related to becoming peer recovery specialists, alcohol and drug counselors, community health workers, and LPNs/RNs, and general education courses on the pathway for social workers or professional counselors. Additionally, working with school-based career coaches and counselors to share about education and career opportunities in community BH can better equip them with the information they need to help students in Maryland's public schools explore behavioral health career paths.

> The Blueprint for Maryland's Future sets a goal for 45% of high school graduates completing an apprenticeship or an industry-recognized occupational credential by the 2030-2031 school year. The ambitious goal of nearly half of the state's high school students participating in apprenticeships indicates the priority of this initiative and the immense benefits that students and employers can gain.
>
> *Blueprint for Maryland's Future, Pillar 3: College and Career Readiness, Roadmap to Implementation, Version 2 (August 2022)*

- *Persistent stigma turns people off from the field.* Although several interviewees believed stigma has decreased, particularly with the increased prevalence of mental health conditions after the onset of Covid-19 and substance use disorders due to the opioid

crisis, most still identified misconceptions about the jobs or false beliefs about the patient population as a significant barrier to attracting new entrants. Interviewees shared that licensed practical nurses, registered nurses, and nurse practitioners were often uninformed or not interested in working in BH settings due to lower pay and a lack of training or exposure to feel comfortable working with patients in those settings. Interviews suggested investments in clinical rotations, paid internships, and fellowships for these positions in these settings is important to help increase interest.

4.3: Strategy 3 – Support Paid Education and Training

The traditional education model requires students to pay for their own education or training out-of-pocket or through student loans, complete unpaid internships, pay ancillary costs for fees and books, navigate the certification and licensure pathway, then apply for paid employment. This model does not work for many adult-learners juggling second jobs and dependent care or low-income learners who cannot do unpaid internships.

> *The traditional education model of training "on your own time" and "on your own dime" is limiting the BH talent pool. Expanding opportunities to "earn and learn", including apprenticeships, paid-internships, training stipends, fellowships, and residences should be a major focus of the Fund.*

This strategy is focused on creating structured "Earn and Learn" opportunities to open more onramps for new entrants to become BH professionals and for incumbent workers to advance in their careers. Interviewees shared that:

- *There are significant barriers to becoming peers and addiction counselors.* Prospective practitioners must navigate confusing processes for certification and pay required costs such as exam fees, course fees, and books. Training is often unpaid, which requires trainees to go without income or take on additional work to make ends meet. In addition, background check rules for certification and/or hiring in public agencies and publicly funded agencies are disqualifying for many with lived experience, who often have former involvement with the justice system resulting from their mental health or substance use experience.

  Unpaid field placements and clinical work requirements cause many students to drop out and not enroll in academic programs, including Social Work, Counseling, and Addiction Studies certificate and degree programs. The requirement for unpaid work is turning people off from the field, and in some cases, resulting in students dropping out of school. Interviewees shared this is especially impacting those from lower-income and/or

diverse backgrounds underrepresented in the profession who cannot afford to go without income.

Master of Social Work degree completions from Maryland's three schools of social work peaked in 2019, awarding 717 MSW. In 2022, 654 MSW were awarded, a decline of 9%. Interviewees shared that more and more students are not able or willing to complete unpaid field placement requirements, contributing to the drop in enrollments.

- *The lack of quality supervision and fellowship opportunities in community BH is limiting recruitment efforts*, as many community-based providers that need licensed clinicians do not have the bandwidth or capacity to 1) establish or maintain relationships with education programs to host interns 2) provide post-graduate supervision opportunities with the necessary structure and support new professionals need to be successful and/or 3) create a financially sustainable internship or supervision program without asking more from existing staff who may already feel overworked.
- *Rural providers on the Eastern Shore and in Western Maryland have unique challenges. Interviewees from these areas experience* challenges attracting and supporting master's level interns and supervision opportunities for licensed clinicians due to a lack of available clinical supervisors and fewer opportunities to connect with students and recent graduates interested in living and working in less urban areas of Maryland.

4.4: Strategy 4 – Promote Timely and Effective Licensing

Challenges with the licensing and certification process was identified as a significant issue by both staff and employers in Maryland. This has both a direct impact on the availability of services, as there are less licensed clinicians, as well as disincentivizing individuals from entering the profession or attaining licensure. Major themes from interviewees included:

- *The Peer Certification Process is confusing and difficult to navigate.* The process, overseen by the Maryland Addiction and Behavioral-health Professionals Certification Board (MABPCB), often requires signing up for several different courses to meet hours requirements in different

> Getting certified as a peer is like... imagine a bingo card, that you don't know how to fill out, but have to complete within a certain timeframe.
>
> *Community Behavioral Health Advocate*

categories. There are few comprehensive training packages, so prospective peers often need to take training with multiple providers. In some areas, particularly rural regions on the Eastern Shore and Western Maryland, the required training may not be available for months. These issues result in peers not completing their required training to become certified, or not entering the field at all.

- *There is a lengthy approval process for counselors and therapists to become licensed* through the Maryland Board of Professional Counselors and Therapists, which discourages people from joining and moving up in the field. This impacts alcohol and drug counselors, professional counselors, marriage and family therapists, behavioral analysts, and art therapists. Interviewees identified delays throughout the certification process, from confirmation an application was received, scheduling exams, receiving results from exams, and receiving licensure. Some employers shared stories of themselves or their staff waiting over six months for an exam date and over a year, or even up to two years, to get licensed.

> Who in their right mind is going to take two years to get licensed?
>
> *Community BH employer*

- It is challenging to recruit *providers from other states,* including licensed counselors, therapists, and social workers, because of the difficulty getting a license to practice in the State of Maryland. Challenges include scheduling exams and getting licensed in a timely manner, and additional and duplicative education requirements, even for providers who have been practicing for decades. Employers mentioned many of their staff are getting licenses to practice in neighboring states but are able to recruit very few professionals – especially counselors and therapists - from outside Maryland to practice in the state because of the state licensing process.

> A top priority should be licensure reciprocity with other states in order to increase the behavioral health workforce.
>
> *Maryland BH Policy and Advocacy Leader*

- *Lack of published information and demographic data* from the licensing boards make it difficult to evaluate progress or trends related to active licenses and diversity of

behavioral health professions. Multiple interviewees expressed frustration with the perceived lack of transparency, citing the lack of information on processing times, lack of recent data on active licenses available on the certifying boards' websites, and lack of information on demographic data. During regional input sessions, several attendees mentioned Virginia's Department of Health Professions Healthcare Workforce Data Center[35] as a leading state in this area that should be considered as a model.

4.5: Strategy 5 – Invest in Job Quality

> If we don't focus on the staff we have now with the Fund, it will be like pouring water into a cup with leaks in the bottom. It won't work.
>
> *BH Policy and Advocacy Leader*

Employers and policy leaders recognize that improved recruitment efforts will not address the workforce shortage if existing staff continue to leave the field at their current pace. In *Section 2* of this report, we estimate that nearly 40% of the 15,770 professionals in target occupations will retire, leave Maryland, or leave their occupation over the next 5 years. Nearly 11% of social and human service assistants (e.g., paraprofessionals), 9% of counselors and 7% of social workers leave BH each year. Employers and BH professionals shared the following themes related to retention, burnout, and job quality.

- *Employers need to adapt to the changing preferences of the modern workforce.* Most employers expressed significant differences in the values and goals of workers entering the field now compared to those from previous generations. They reported that many newer entrants into the workforce are looking for flexible schedules and the ability to work remotely and are less interested in benefit packages and a consistent schedule, making it hard to compete with telehealth providers and technology-based treatment providers. In some cases, program requirements and client/patient needs are not conducive to working from home.
- *Improving job quality can improve retention.* Interviewees reported a focus on how organizations in community behavioral health settings can make their employment

[35] The Virginia Department of Health Professions Health Workforce Data Center serves as a clearing house for data products related to the healthcare workforce and can be found at https://www.dhp.virginia.gov/PublicResources/HealthcareWorkforceDataCenter/ProfessionReports/BehavioralSciencesReports/

offerings uniquely attractive. Employers described successful efforts to increase benefits and improve the work setting such as offering paid internships, formalizing supervision programs, offering hybrid and flexible work schedules, promoting work-life balance, offering increased time off, and offering sabbaticals as having successfully improved retention and reduced burnout.

- *Creating structured advancement opportunities,* especially to help lower paid professionals including peers, outreach workers, unlicensed case workers, and alcohol and drug counselors take the next step in their careers. Strategies highlighted included employer-sponsored tuition assistance programs, registered apprenticeship programs, paid release time to attend courses, support with licensing and fees, and creating additional career steps with promotions and wage increases to acknowledge experience and training. Some employers are supporting staff by providing funding for continuing education credits, offering certifications, encouraging additional schooling, and offering training stipends. Practitioners noted that hands-on supervision focused on building tangible skills was important for professional growth.

- *Culture matters***.** Providers described how changes to work environments improved their experience and willingness to stay in the field. Maryland BH employers are instituting initiatives such as open-door policies for organizational leaders, team building activities, and events to show appreciation, which some report have improved morale and retention. Many discussed the importance of meaningful supervision, including regular meetings, a focus on skill building, and providing emotional support. Several mentioned increased efforts to gather feedback from employees, including conducting listening sessions and conducting surveys with a commitment to addressing issues that surface.

- *Providers care deeply about their work and making a difference*. Frontline professionals we interviewed spoke passionately about their role in their clients or patients' lives and the impact they were making in the community. Several shared they knew that compensation in the field was low but were committed to helping others. Therefore, feeling like their work is meaningful is critical to job satisfaction. When asked how the Fund could improve their job satisfaction, many practitioners brought up ways to improve service delivery, such as increased availability of services for clients and better training about available resources. Opportunities to help providers see the impact they are making were

> "At the end of the day, you get to look at yourself in the mirror and be proud of what you have been able to accomplish."
>
> *Case Manager*

shared as a critical strategy to reduce burnout and reduce turnover in the field.

4.6: Strategy 6 – Expand Impact of Current Workforce

In addition to interventions designed to attract and retain more workers, interviewees shared opportunities to improve efficiency and increase capacity of the existing healthcare workforce to meet the substance use and mental health service needs of Maryland residents. While each of these strategies requires further vetting, prioritization, and feasibility, this section highlights areas to explore as part of a larger workforce strategy, including:

- *Expanding the adoption and usage of the Collaborative Care Model (CoCM).* Many interviewees suggested that the workforce shortage is so great that a major focus area for the State could be focused on expanding adoption and usage of CoCM, a systematic strategy for treating behavioral health conditions in primary care through the integration of care managers and psychiatric consultants. Interviewees referenced and shared

> I can see one patient in an hour, but using Collaborative Care, I can assist with the treatment of 10-12 patients in the same amount of time. That's a very dramatic expansion.
>
> *Rachel Weir, MD*
> *Chief of Mental Health Integration, University of Utah Health, 2022* [36]

While the impact has been well documented, major challenges exist to broader adoption of this evidence-based model that are outside of the scope of this report or the Fund to address, including:

- Clinical challenges such as lack of acceptance of the model by the primary care workforce, insufficient knowledge in the primary care workforce on diagnosis and treatment of behavioral health conditions, and poor communication concerning the change process.

[36] Weiner, Stacy. A Growing Psychiatrist Shortage and an Enormous Demand for Mental Health Services, AAMC News. August 2022. Article. https://www.aamc.org/news/growing-psychiatrist-shortage-enormous-demand-mental-health-services

- Organizational challenges including time allotted in primary care to evaluate and treat behavioral health conditions and limited access to psychiatric prescribers as consultants and case managers.
- Low Medi-Caid reimbursement rates for collaborative care
- Billing restrictions associated with same day billing for medical and psychiatric services.

- *Expanding telehealth and contract work arrangements.* The lack of prescribers has led employers to explore alternative employment models. The lack of psychiatrists working in community settings has led providers to find new ways to expand prescribing capabilities. While emphasizing the state undoubtedly needs more psychiatrists working in specific settings and neighborhoods, some interviews suggested a focus on highlighting and potentially expanding promising models related to using telehealth, and contract arrangements to facilitate psychiatrists working in other settings or to bring semi-retired professionals to support community BH programs on a part-time or contract basis.

- *Exploration into responsibly incorporating AI and other technology innovations into the system of care*. Interviewees and input session participants shared the importance of staying abreast of technological advances in this area and having a perspective of if and how new AI and technology tools can help meet unmet need for BH services, including how AI can potentially be used to reduce administrative requirements, create billing efficiencies, and potentially support in diagnostics overtime.

SECTION 5: THE BEHAVIORAL HEALTH WORKFORCE INVESTMENT FUND RECOMMENDATIONS

We recommend the Fund established through SB 283 be primarily focused on **Strategy #3 Provide Paid Education and Training** and **Strategy #5 Invest in Job Quality.** These two strategies are where capital constraints (e.g., lack of funding) are the primary challenges to scaling and expanding capacity in the workforce pipeline in Maryland, whereas the other strategies involve major policy, procedural, or structural changes (e.g., increased Medicaid payment rates for **Strategy #1 Provide Competitive Compensation**).

In this section, we make recommendations about the size of the Fund and the types of programs for initial investment for the eight target occupations and target settings.

> *The goal of this section is to provide a working model to identify, raise, and braid sufficient funding from a variety of different sources – including a catalyzing "down-payment" from the State of Maryland, supplemented by federal matching, grant and formula funds, state funds from multiple agencies, and private philanthropic funds – to produce and retain sufficient skilled, qualified, diverse, and culturally competent BH professionals to meet the need of Maryland resident's, regardless of their ability to pay for care.*

5.1: Sizing the Financial Need Over the Next Five Years

To develop an estimate of the amount of funds needed to invest in new or expand existing BH education programs, we used the gap between the number of additional professionals needed over the next five years (*Section 2*). We calculated the BH talent gap in the State of Maryland over the next five years using two estimates:

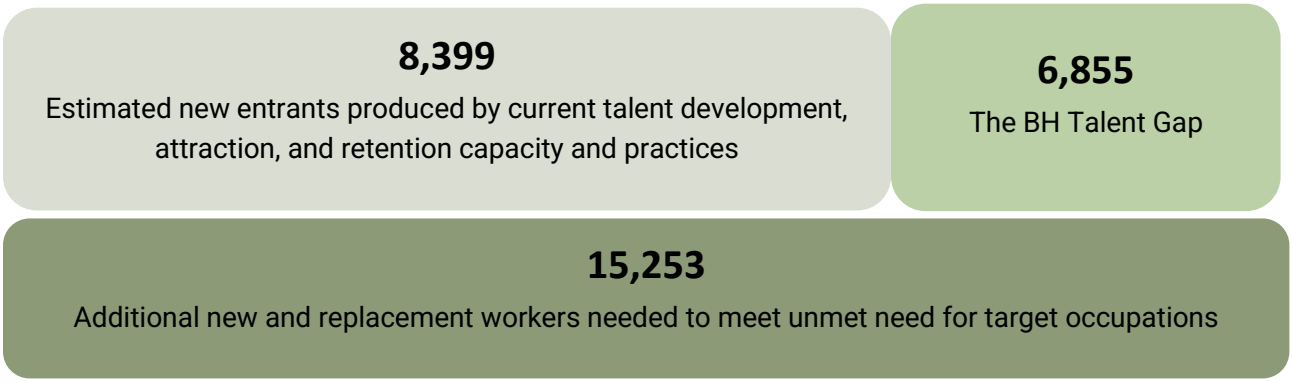
- The additional new and replacement workers needed (*Section 2*)
- The estimated new entrants into each occupation absent a major additional investment, which we based on current occupational growth and replacement rate trends[37].

[37] Data specific to the Maryland higher education system can be found in Section 3. Given's Maryland's proximity to major university systems in Washington D.C. and surrounding states we opted not to use strictly Maryland higher education system degree completions.

The resulting "talent gap" is the difference between the number of BH professionals needed to meet unmet need in five years and historical and current employment growth, turnover, and retirement trends for the following occupations:

- Certified peer recovery specialists
- Alcohol and drug counselors
- Professional counselors
- Social workers employed in BH settings
- Licensed practical nurses and registered nurses working in BH settings
- Nurse practitioners working in BH settings

Figure 41: Closing the Workforce Shortage in Target Occupations by 2028



The workforce challenge is somewhat different for psychiatrists, an overall shortage today is not the primary issue. There were 1,196 psychiatrists in Maryland in 2023 according to the AMA Physician Masterfile, or 19.3 per 100,000 residents, above the widely used US Department of Health and Human Services (DHHS) 15.4 benchmark per resident. However, 85% of Maryland's psychiatrists work in Baltimore City and County, Montgomery County, and Howard County, and many work in private practice and do not take patients if they do not have private insurance.

Further, more psychiatrists are retiring in Maryland than are being trained in residency programs. In 2024, 32 psychiatrists are expected to retire or leave the field, but only 27 psychiatry residents matched at John Hopkins (11 matches) and the University of Maryland / Sheppard Pratt (16 matches). Maryland 38th out of 50 states in matches per capita.

We recommend an increase of 10 psychiatry residents per year, bringing the total to 37. This would increase Maryland's resident per capita rank up to 25th out of the 50 states and above the projected number of psychiatrists who are projected to retire or otherwise leave the field each year between now and 2028.

Figure 42: Recommended Increase in Psychiatry Residency Matches

	PSYCHIATRY RESIDENT MATCHES	PER CAPITA STATE RANK (2024 DATA)	ADDITIONAL NEEDED
2024 Matches (Actual)	27	37th	0
Recommended	37	25th	10

After establishing targets for additional professionals needed for each occupation, we estimate the cost to train, recruit, and/or retain an additional worker based on existing investments and programs in Maryland, insights from interviews with employers and academic programs, and a review of programs from other States.

We estimate Maryland needs to expand capacity to train, employ, and retain an additional 7,000 professionals in eight BH occupations over the next five years. Based on cost estimates for each target occupation, we estimate $149M is needed to close the BH workforce gap over the next five years.

Figure 43: Estimated Total Funds for to Address Shortage in Critical Occupations

TARGET OCCUPATION	2023 WORKERS	ADDITIONAL NEEDED (NEXT 5 YEARS)	EST. NEW ENTRANTS (NEXT 5 YEARS)[38]	GAP (NEXT 5 YEARS)	EST. COST TO TRAIN/RECRUIT/RETAIN ADDITIONAL WORKER	5 YEAR DIRECT PROGRAM COST
Certified Peer Recovery Specialists[39]	1,137	1,204	625	579	$7,500	$4,342,500
Alcohol and Drug (A&D) Counselors[40]	2,332	2,545	1,456	1,090	$10,000	$10,900,000
Professional Counselors[41]	6,039	6,592	3,770	2,822	$20,000	$56,440,000
Social Workers (in BH)	2,799	2,675	1,444	1,231	$20,000	$24,620,000
LPNs and RNs	2,465	1,899	934	965	$15,000	$14,475,000
Nurse Practitioners in BH	313	338	170	168	$100,000	$16,800,000
	2024 MATCHES	**ADDITIONAL NEEDED PER YEAR**		**GAP (NEXT 5 YEARS)**	**EST. COST PER YEAR**	**5 YEAR DIRECT PROGRAM COST**
Psychiatry Residents	27	10		50	$150,000	$7,500,000
Total Direct Costs	15,112	15,253	8,409	6,905		$135,077,500
Administration (10%)						$13,507,750
Total Cost						$148,585,250

Other states are making similar investments in their BH workforces using American Rescue Plan Act (ARPA) funds, Opioid Settlement Funds, and State general funds. Massachusetts, a state of similar size, population, and administration (e.g., a state-administered system) established a $192M fund using ARPA funds that need to be obligated by the end of 2024 and fully spent by 2026.

Colorado, Ohio, and California have also capitalized similar grant programs and funds at varying amounts alongside county investments and established systems for subsidized student loans,

[38] Estimates based on the assumption that the current education and training system (absent additional investment) is currently producing enough workers in each occupation to a) replace workers leaving the field and b) to continue to support the occupation growth rates we saw from 2022-2023 forward the next five years.
[39] This report estimates 15% of CPRS make up the larger Social and Human Service Assistant SOC code and estimates of the shortage provide in section 3.
[40] This report estimates 27% of Counselors and Therapists are A&D Counselors based on 2021 Maryland Board of Counselors and Therapists active licensure data.
[41] For this section, this report estimates 69% of Counselors and Therapists are Professional Counselors based on 2021 Maryland Board of Counselors and Therapists active licensure data.

public service loan forgiveness programs, and federal and state education training grants and formula funds (e.g. Pell grants).

Figure 44: Examples of State BH Workforce Funds or Grant Programs

STATE *LEAD AGENCY* (PRIMARY FUNDING SOURCE)	2023 POPULATION	BH WORKFORCE FUND SIZE
Commonwealth of Massachusetts *Executive Office of Health and Human Services* (American Rescue Plan Act Funds)	7,001,399	$192,000,000
State of California *Department of Health Care Access and Information* (Opioid Settlement Funds, CA Mental Health Services Act, General Funds)	38,965,193	$328,863,794
State of Colorado Behavioral Health Administration *(American Rescue Plan Act Funds)*	5,877,610	$70,000,000
State of Ohio Department of Mental Health and Addiction Services *(American Rescue Plan Act Funds)*	11,785,935	$85,000,000

5.2: Programs and Investment Areas

This section provides brief descriptions, potential program models, examples of similar workforce investments, and consideration for fund distribution and administration. Investment areas were selected based on the following criteria:

- *Alignment with research findings*: The investment areas and administrative considerations address the major challenges and needs shared during interviews, regional input sessions, and data analysis discussed in *Sections 1-3*.
- *Capital as the major barrier*: Investment areas are focused on solutions where funding is the primary limiting factor to educating, training, or retaining additional BH professionals to work in community settings.

- *Opportunity to braid funding*: Programs highlighted have the potential to leverage other state and federal funding sources to sustain the program long-term.
- *Enhancing what is already workin*g: Investment areas are not strictly about "building something new" but are written to help support or expand existing activities and programs already in place that need additional funding to expand.

Program models were selected based on the effectiveness of similar programs in Maryland or other states, successful implementation of comparable programs in related fields, and feedback from interviewees. Given the breadth and variance of the types of potential programs for consideration below, the information on each program area below is intended to serve as starting points for prioritization and further vetting. Additional work from state agency staff and other relevant subject matter experts is needed to operationalize each program, including developing potential scopes of work for Request for Proposals (RFPs).

Figure 45: Summary of Potential Fund Investment Areas

PROGRAMS AND INVESTMENT AREAS	RECOMMENDED AMOUNT OVER 5 YEARS
Certified Peer Recovery Training and Placement Grants Performance-based contracts to educational programs, community-based providers, 501c3 non-profits, and other organizations that support residents with lived experience through the enrollment, certification, placement, and retention of Certified Peer Recovery Specialists in Community BH settings.	$4,342,500
Alcohol and Drug Counselor Apprenticeship Program Grants to colleges and non-profit training institutions to set up or expand Alcohol and Drug Counseling registered apprenticeship programs and/or similar programs that provide A&D trainees free classroom training and paid work experience to begin or advance on the A&D counselor pathway (e.g., ADT to LCADC)	$10,900,000
Social Worker Residency Program A multi-year grant award to one or more of the universities in Maryland with existing Master of Social Work programs to develop a Social Work Residency Program. Schools would be required to design a course of study around a full-time work schedule and target recruitment at current behavioral health or social service programs who agree to provide paid practicum experiences. The goal of this "earn and learn" model is to help working adults currently employed in community BH to earn a Master's degree and become an LCSW with minimal financial burden; that is, they continue to work at their current job throughout the program and practicum and have dedicated financial aid, tuition assistance, and/or loan forgiveness support.	$21,060,000
Expanding Maryland Loan Repayment Programs to Include Social Workers and Professional Counselors	$10,000,000

PROGRAMS AND INVESTMENT AREAS	RECOMMENDED AMOUNT OVER 5 YEARS
Expand investments and include licensed clinical social worker and licensed clinical professional counselor in state and HRSA loan forgiveness programs operated by Office of Population Health Improvement.	
Community Behavioral Health Talent Attraction and Retention Investments Grants and related technical assistance for non-profit BH employers to establish new or enhance existing efforts to make their work settings more attractive places to work. This might include creating new or expanding existing tuition assistance programs, establishing high quality supervision programs, participating in apprenticeship programs, providing paid internships, offering employer-sponsored loan forgiveness (or provide help navigating existing programs), providing retention bonuses, offering sabbaticals, implementing flexible/hybrid scheduling, or other job design changes to improve retention and attract new candidates.	$50,000,000
Statewide Community Behavioral Health Nursing Apprenticeship Program A statewide grant to a university, college, consortium, and/or intermediary to coordinate with in-patient BH providers colleges/universities, and other partners to provide scholarships, supportive services, and paid release time to help current CBH staff to advance in the nursing pathway (e.g., CNA, LPN, RN).	$14,475,000
Community Psychiatric Mental Health Nurse Practitioner Fellowship Program(s) Provide grants to medical schools and/or universities with Psychiatric Mental Health Nurse Practitioner programs to create new or expand existing post-graduate fellowship programs for nurse practitioners to gain experience in community psychiatric settings working Medicaid eligible populations living with serious mental illness (SMI).	$16,800,000
Psychiatry Residency and Fellowship Program Expansion Provide grants to educational institutions, medical sites, or other organizations to develop or expand the number of annual psychiatry residency matches from 27 in 2024 up to 37 in the State of Maryland. Currently, more psychiatrists are expected to retire or leave the field in Maryland each year than are being matched in Maryland residency programs. In 2024, Maryland ranked 37th out of 50 states in psychiatry resident matches per capita; the 10 additional residency slots would bring Maryland's per capita match ranking to 25th out of 50. This investment could include community psychiatry didactic and clinical rotations in counties with the least psychiatrists per capita.	$7,500,000
Total Direct BH Workforce Program Investments (Does not Include Administration of Fund)	$135,077,550

PROGRAM 1: CERTIFIED PEER RECOVERY TRAINING AND PLACEMENT GRANTS
Investment: $4,342,500 over 5 years
Expected Outcomes: 579 trained over 5 years
Cost per trainee: $7,500

The Need: Certified Peer Recovery Specialists (CPRS) can play a critical role in treatment for those dealing with mental health and substance use disorders. Peer providers have been shown to improve treatment outcomes, including reduced hospitalizations and increased patient activation.[42] Interviews with community-based employers showed that CPRS are in high demand, but interviews with peers and community-based organizations share that it is difficult for peers to pay required course fees and navigate the current training requirements and certification process on their own. Additionally, many peer positions are currently only part-time or unpaid; peers we spoke to often had second jobs and did not see the peer position as a viable career option long term.

Many community BH settings, especially in rural settings, also do not have funds to pay a Registered Peer Supervisor (RPS) to provide the required 25 hours of supervision an individual needs to complete this training.

Overview of Potential Investment: Previous efforts to train Peer Recovery Specialists have been previously funded through the Behavioral Health Administration and the Baltimore Mayor's Office of Economic Development. By providing funding to scale these programs the Fund can support the expansion of evidence-based programs which have already been implemented successfully in the state.

The Fund can provide grants to community-based organizations providing training for peers. Programs offering comprehensive training, including all required courses, should be prioritized. Funding can cover course fees, paying a Registered Peer Supervisor (RPS) to provide required supervision, stipends, supportive services, and wage subsidies for employers hiring peers to make them full-time positions. The goal of this investment is to make the certification and placement in a paid peer role with a community-based organization accessible for Maryland residents, regardless of an individual's ability to pay for training and education.

Funding and Expected Outcomes: An investment of $4,342,500 could train an estimated 579 individuals. We recommend using the State of Maryland Department of Labor negotiated federal levels of performance for Workforce Innovation and Opportunity Act (WIOA) Adult and

[42] Chapman SA, Blash LK, Mayer K, Spetz J. Emerging Roles for Peer Providers in Mental Health and Substance Use Disorders. Am J Prev Med. 2018 Jun;54(6 Suppl 3):S267-S274. doi: 10.1016/j.amepre.2018.02.019. PMID: 29779551.

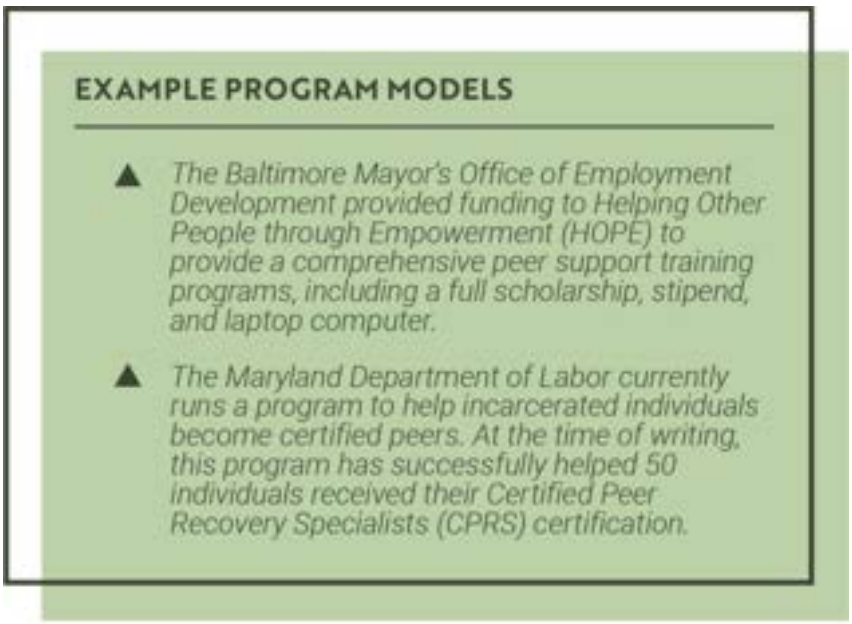
Dislocated[43] programs in 2023 to help benchmark potential outcomes to facilitate interagency alignment for this investment:

- 57% - 62.5% enrolled in training pass CPRS certification exam
- 76% - 80% are employed 90 days after completing their training program

Alignment with Existing Fund Sources: The Maryland Department of Health already provides funding to support prospective peers and peer-run organizations and there is an opportunity to partner across state agencies to meet the funding target. Additional sources of federal funding that may be well aligned to this program model include:

- The Workforce Innovation and Opportunity Act (WIOA) – Training programs on the Eligible Training Provider List (ETPL), administered by the Maryland Department of Labor, can receive federal funding through WIOA. Additionally, WIOA On-the-Job Training (OJT) funds could be set aside for community-based organizations hiring peers with subsidies up to 50% of wages for the first six months, potentially supporting more full-time employment opportunities.
- SNAP Employment and Training (E&T) – SNAP E&T can reimburse up to 50% of the costs to train eligible participants who are receiving SNAP benefits.
- Temporary Assistance for Needy Families (TANF) – TANF can support training for low-income families, whether or not they are receiving cash assistance.
- Competitive grants from the US Department of Labor Employment and Training Agency (DOLETA) and various US Department of Health and Human Services Agencies (e.g., The Substance Abuse and Mental Health Services Administration (SAMHSA).

[43] US Department of Labor, Employment and Training Administration. WIOA State Negotiated Levels of Performance. https://www.dol.gov/agencies/eta/performance/goals/negotiated-performance-levels



PROGRAM 2: ALCOHOL AND DRUG COUNSELOR REGISTERED APPRENTICESHIP PROGRAM
Investment: $10,900,000 over 5 years
Expected Outcomes: 1,090 trained over 5 years
Cost per trainee: $10,000

The Need: Maryland needs to train an additional 1,090 Alcohol and Drug counselors over the next five years to meet the treatment needs of Maryland residents. These positions are critical to addressing Maryland's opioid crisis that is showing increasing rates of substance use and fatal overdoses[44]. While many alcohol and drug counselors complete required coursework for certification through online or private providers, data from the MLDS shows that Maryland's colleges awarded approximately 200 addiction studies associate degrees and certificates each year from 2019 to 2022, not enough to close the gap.

Many individuals who are interested in this career path are adult learners, who are often unable to take time away from work to complete coursework and required training and cannot take courses outside of work due to family and childcare obligations. In addition, at current pay rates, prospective counselors may be unwilling to pay out-of-pocket or take out the loans that are often necessary in the current training environment. Opportunities for working adults to take the required classroom training while continuing to work full-time and balance other life

[44] Maryland Overdose Data Dashboard, maintained by Maryland's Office of Overdose Response

responsibilities – such as the proven Registered Apprenticeship model – are needed to bring the necessary number of professionals into the alcohol and drug counselor training pipeline.

Overview of Potential Investment: Apprenticeship programs are evidenced-based training programs that allow people to "earn" money at a job doing productive work for a host employer while "learning" the skills in a classroom and on-the-job required to advance in each career pathway.[45] Registered Apprenticeships benefit both participants, who have high levels of employment and earnings growth,[46] and employers, who can earn a return on investment of over 40%.[47] Earnings growth has been particularly high for healthcare occupations.[48] This model offers potential solutions to many of the challenges faced to becoming a certified addiction counselor in Maryland described by community based employers and their staff. These include challenges navigating the certification process, challenges faced by working adults completing unpaid internships and reducing hours at their current jobs to attend class, paying out of pocket for certification and exam fees, and coordinating their education with their work responsibilities.

Apprentices could be employed at participating community BH partner sites, potentially identified partnership with the Maryland Association for the Treatment of Opioid Dependence (MATOD) and/or the Mental Health Association of Maryland (MHAMD) and employed as "Apprentice" Care Manager / A&D Counselor or another related role for two to three years while they meet the following requirements for Certified Associate Counselor – Alcohol and Drug certification through the Maryland Board of Professional Counselors and Therapists:

- Ethics course and support becoming an Alcohol and Drug Trainee (ADT)
- Release time to get an associate degree in addiction studies
- 1,000 hours of supervised work experience to become a Certified Supervised Counselor (CSC – A&D)
- Support passing required exam and paying licensing fees

[45] Kleinman, Liu, Mastri, Reed, Reed, Sattar, & Ziegler. 2012. An Effectiveness Assessment and Cost-Benefit Analysis of Registered Apprenticeship in 10 States. Prepared for the U.S. Department of Labor, Employment and Training Administration. Mathematica Policy Research.
[46] Walton, Douglas, Karen N. Gardiner, and Burt Barnow. 2022. Expanding Apprenticeship to New Sectors and Populations: The Experiences and Outcomes of Apprentices in the American Apprenticeship Initiative. Prepared for the U.S. Department of Labor, Employment and Training Administration. Abt Associates.
[47] Kuehn, Daniel, Siobhan Mills De La Rosa, Robert Lerman, and Kevin Hollenbeck. 2022. Do Employers Earn Positive Returns to Investments in Apprenticeship? Evidence from Registered Programs under the American Apprenticeship Initiative. Report prepared for U.S. Department of Labor, Employment and Training Administration. Abt Associates and Urban Institute.
[48] Walton, Douglas, Karen N. Gardiner, and Burt Barnow. 2022. Expanding Apprenticeship to New Sectors and Populations: The Experiences and Outcomes of Apprentices in the American Apprenticeship Initiative. Prepared for the U.S. Department of Labor, Employment and Training Administration. Abt Associates.

If desired, programs could extend to support working learners to become Certified Associate Counselors (CAC-A&D), which would include:

- Bachelor's degree in a related field
- Two years of post-baccalaureate supervised work experience
- Pass the IC & RC exam
- Employer-paid exam and certification fees

This investment could provide one-time grants to colleges, universities, non-profit training institutions, and consortiums to set up, operate, and expand Registered Apprenticeship Programs in Alcohol and Drug Counseling, or other programs with an "earn and learn" model, providing both free classroom training and paid work experience. Funding can support instruction, as well as supervision and other administrative costs.

Funding and Expected Outcomes: An investment of $10,900,000 could enroll the needed 1,090 individuals into Maryland Alcohol and Drug Counselor training programs, certifying them as Alcohol and Drug Trainees (ADTs). Like the peer program, using the State of Maryland Department of Labor negotiated federal levels of performance for Workforce Innovation and Opportunity Act (WIOA) Adult and Dislocated[49] programs could help facilitate alignment in this program across state and federal funding sources. This could equate to:

- 57% - 62.5% of those who enroll a program complete the program and become Certified Alcohol and Drug Counselors (CAC or CSC)
- 76% - 80% are employed 90 days after completing their training program

Alignment with Existing Fund Sources: Apprenticeship is a recognized career development model that can be funded by the Maryland Department of Labor through WIOA programs, as well as other Labor administered programs that provides subsidies and incentives for employers, apprenticeship sponsors, and apprentice supports (e.g., transportation) such as the:

- Sponsor Apprenticeship Incentive Reimbursement Program (SAIR)[50]

[49] WIOA State Negotiated Levels of Performance. US Department of Labor, Employment and Training Administration. https://www.dol.gov/agencies/eta/performance/goals/negotiated-performance-levels

[50] SAIR, operated by Maryland Department of Labor, provides reimbursement of up to $2,500 per Registered Apprentices against the cost of required Related Instruction. https://labor.maryland.gov/employment/appr/apprgrantreimb.shtml

- Maryland Business Works program[51]
- Maryland Tax Credit for Eligible Apprentices[52]
- Maryland's Fostering Employment Program[53]

Additionally, apprenticeship has been a focus area for the US Department of Labor, which has allocated over $100 million to develop and expand registered apprenticeships between January and July 2024.

EXAMPLE PROGRAM MODEL

The Health Care Apprenticeship consortium, a multi-employer Joint Apprenticeship Training committee in Washington State, operates a Substance use Disorder Professional Apprenticeship.[54] Apprentices work full time for 2 to 2 and half years while taking courses and earning college credit and receive 560 hours of classroom training, 4,000 hours of paid work experience, and support passing the National Certified Addiction Counselor Level 1 (NCAC I) certification exam, which has reciprocity with the Washington SUDP certification. Participants sign a two-year post-graduation service commitment agreement to ensure they stay in the field.

[51] The Maryland Business Works Program, operated by Maryland Department of Labor, funds training for incumbent workers. https://www.dllr.state.md.us/employment/mbw.shtml
[52] The Tax Credit for Eligible Apprentices provides a state tax credit to Maryland businesses which employ eligible apprentices. https://labor.maryland.gov/employment/appr/apprtaxcreditinfo.shtml
[53] The Maryland Fostering Employment Program supports foster care recipients and unaccompanied youth experiencing homelessness to enter Registered Apprenticeships and Pre-Apprenticeships. https://www.labor.maryland.gov/employment/appr/apprfosteringemployment.shtml
[54] The Health Care Apprenticeship Consortium includes three behavioral health apprenticeships in three occupations: Behavioral Health Technician, Peer Counselor, and Substance Use Disorder Professional. https://healthcareapprenticeship.org/bh-apprenticeships/

PROGRAM 3: SOCIAL WORKER RESIDENCY PROGRAM
Investment: $21,060,000 over 5 years
Expected Outcomes: To be determined by potential applicants
Cost per trainee: To be determined by potential applicants

The Need: Maryland needs to train an additional 1,231 social workers working in mental health and substance use settings over the next five years. However, data from MLDS shows there has been a steady decline of MSW graduates from a peak of 717 in 2019 down to 654 in 2022, a 14% decline. Additionally, many MSW graduates do not end up working in BH; many professionals go into healthcare, private practice, child welfare, or school settings. MSW requirements for full-time study and unpaid internships or practicums put this profession out of reach for many working professionals. And with a median wage for social workers working in BH settings in Maryland estimated to be $49,336[55] out of college, many prospective students recognize the challenge in paying back the significant loans they may have to take out.

An alternative model for working professionals is needed. A novel social work residency program would allow paraprofessionals working in community BH opportunities to enroll and complete MSW programs while continuing to work full time, opening up a large number of new prospective students for the University of Maryland Baltimore, Salisbury University, and Morgan State University to recruit. This approach may help reverse downward MSW degree completion trends observed over the last four years and address the shortage.

Overview of Potential Investment: A residency program for social workers solves many of the challenges identified by behavioral health employers and frontline staff, including difficulty recruiting new social workers, lack of diversity among providers, and unpaid internship and practicum requirements. It can also increase retention for those working in community behavioral health settings by providing a concrete and attainable career path which lead to higher wage jobs. Grants to colleges or universities with existing Master of Social Work programs to develop Social Work Residency Programs through an REOI/RFP process. Schools would be required to design a course of study around a full-time work schedule and target recruitment at current behavioral health or social service programs who agree to provide paid practicum experiences. The goal of this “earn and learn” model is to help working adults currently employed in community BH to earn a master’s degree and become an LCSW with minimal financial burden (e.g., they continue to work at their current job) and dedicated financial

[55] Trailhead analysis of Lightcast job posting analysis.

aid and loan forgiveness support. Ultimately, students should be able to complete their MSW with little or no money in debt or out of pocket costs.

Funding and Expected Outcomes: With few existing models of similar programs, the outcomes of this $21,060,000 would be determined by potential bidders in a Request for Expression of Interest (REOI) or Request for Proposal (RFP) process.

Alignment with Existing Fund Sources: Maryland may be able to supplement new investments by leveraging existing funding for social work programs including:

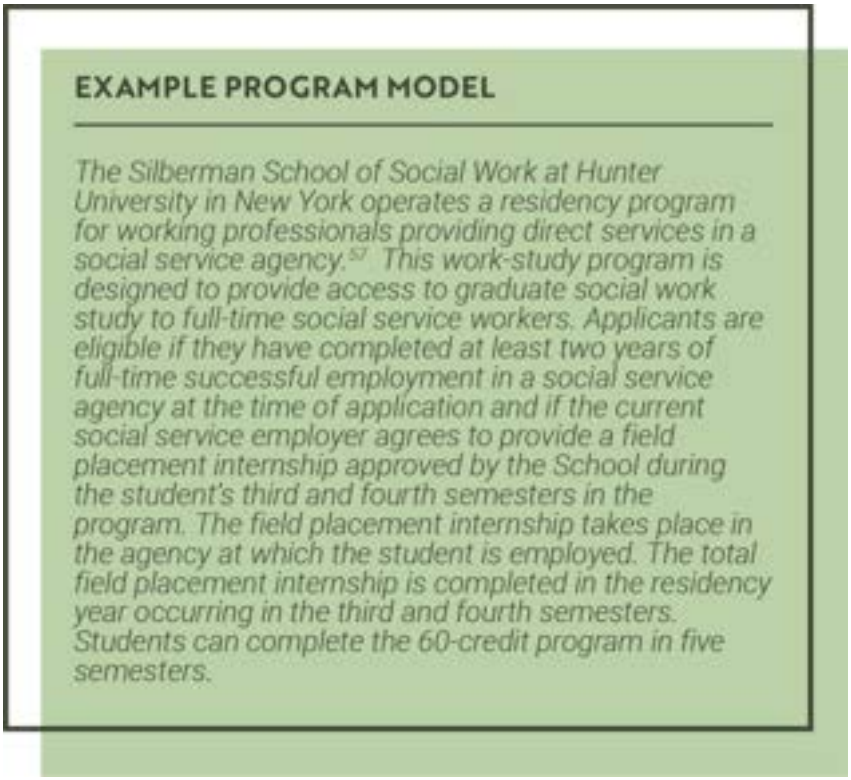
- The Workforce Shortage Student Assistance Grant Program. which provides financial assistance to Maryland residents who are planning to work in specific occupations, including social work.
- The State Opioid Response (SOR) funded Workforce Expansion program, which provides funding to Master of Social Work programs.
- The American Rescue Plan Act (ARPA) funded Workforce Expansion program, which provides funding to Master of Social Work programs.

Additionally, this may be an area to engage with philanthropic or social impact investors interested in supporting job quality through creative public/private partnerships, such as the Denver Para-to-Teacher Pipeline Project, a similar model to improve advancement opportunities and job quality for paraprofessionals working in public schools to become teachers.[56]

[56] The Denver Para-to-Teacher Pipeline Project uses outcome financing to support provide training to paraprofessionals interested in becoming full-time teachers. https://www.datocms-assets.com/45951/1667327463-denver-para-to-teacher-pipeline-project-fact-sheet.pdf

DENVER PARA-TO-TEACHER PIPELINE PROJECT:

Amid a severe teacher shortage in Colorado and nationwide, the Denver Para-to-Teacher Pipeline Project scales a proven strategy to build a bigger and more diverse teacher pipeline and reduce turnover in Denver-area schools. Launched by a coalition of impact investors, service providers, workforce experts, and school districts, the project expands the Center for Urban Education at the University of Northern Colorado—a high-quality teacher training program that offers local paraprofessionals a pathway to become full-time teachers. The project used upfront financing from philanthropies and investors to expand the program. The Fund is repaid by employers that hire the newly credentialed teachers, which is then recycled to train the next cohort.



[57] Hunter University's One-Year Residency program is targeted at full-time social service workers. https://sssw.hunter.cuny.edu/programs/msw/#squelch-taas-accordion-shortcode-content-4

PROGRAM 4: EXPANDING MARYLAND LOAN REPAYMENT PROGRAMS TO INCLUDE SOCIAL WORKERS AND PROFESSIONAL COUNSELORS
Investment: $10,000,000 over 5 years
Expected Outcomes: An additional 250 licensed clinicians receive loan forgiveness
Cost per professional: $40,000 average loan forgiveness amount

The Need: While there is a need for more social workers and professional counselors across the state of Maryland, certain areas, particularly rural counties in the Eastern and Western part of the state, face severe shortages. The State Loan Repayment Program (SLRP) and the Maryland Loan Assistance Repayment Program, collectively known as the Maryland Loan Repayment Programs (MLRP), administered by the Maryland Department of Health Office of Population Health Improvement, have been successfully supporting the recruitment and retention of physicians and physician assistants into underserved areas for decades. A recent expansion to the programs now includes eligibility for advanced practice registered nurses, nurses, and nursing support staff. Further expanding this existing program to include social workers and professional counselors will increase the number of clinicians in Mental Health Professionals Shortage Areas (MHPSAs) and medically underserved areas/populations (MUA/Ps). The SLRP, which is a federal program, has traditionally required a 1:1 match state match, provided via MLARP for physicians and physician assistants and MLARP for nurses and nursing support staff.

Overview of Potential Investment: Previous analysis of MLRP programs in Maryland has identified educational loan repayment programs as an effective tool both for healthcare workforce development and increasing the number of providers in underserved areas.[58] Recognizing the value of these programs, the state has made recent efforts to expand the program to nursing professions; this investment would further that expansion. Additional funding for the MLARP program to provide assistance to social workers and professional counselors who commit to at least two years of service working in community-based or school settings in HPSAs or MUA/Ps.

[58] Workgroup Report: Maryland Loan Assistance Repayment Program (MLARP) for Physicians and Physician Assistants – Administration and Funding. December 2021. https://health.maryland.gov/pophealth/Documents/SB%20501,%20CH%20403%20%282020%29%20and%20HB%20998,%20CH%20402%20%282020%29%20–%20MLARP%20Workgroup%20-%20Administration%20and%20Funding%20-%20Final%20Report.pdf

Funding and Expected Outcomes: With an initial investment of $10,000,000 over 5-years, Maryland should expect the following outcomes:

- Support an additional 250 social workers and professional counselors (average amount in repayment assistance would be $40,000) to complete at least two years of service in community-based settings in underserved areas
- Apply for additional federal funds to leverage increasing state investment
- Potential to pair with Program #3: Social Work Residency Program

Alignment with Existing Fund Sources: This investment will expand an existing successful Maryland program to a new population. It would supplement a number of existing loan service programs for social workers including:

- The Public Service Loan Forgiveness Program, which can be used for social workers with certain federal loans working at government or qualifying non-profit organizations.
- The National Health Service Corps (NHSC) Loan Repayment Program, which provides loan relief for Social Workers to work in an NHSC approved facility in a HPSA.
- The State Opioid Response (SOR) funded Workforce Expansion program, which provides funding to Master of Social Work programs.
- The American Rescue Plan Act (ARPA)-funded Workforce Expansion program, which provides funding to Master of Social Work programs.

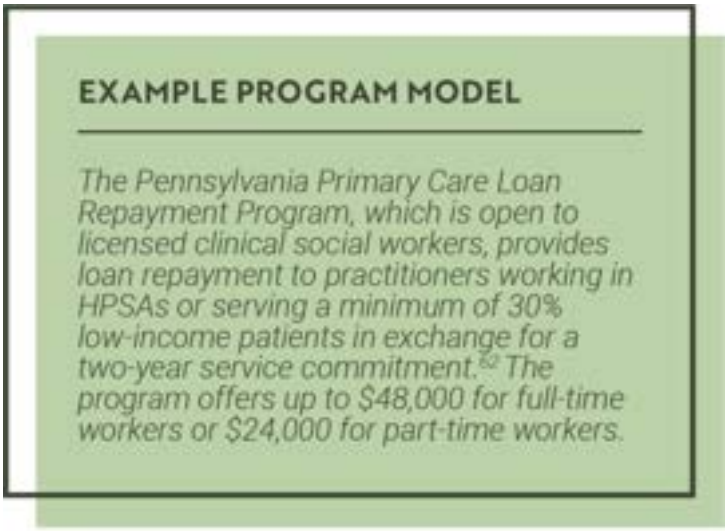
An alternative financing opportunity could exist if the above options are exhausted or not possible but there are still students in need of student financing. Several states and counties have established "Pay it Forward" funds that provide below market-rate (sometimes 0% interest), no fee loans to promote upskilling in a particular industry. San Diego County has secured over $10M for a Behavioral Health renewable training fund[59] and Massachusetts has recently announced a $10M Climate Careers Fund 0% interest loan fund for residents looking to pursue jobs related to climate resilience and clean energy. [60] The most established of these funds may be a $14.5M New Jersey Pay It Forward program, capitalized through state general

[59] The San Diego County Behavioral Health Renewable Training Fund will be an outcomes-based renewable training fund, providing 0% interest loans to students as well as upfront financing for training programs. https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/documents/NOC/bhab/Board%20Letter%20Att%20A%20Proposal%20Behavioral%20Health%20Workforce%20Innovation%20Program.pdf

[60] Governor Maura T. Healey announces the Massachusetts Climate Careers Fund, which will support education and workforce programs to help participants access high-quality training programs which lead to climate jobs. https://www.mass.gov/news/at-vatican-climate-summit-governor-healey-announces-climate-careers-fund-to-grow-massachusetts-climate-workforce

fund, corporate donors, and philanthropies, that provides loans for students pursuing nursing, trades, or technology careers.[61]

*The **New Jersey Pay It Forward Program** is a 14.5M fund capitalized with state general funds and philanthropy to provide **zero-interest**, **no-fee loans** for participants to enroll in high-quality job training, especially those who may not have the savings to pay for training or the credit history for a loan. Participants pay **no upfront costs** and receive **living stipends** and supportive services including access to emergency aid funds and mental health counseling to help them succeed. There is no return to investors and all loan repayments are recycled back into the fund to support future learners.*



[61] The New Jersey Pay It Forward program provides zero-interest, no-fee loans to participants, who also receive stipends and supportive services, in high-quality job training programs. https://socialfinance.org/work/new-jersey/

[62] The Pennsylvania Primary Care Loan Repayment Program aims to increase access to primary care services and improve the recruitment and retention of health practitioners in underserved communities. https://www.health.pa.gov/topics/Documents/Health%20Planning/LRP%20Fact%20Sheet.pdf

PROGRAM 5: COMMUNITY BH TALENT ATTRACTION AND RETENTION GRANTS
Investment: $50,000,000 over 5 years
Expected Outcomes: 100 BH employers will improve job quality for frontline professionals, increasing retention and shortening time-to-hire for critical BH roles.

The Need: Over 6,000 of the 15,770 currently employed BH professionals in the Fund's target occupations are projected to leave the field in the next five years. Investments to attract new workers will be misguided if Maryland does not reduce the rate at which frontline providers are leaving the field. Interviews with frontline employees showed that symptoms of burnout are leading to low morale and thoughts of leaving for other healthcare settings, private practices, or jobs in other industries. Paying interns, offering high-quality supervision and mentorship opportunities, establishing tuition assistance programs that lead to concrete advancement opportunities, reducing role stressors, and making other critical job quality investments is essential to filling vacancies and retaining staff in community BH settings.

Overview of Potential Investment: Employers recognized burnout as a significant issue for their employees and highlighted the importance of improving retention, as investments in recruitment and training will not make a meaningful difference if providers do not stay in the field. While they understood salaries were a critical factor, they also identified job design features such as office culture, staff development, support for education and training, and quality supervision as major drivers of retention rates. Addressing these issues and increasing worker satisfaction will require resources and support. Grants for community-based BH providers of between $100,000 and $1,000,000 can help employers improve job quality at their organizations. Providers should be given flexibility to apply for funding for a range of projects, approved by the State, based on the needs of their organization and local conditions. Initiatives could include offering paid internships, establishing or expanding supervision opportunities, establishing apprenticeships, designing and implementing tuition assistance and loan forgiveness programs, retention bonuses, or designing and implementing alternative work arrangements (e.g., flexible/hybrid schedules, contract positions, sabbaticals).

Funding and Expected Outcomes: With an investment of $50,000,000 with grants averaging $500,000 this program would support approximately 100 Maryland employers to make job quality investments. The primary goal of these investments would be to:

- Increase retention rates / reduce turnover
- Increase rates of internal advancement and promotion
- Decrease time-to-hire for critical BH vacancies

Alignment with Existing Fund Sources: Direct grants to employers to improve job quality for existing staff do not align with program and allowable uses of federal workforce funding (e.g., WIOA, TANF, SNAP E&T). Other states are using the following funding sources for similar investments:

- Unobligated American Rescue Plan Act (ARPA) funds
- Unobligated Opioid Settlement Funds
- State General Funds
- Competitive federal grants from HRSA and DOE to provide paid internships and post-graduate supervision

> *Federal ARPA funds that are **unobligated** beyond December 2024 or unspent by December 2026 will be returned to the federal government. If Maryland has any unobligated ARPA funds that could be used to support this recommendation, contracting with a third-party administrator or trustee before the end of 2024 could be an option. Massachusetts, for example, is using this strategy to obligate at least $20M in ARPA funds to be used for a BH clinical and supervision incentive program.*

Longer term, the goal of these investments would be to help community BH providers establish internal programs, practices, and policies that can be sustained over time through increased revenue from patient encounters because of filling vacancies, increased retention, greater employee engagement and satisfaction, and less burnout.

PROGRAM 6: STATEWIDE COMMUNITY BH NURSING APPRENTICESHIP PROGRAM
Investment: $14,475,000 over 5 years
Outcomes: 965 residents get their LPN or RN degree and are exposed to BH settings
Cost per trainee: $15,000

The Need: Inpatient BH providers in Maryland face a shortage of 965 LPNs and RNs, critical positions to keep inpatient programs operating, over the next five years. LPNs and RNs can work in a variety of settings and may not be choosing community BH due to lack of awareness of available roles or stigma; established pathways with a service requirement can expose nursing staff to BH positions. The nursing field offers a clear career progression with steadily increasing wages and responsibilities. Providing access to advancement opportunities can keep practitioners in the field. There are established and successful models for career development along the nursing pathway (CNA to LPN to RN), which can be replicated for BH.

[63] The Department of Health care Access and Information administers a four-year grant program to assist community-based organizations to recruit, retain, and train behavioral health providers. https://hcai.ca.gov/wp-content/uploads/2022/10/2022-23-CBO-BH-Workforce-Grant-Guide-Accessible-October.pdf

Overview of Potential Investment: In a 2022 survey, only 2.5% of nurses reported that their primary specialty was psychiatric/mental health/substance abuse and 3.7% indicated that community health or public health was the setting of their primary practice.[64] Increasing these numbers will require more exposure to community behavioral health and recruitment targeted at those likely to be interested in working in these settings. This investment would create a countywide grant to one intermediary or consortium that includes in-patient mental health and substance use disorder program employers, post-secondary programs, and other supportive service providers to design and implement an LPN to RN registered apprenticeship program with didactic and clinical rotations in community-based BH settings.

Funding and Expected Outcomes: With an investment of $14,475,000, 965 current BH providers or residents could earn an LPN or RN degree and receive didactic and clinical experience in BH settings.

Alignment with Existing Fund Sources: This funding can supplement a variety of existing resources for nursing in Maryland, including the Nurse Corps Scholarship program, Workforce Shortage Student Assistance Grant Program, and Tuition reduction for Non-Resident Nursing Students. In addition, LPN programs may be eligible for WIOA funding if providers are on Maryland's Eligible Training Provider List (ETPL).

EXAMPLE PROGRAM MODEL

An example of a Nursing Career pathway program for incumbent workers can be seen in Vermont. Healthcare system employers, community colleges, four-year universities, and the Vermont Business Roundtable, an industry association, developed a nursing apprenticeship program[65] to help mental health technicians, personal care aides, nursing assistants, and medical assistants become LPNs and RNs while working over a six-year period. The program includes practicing clinical instructors, paid release time for students to take required didactic classroom training and complete clinical field placements, and wrap-around supports for trainees, including transportation support, financial coaching, and tutoring. The program is financed through federal HRSA and DOL apprenticeship grants, state workforce and education funding, and student loan repayment by participating employers in exchange for years of service. At the end of six years, individuals are RNs with zero student debt, often working for the same employer throughout the entire program.

[64] Smiley R.A., Allgeyer R.L., Shobo Y., Lyons K.C., Letourneau R., Zhong E., Kaminski-Ozturk N., Alexander M. The 2022 national nursing workforce survey. Journal of Nursing Regulation. 2023;14(2S):S1–S92.
[65] Governor Phil Scott Announces Nursing Workforce Grants. State of Vermon. https://governor.vermont.gov/press-release/governor-phil-scott-announces-nursing-workforce-grants

PROGRAM 7: CHILD/ADOLESCENT NURSE PRACTITIONER COMMUNITY PSYCHIATRY FELLOWSHIP PROGRAM
Investment: $16,800,800 over 5 years
Outcomes: 168 Psychiatric Mental Health Nurse Practitioners complete fellowship programs
Cost per resident/fellow per year: $100,000

The Need: Almost all interviewees cited the lack of prescribers as a significant barrier to providing quality care. In particular, the lack of those with expertise with children and adolescents was identified as an acute need. At the same time, the number of nursing graduates with the advanced degrees required to become prescribing nurse practitioners has dramatically increased over the last five years.

Maryland colleges and universities awarded 639 Masters of Nursing and 268 Doctors of Nursing Practice degrees in 2022, up 40% since 2014. However, interviewees suggested very few of these graduates end up working in community BH settings, despite the significant need, especially for children and adolescents. Stigma associated with the patient population, lack of exposure to community BH settings, and uncompetitive salaries were all cited by interviewees as a major challenge to recruiting more NPs to work in community settings.

Overview of Potential Investment: The current psychiatry workforce does not have the capacity to meet the need for prescribers, particularly for those with publicly funded insurance; Psychiatric Mental Health Nurse Practitioners have been filling the gap, with the number of PMHNPs treating Medicare beneficiaries growing while psychiatrists working with the same population have decreased.[66] Children are about 25% of the United States Population, yet less than 10% of licensed nurse practitioners are certified in pediatrics.[67,68] The lack of PMHNPs focused on children and adolescents is caused by a number of factors including an emphasis on adult programs, students being against entering youth-focused programs, and a shortage of preceptors.[69] A post-graduate community BH fellowship, which offers a competitive salary to other entry-level nurse practitioner roles and structured support from faculty can help address these issues and attract more early career nurse practitioners into publicly funded BH settings.

[66] Cai A, Mehrotra A, Germack HD, Busch AB, Huskamp HA, Barnett ML. Trends In Mental Health Care Delivery By Psychiatrists And Nurse Practitioners In Medicare, 2011-19. Health Aff (Millwood). 2022 Sep;41(9):1222-1230. doi: 10.1377/hlthaff.2022.00289. PMID: 36067437; PMCID: PMC9769920.
[67] Vinci RJ. The Pediatric Workforce: Recent Data Trends, Questions, and Challenges for the Future. Pediatrics. 2021 Jun;147(6):e2020013292. doi: 10.1542/peds.2020-013292. Epub 2021 Mar 10. PMID: 33692163.
[68] Pediatric National Association of Nurse Practitioners. Critical shortage of pediatric nurse practitioners emerging over next decade. 2019. https://www.napnap.org/critical-shortage-of-pnps-emerging-over-next-decade/
[69] Courtwright SE, Barr EA. Pediatric nurse practitioner workforce shortage threatens child health equity: Key contributors and recommendations. J Am Assoc Nurse Pract. 2023 Nov 1;35(11):661-665. doi: 10.1097/JXX.0000000000000954. PMID: 37883490; PMCID: PMC10606953.

This investment would include grants to medical schools, universities, or hospital systems to develop and implement 12-month postgraduate fellowships that include didactic classroom instruction, clinical experience, and meaningful supervision where fellows gain experience working in multiple community BH settings. Initially, a specialty in child/adolescent was identified as the highest priority from community BH employers interviewed and could be a starting point for investment, although other specialties could be focused on older adults or rural geographies for fellowship placement sites.

Funding and Expected Outcomes: Five-year investment of $16,800,000 in Maryland could result in 168 early career nurse practitioners completing 12-month fellowships over the course of five years. This would equate to 30-35 fellows per year for five years, or about 3.5% of the approximately 900 graduates of advanced degree nursing programs from Maryland universities.

Ultimately, the goal of this investment is to attract a portion of these fellows into community BH employment post-fellowship. Applicants to a potential REOI/RFP process should be asked to estimate target measures for community BH employment one and five years post-fellowship.

Alignment with Existing Fund Sources: Maryland has previously funded other initiatives to support nursing and nursing fellowships, such as MHEC's Nurse Support Program. Federal grants may be available to support some of the costs, such as the 2023 Advanced nursing Education Nurse Practitioner Residency and Fellowship Program, administered by HRSA.

EXAMPLE PROGRAM MODELS

The University of Maryland Medical center has a child and adolescent psychiatry fellowship, which could be a useful model. In addition, there are several child and adolescent psychiatric nurse practitioner fellowship programs across the country including:

- *The Vanderbilt University Medical Center Psychiatric Mental Health Nurse Practitioner Fellowship Program (Child and Adolescent Psychiatry)*[70]
- *Nationwide Children's Hospital Barbara Trueman Child and Adolescent Psychiatry Nurse Practitioner Postgraduate Fellowship*[71]
- *The UC San Diego School of Medicine Psychiatric Nurse Practitioner Fellowship Program*[72]

[70] The fellowship is a 12-month program where participants are exposed to a variety of experiences within Child and Adolescent Psychiatry working in collaboration with a multidisciplinary health care team, with a focus on outpatient care. https://www.vumc.org/psychiatry/PMHNPfellowship

[71] The fellowship provides evidence-based practice curriculum and a variety of specialty clinical rotations and includes weekly educational sessions and mentorship. https://www.nationwidechildrens.org/for-medical-professionals/education-and-training/postdoctoral-and-advanced-training-programs/child-and-adolescent-psychiatric-nurse-practitioner-fellowship

[72] Fellowship participants gain experience working in training sites throughout the county focusing on high-risk populations in underserved communities suffering from severe mental illness. https://psychiatry.ucsd.edu/education-training/nurse-practitioner/child-np.html

PROGRAM 8: COMMUNITY PSYCHIATRY RESIDENCY EXPANSION
Investment: $7,500,000 over 5 years
Outcomes: Increase the number of annual psychiatrist residents by 10
Cost per resident/fellow per year: $150,000

The Need: Maryland currently has two psychiatry residencies operating in the state that matched with 27 residents in 2024. John Hopkins University had 11 matches, and the University of Maryland Medical Center / Sheppard Pratt matched with 16 residents. On a per capita basis, Maryland ranks 38th out of the 50 states in residents per capita behind other similarly sized states including Wisconsin, Missouri, and Minnesota. **In order to rank 25th out of the 50 states on a per capita basis, Maryland would have needed 10 additional psychiatry residency matches in 2024.**

Overview of Potential Investment: Interviewees described a lack of psychiatrists as a major challenge, which is supported by academic research;[73] many psychiatrists do not accept Medicaid, with some not accepting any form of insurance.[74] Lack of funding has been identified as a primary barrier to expanding psychiatric residency and fellowship programs.[75] This investment would be a 5-year grant to one of the existing residency programs to support the initial start-up and faculty costs to support 10 additional residency slots, with a particular focus on didactics and clinical rotations in outpatient community BH settings, bringing expanded partnerships between existing residency programs and community programs in underserved areas or sub-specialties. Programs could include subspecialties (child and adolescent, elder care, addiction) through partnerships with specific clinical site hosts as determined by grant applicants based on community need, and geographic location.

Funding and Expected Outcomes: An estimated $7,500,000 is needed to cover the initial costs of establishing 10 additional residency slots per year for 4-year residencies (10x4), ultimately increasing the number of annual matches from 27 psychiatry residents to 37 psychiatry residents.

[73] University of Michigan Behavioral Health Workforce Research Center. Estimating the Distribution of the U.S. Psychiatric Subspecialist Workforce. Ann Arbor, MI: UMSPH; 2018.
[74] National Center for Health Workforce Analysis. Behavioral Health Workforce 2023 Brief. December, 2023. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/Behavioral-Health-Workforce-Brief-2023.pdf
[75] Pheister M, Cowley D, Sanders W, Keeble T, Lu F, Pershern L, Wolf K, Walaszek A, Aggarwal R. Growing the Psychiatry Workforce Through Expansion or Creation of Residencies and Fellowships: the Results of a Survey by the AADPRT Workforce Task Force. Acad Psychiatry. 2022 Aug;46(4):421-427. doi: 10.1007/s40596-021-01509-9. Epub 2021 Jul 22. PMID: 34292538; PMCID: PMC829683

EXAMPLE PROGRAM MODEL

UC San Diego has developed a Community Psychiatry Residency Track and a 12-month Child and Adolescent Community Fellowship, which provides specialized training for residents and post-residency psychiatrists to work in community settings across San Diego County in partnership with the County of San Diego, public schools, local jails and juvenile detention facilities, community-based providers, and FQHCs.[76] Residents rotate between community-based organizations training sites, which focus on treating underserved communities. During this time, providers are exposed to a variety of clinical settings and specialty populations to allow fellows to develop an understanding of the public mental health system and the skills necessary to provide quality patient care to each unique population.

According to the UCSD School of Medicine faculty that administers the program a higher proportion of their residents in the community psychiatry program accept offers to work in community psychiatry post-residency than their residents not in the program.

5.3: A Five-Year Capital Plan to Support the Fund

The BH workforce shortage, especially for providers that serve individuals regardless of their ability to pay, is a public health emergency in Maryland that requires urgent attention and significant investment. However, the state doesn't have unlimited funding, academic programs need time to ramp up, and sufficient individuals must know about, be prepared for, and be interested in education and training opportunities to justify expansion. In this section, we provide a five-year capital plan to finance the programs listed above. The capital plan includes:

- State general funds and/or or unobligated federal American Rescue Plan Act (ARPA) funds to serve as catalytic capital.

[76] The UC San Diego School of Medicine has developed a residency and fellowship to increase psychiatrist's exposure to community behavioral health settings. https://psychiatry.ucsd.edu/education-training/residency-programs/community-psychiatry/psychiatry-training/index.html

- Existing state administered programs that can be used in alignment with this strategy (e.g., State Opioid Response (SOR) Workforce Expansion Program)
- Existing or unrealized federal formula funding sources: Workforce Innovation Opportunity Act (WIOA), Supplemental Nutrition Assistance Program Employment & Training (SNAP E&T) funds, Temporary Assistance for Needy Families (TANF) funds, and unrealized HRSA matching funds Maryland is entitled to.
- Federal competitive grants, with specific target agencies being the US Department of Labor Employment and Training Administration (DOLETA) and the US Department of Health and Human Services Health Services and Administration (HRSA) and Substance Use and Mental Health Services Administration (SAMHSA) grant programs
- Philanthropy, employer contributions, social impact investments, and recycled funds from billable patient encounters.

This report estimates $14.5M is needed over five years to support the programs listed above. Not all of these funds need to be "new" money. A downpayment of approximately $60M over five years of State funds could be used to "unlock" the full amount needed through alignment with existing State and federal workforce funding streams, successful federal grant applications, private sources, and recycled billable patient encounters.

Figure 46: Potential Funding Types and Capital Targets for the Fund Over Five Years

Figure 47: Potential Funding Types and Capital Targets for the Fund Over Five Years, Detailed

FUNDING TYPE	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL
Catalytic State Funds "A Downpayment"	$13,775,000	$13,660,000	$13,560,000	$13,705,000	$4,725,250	$59,425,250
State: Alignment with Existing State Programs	$1,250,000	$1,250,000	$1,250,000	$1,250,000	$1,250,000	$6,250,000
Federal Funds Administered by State Agencies (e.g., WIOA/SNAP E&T Funds/HRSA Federal Match)	$3,100,000	$3,200,000	$3,875,000	$3,925,000	$3,950,000	$18,050,000
Federal: Successful Competitive Grant Applications	$0	$2,000,000	$5,575,000	$6,725,000	$5,500,000	$19,800,000
Private: Philanthropy / Employers / Social Impact Investment	$2,500,000	$9,500,000	$9,500,000	$9,500,000	$9,560,000	$40,560,000
Recycled Funds from Billable Patient Encounters	$0	$750,000	$1,000,000	$1,250,000	$1,500,000	$4,500,000
Total	$20,625,000	$30,360,000	$34,760,000	$36,355,000	$26,485,250	$148,585,250

Figure 48 below shows the funding types and sources that could be used to support each recommended program. Some programs likely need little or no "new" money to expand to close the workforce gap in that particular occupation, including the Certified Peer Recovery Training and Placement Grants, the Alcohol and Drug Counselor "Earn and Learn" grant program, and the Statewide Community Behavioral Health Nursing program. Federal formula funds from WIOA, SNAP E&T, and TANF, as well as federal competitive apprenticeship grants and state administered programs could potentially be directed to meet the growing need if these funding streams were set aside to support the overarching goals of the fund, potentially issued through joint agency procurement processes.

Other programs, including the Social Work Residency Program, Student Loan Forgiveness Programs, and the Community Behavioral Health Talent Attraction and Retention Investments are in need of significant "new" money to catalyze matching fund investments from universities, philanthropies, competitive federal grant programs, and potentially, creative public/private financing strategies mentioned above through examples including the New Jersey Pay-it-Forward Fund or the Denver Para-to-Teacher Pipeline project.

Finally, investments in expanding Psychiatric Mental Health Nurse Practitioner Community Fellowship Programs and Community Psychiatry Residency and Fellowship Programs require

significant capital upfront from the State and/or competitive grants but could be partially offset over time through increased billable patient encounters in community settings through clinical rotations.

Figure 48 below is intended to serve as a working roadmap with examples of possible funding sources in service of the goal to dramatically expand the capacity of Maryland's BH talent ecosystem to attract, develop, and retain thousands of more BH workers. The possible funding streams for each program represent potential sources of capital to explore and do not represent specific commitments from partner agencies, universities, or private sector partners.

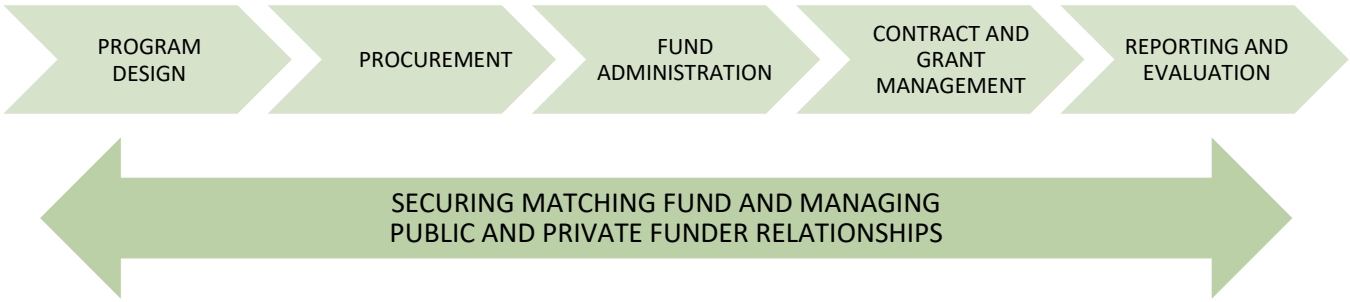
Figure 48: Example Five-Year Fund Capital Plan, Targets and Possible Funding Sources

PROGRAM	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	TOTAL
Target Funding Source						
Certified Peer Recovery Training and Placement Grants	**$750,000**	**$850,000**	**$900,000**	**$950,000**	**$892,500**	**$4,342,500**
Catalytic State Funds (A Downpayment)	$150,000	$150,000	$150,000	$150,000	$67,500	$667,500
Federal: WIOA Adult/DW Funds, SNAP E&T 50% Funds, TANF	$600,000	$700,000	$750,000	$800,000	$825,000	$3,675,000
Alcohol and Drug Counselor Registered Apprenticeship Program	**$1,250,000**	**$1,250,000**	**$2,650,000**	**$2,875,000**	**$2,875,000**	**$10,900,000**
Federal: WIOA Adult/DW Funds	$1,250,000	$1,250,000	$1,875,000	$1,875,000	$1,875,000	$8,125,000
Federal: Competitive DOL/SAMHSA/HRSA Apprenticeship Grants			$775,000	$1,000,000	$1,000,000	$2,775,000
Social Worker Residency Program	**$1,500,000**	**$5,000,000**	**$5,000,000**	**$5,000,000**	**$4,560,000**	**$21,060,000**
Catalytic State Funds (A Downpayment)	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$500,000	$4,500,000
Federal: SAMSHA State Opioid Response (SOR) Workforce Expansion	$500,000	$500,000	$500,000	$500,000	$500,000	$2,500,000
Private: Philanthropic / Endowment Matching Funds		$500,000	$500,000	$500,000	$500,000	$2,000,000
Private: Social Impact Investment		$3,000,000	$3,000,000	$3,000,000	$3,060,000	$12,060,000
Expanding Maryland Loan Forgiveness Programs	**$2,000,000**	**$2,000,000**	**$2,000,000**	**$2,000,000**	**$2,000,000**	**$10,000,000**
Catalytic State Funds (A Downpayment)	$750,000	$750,000	$750,000	$750,000	$750,000	$3,750,000
Federal: HRSA Unrealized Match for Student Loan Repayment Program	$250,000	$250,000	$250,000	$250,000	$250,000	$1,250,000
Private: Philanthropy to support revolving loan fund	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$5,000,000
Community Behavioral Health Talent Attraction and Retention	**$7,500,000**	**$10,500,000**	**$12,500,000**	**$13,500,000**	**$6,000,000**	**$50,000,000**
Catalytic State Funds (A Downpayment)	$7,500,000	$7,500,000	$7,500,000	$7,500,000		$22,500,000
Private: Philanthropy		$3,000,000	$3,000,000	$3,000,000	$3,000,000	$12,000,000
Federal: HRSA Competitive Grants for Paid Internship and Supervision			$2,000,000	$3,000,000	$3,000,000	$8,000,000
Community Behavioral Health Nursing Apprenticeship Program	**$1,750,000**	**$2,250,000**	**$3,250,000**	**$3,475,000**	**$3,750,000**	**$14,475,000**
State: Existing Nurse Corps Scholarship and Tuition Reductions	$500,000	$500,000	$500,000	$500,000	$500,000	$2,500,000
State: Existing Loan Forgiveness Program	$250,000	$250,000	$250,000	$250,000	$250,000	$1,250,000
Employers: Paid Release Time and Tuition Assistance		$500,000	$500,000	$500,000	$500,000	$2,000,000
Federal: WIOA Adult/DW Funds	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$5,000,000
Federal: Competitive DOL Apprenticeship Grant			$1,000,000	$1,225,000	$1,500,000	$3,725,000
Nurse Practitioner Community Psychiatry Fellowship Program	**$3,000,000**	**$4,500,000**	**$3,800,000**	**$3,500,000**	**$2,000,000**	**$16,800,000**
Catalytic State Funds (A Downpayment)	$2,000,000	$1,000,000	$500,000	$500,000	$500,000	$4,500,000
Private: Philanthropy/University Endowment Match	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$5,000,000
Federal: HRSA Advanced Nursing Education Residency Grants		$2,000,000	$1,800,000	$1,500,000		$5,300,000
Federal: Share of Medicaid Eligible Patient Encounters Reinvested		$500,000	$500,000	$500,000	$500,000	$2,000,000
Community Psychiatry Residency and Fellowships Expansion	**$1,000,000**	**$1,250,000**	**$1,500,000**	**$1,750,000**	**$2,000,000**	**$7,500,000**
Catalytic State Funds (A Downpayment)	$500,000	$500,000	$500,000	$500,000	$500,000	$2,500,000
Private: Philanthropy or University Match	$500,000	$500,000	$500,000	$500,000	$500,000	$2,500,000
Federal: Share of Medicaid Eligible Patient Encounters Reinvested		$250,000	$500,000	$750,000	$1,000,000	$2,500,000
Administration, Fund Operations and Reporting	**$1,875,000**	**$2,760,000**	**$3,160,000**	**$3,305,000**	**$2,407,750**	**$13,507,750**

SECTION 6: THE FUND OPERATIONS

This report recommends setting aside 10% of the target fund size, $13,507,750 over five years to set up and administer the Fund. There are five major components to fund administration, which are described below:

Figure 49: Major Components to Successful Fund Administration



Program Design: Well-designed and carefully thought-out programs that are aligned with program goals and geared toward producing the desired outcomes will be critical to the success of this fund. While this report outlines some high-level concepts for programs the Fund could support, further detail is needed to develop complete statements of work, eligibility criteria, performance goals, and RFP frameworks and evaluation criteria. All programs should be designed to solve a specific workforce shortage, using the data in this report as a resource, and developed through an equity lens to ensure the Fund increases opportunities for current and prospective professionals that come from and/or are most likely to serve communities most in need.

Program design could be completed by State staff and/or consultants in consultation with subject matter experts for each specific program area. In some cases, there have been previous or are current State efforts to address these issues. Lessons from those programs should inform how the Fund distributes resources, leveraging the significant knowledge base of State staff. Whenever possible, the State should solicit involvement from community members to ensure that programs are aligned with the needs of providers.

Procurement: Distributing funds from multiple funding sources requires dedicated resources and expertise to ensure all relevant funding requirements and procurement policies are followed, timelines are managed across agencies and budget cycles, and that solicitations have clear goals, guidelines, and selection criteria, informed by information gathered in the program design phase. A framework for the procurement, including eligible applicants, target licensure and occupations, allowable activities, number of awards and award amounts, expected

outcomes, and evaluation criteria, should be validated with non-conflicted subject matter experts within State agencies and, when appropriate and allowable, from BH practitioners, community-based partners, and colleges and universities. Procurements should be specific, particularly in terms of eligible applicants and expected outcomes, but also allow for flexibility to support respondents in crafting programs that meet the needs of their region and population. Increasing equity should be a key component of the evaluation process, and it may be advisable to include explicit targets for reaching diverse populations.

Fund Administration and Distribution: Maryland should evaluate whether the fund administrator should be a state agency or a third-party. In Maryland, both the Maryland Department of Health and the Department of Labor have experience managing and distributing healthcare workforce training grants and funding. Some jurisdictions, including the State of Massachusetts and the County of San Diego (CA), have issued RFPs for a Fund Administrator to serve as a Trustee of any funds being invested for BH workforce priorities, and that third-party is responsible for ensuring proper process and policies are in place to satisfy all cash management, distribution, and reporting requirements. Key factors to inform this decision include subject matter expertise, cost, management capacity, procurement processes, and the ability to disperse funds efficiently.

Contract and Grant Management: Effective contract management begins during the procurement or solicitation process, with a clear document that accurately describes what the state would like to purchase. This scope, when transferred into the contract or grant agreement, along with well-defined performance measures allow the State to hold fund recipients accountable. A detailed program operations manual, which includes fiscal and program policies and procedures, reporting requirements, timelines, and other key information will support program administration and help get programs off the ground quickly.

We recommend setting up an active performance management (APM) structure, that includes regularly analyzing data and education, employment and retention outcomes at the grantee level, reallocating funding and financing as needed, and course correcting in real time to address underperformance from one grantee to another as a way to proactively support each grantee's success and the fund's impact overall. Ideally, the administrator will conduct quarterly meetings with contractors/grantees to discuss progress on goals, identify roadblocks, and review spending, in addition to as-needed technical assistance. The State can build a community of practice where contractors/grantees can learn from each other, share best practices, and provide support to each other through quarterly virtual convenings.

Reporting and Evaluation: The primary impact goals of the fund are to address the overarching workforce shortage in critical BH occupations. Overarching impact metrics in pursuit of that goal could be to:

- Increase the number of current and prospective BH professionals from diverse background that are graduating from relevant certificate and degree programs in Maryland;
- Increase the number of people from diverse backgrounds with active licenses in relevant BH professions;
- Increase the number of graduates with diverse background from relevant education and training programs working in Maryland's BH system; and
- Increase retention of professionals working in Maryland's BH system.

Evaluating and reporting out to the legislature, state agency, partners, and key BH stakeholders on these and other measures is critical to understanding the impacts of the Fund, identifying challenges and roadblocks, and communicating the impact of the investment. MHCC through the working relationship established with MLDS established through this engagement, may be well positioned to support this overarching evaluation of the Fund if properly resourced.

Additionally, the proper program-level and compliance reporting and data infrastructure is critical to the long-term success of the fund. Assuming funding is successfully secured from multiple public agencies, funding streams, and private funders to jointly support specific projects, each funding source will have different reporting requirements, timelines, and potential performance measures agencies and partners will need to track to satisfy individual funding stream requirements.

Reporting structures should support quality assurance as well as facilitate the collection of data required for continuous improvement. Monthly reports and annual fiscal and programmatic reviews are essential for monitoring compliance and identifying potential issues early. Regular collection of performance data, along with qualitative interviews with trainees and employers, will support assessing outcomes and identifying ways to enhance outcomes. As many of these investments will be completed over several years, annual evaluations can identify best practices which can be shared with current contractors/grantees and inform future procurements.

Securing Matching Funds: The funding targets laid out in this report include $149 Million in new investment, with over $90 Million coming from non-state sources, including state administered federal funds. Securing the additional resources will require a comprehensive fundraising strategy with significant resources devoted to its implementation, including:

- A skilled and fully dedicated grant writing staff, or outside partner, with experience accessing federal workforce programs to apply for grants through agencies such as the Department of Labor, HRSA, and SAMHSA.
- A well-connected staff member, or outside partner, with deep connections to Maryland's philanthropic community, to build coalitions of funders and raise private capital.
- State staff with extensive knowledge of federal workforce funding to develop a strategy to leverage programs such as WIOA, TANF, and SNAP E&T.

Once resources have been identified and are secured, the State will need a plan for deploying and braiding funding to maximize its effectiveness and maintain compliance with federal and grantee requirements. This requires dedicated staff time to lead timely and effective planning meetings across agencies, conduct briefings to agency leaders, and work through the complications and mechanics of aligning multiple funding sources across agencies toward a common goal.

APPENDIX

Appendix A: Employment Estimates by County, 2023

Appendix B: Employment Estimates by County Per 30,000 Residents, 2023

Appendix C: Demographic Estimates by BH Occupation and County, 2023

Appendix D: Estimates of Workers Needed in Maryland, 2028, 2033, and 2043

Appendix E: NAICS Classification Used for Wage and Education Data Analysis

Appendix F: Maryland Longitudinal Data System Center Data Overview

Appendix G: Letter Received from the Maryland Assembly on School-Based Health Care

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Appendix A: Employment Estimates by County, 2023

JURISDICTION	2023 POPULATION	TOTAL BH WORKERS	SOCIAL AND HUMAN SERVICE ASSISTANTS	PSYCHIATRIC TECHNICIANS	COUNSELORS AND THERAPISTS	SOCIAL WORKERS IN BH	CLINICAL PSYCHOLOGISTS	PSYCHIATRISTS	NURSE PRACTITIONERS IN BH
Baltimore City	563,687	6,278	1,488	243	1,706	522	188	333	79
Talbot	38,402	353	73	64	68	25	26	4	4
Dorchester	33,137	249	45	53	67	22	15	7	1
Kent	19,428	142	29	22	32	12	11	1	1
Allegany	66,676	478	64	52	150	30	53	4	3
Wicomico	105,090	735	135	19	269	67	18	4	11
Washington	157,205	1,058	317	46	327	78	54	11	12
Baltimore County	851,159	4,977	1,027	263	1,625	451	173	193	54
Montgomery	1,053,094	5,481	1,439	196	1,201	505	206	361	38
Howard	338,242	1,632	315	64	543	144	71	129	17
St. Mary's	115,538	534	150	63	83	47	89	2	4
Anne Arundel	598,201	2,732	687	106	798	233	98	37	33
Somerset	24,448	111	31	2	28	10	4	0	1
Cecil	105,793	406	52	13	162	49	16	7	1
Garrett	28,558	108	23	15	16	5	8	1	2
Caroline	33,564	118	29	14	22	7	7	1	1
Frederick	296,364	996	288	36	221	101	27	19	8
Harford	266,656	882	172	44	310	83	31	10	9
Prince George's	954,320	3,102	861	121	681	272	125	51	20
Carroll	177,618	535	116	24	171	47	18	10	6
Worcester	54,622	161	35	4	51	13	3	1	2
Charles	172,319	450	124	18	115	47	14	3	3
Calvert	95,449	228	56	10	38	17	6	6	2
Queen Anne's	52,323	119	27	3	47	13	3	1	1

Appendix A: Employment Estimates by County, 2023

JURISDICTION	2023 POPULATION	NURSING ASSISTANTS	LICENSED PRACTICAL NURSES	REGISTERED NURSES	OCCUPATIONAL THERAPISTS	REHABILITATION COUNSELORS	COMMUNITY HEALTH WORKERS	PHYSICIAN ASSISTANTS
Baltimore City	563,687	205	55	607	550	252	535	65
Talbot	38,402	10	3	19	21	30	27	3
Dorchester	33,137	4	2	6	10	15	13	1
Kent	19,428	4	1	5	6	14	9	0
Allegany	66,676	16	6	35	72	28	33	3
Wicomico	105,090	34	10	50	55	38	76	4
Washington	157,205	22	7	45	92	55	75	7
Baltimore County	851,159	187	63	308	501	219	372	41
Montgomery	1,053,094	227	62	331	415	453	417	45
Howard	338,242	37	14	80	156	75	130	13
St. Mary's	115,538	10	4	21	20	43	16	2
Anne Arundel	598,201	85	36	214	228	151	225	29
Somerset	24,448	4	2	2	3	17	10	0
Cecil	105,793	10	4	5	15	16	70	1
Garrett	28,558	8	2	8	10	11	8	1
Caroline	33,564	2	1	2	6	27	6	1
Frederick	296,364	37	10	57	94	98	85	9
Harford	266,656	28	10	71	103	42	64	7
Prince George's	954,320	95	31	168	234	395	257	24
Carroll	177,618	31	8	41	67	14	42	5
Worcester	54,622	10	3	10	15	7	21	1
Charles	172,319	15	4	24	40	48	31	3
Calvert	95,449	10	2	13	21	48	16	2
Queen Anne's	52,323	1	1	4	13	8	10	1

Appendix B: Employment Estimates by County Per 30,000 Residents, 2023

JURISDICTION	2023 POPULATION	SOCIAL AND HUMAN SERVICE ASSISTANTS	PSYCHIATRIC TECHNICIANS	COUNSELORS AND THERAPISTS	SOCIAL WORKERS IN BH	CLINICAL PSYCHOLOGISTS	PSYCHIATRISTS	NURSE PRACTITIONERS
Baltimore City	563,687	79.21	12.92	90.77	27.76	10.02	17.72	4.2
Talbot	38,402	56.68	49.75	53.01	19.41	20.2	3.12	2.76
Dorchester	33,137	40.51	48.37	60.55	19.86	13.6	6.34	0.92
Kent	19,428	44.59	34.39	50.17	17.76	17.34	1.54	1.23
Allegany	66,676	28.84	23.44	67.7	13.64	23.71	1.8	1.39
Wicomico	105,090	38.58	5.45	76.88	19.01	5.04	1.24	3.23
Washington	157,205	60.55	8.86	62.42	14.83	10.38	2.1	2.28
Baltimore County	851,159	36.21	9.26	57.28	15.89	6.11	6.8	1.92
Montgomery	1,053,094	41	5.57	34.2	14.39	5.87	10.28	1.08
St. Mary's	115,538	27.98	5.71	48.13	12.73	6.26	11.44	1.5
Anne Arundel	598,201	39	16.46	21.45	12.25	23.09	0.52	1.01
Somerset	24,448	34.43	5.34	40.01	11.71	4.93	1.86	1.67
Howard	338,242	38.54	2.16	34.62	12.39	4.63	0	1.19
Cecil	105,793	14.66	3.56	46.03	13.9	4.58	1.99	0.31
Garrett	28,558	23.84	15.78	16.93	5.06	8.78	0.79	1.58
Caroline	33,564	26.36	12.62	19.52	5.91	5.98	0.89	0.56
Frederick	296,364	29.12	3.64	22.38	10.18	2.7	1.92	0.78
Harford	266,656	19.32	4.98	34.88	9.36	3.53	1.13	1.04
Prince George's	954,320	27.06	3.81	21.4	8.55	3.94	1.6	0.64
Carroll	177,618	19.55	4.09	28.95	8	3.09	1.69	1.09
Worcester	54,622	19.24	1.95	28.12	7.39	1.63	0.4	1.1
Charles	172,319	21.56	3.18	20.05	8.25	2.48	0.52	0.5
Calvert	95,449	17.63	3.06	12.1	5.32	2.01	1.89	0.56
Queen Anne's	52,323	15.53	1.78	26.95	7.19	1.9	0.57	0.5

Appendix B: Employment Estimates by County Per 30,000 Residents, 2023

JURISDICTION	2023 POPULATION	NURSING ASSISTANTS	LICENSED PRACTICAL NURSES	REGISTERED NURSES	OCCUPATIONAL THERAPISTS	REHABILITATION COUNSELORS	COMMUNITY HEALTH WORKERS	PHYSICIAN ASSISTANTS
Baltimore City	563,687	10.92	2.91	32.33	29.3	13.42	28.48	3.47
Talbot	38,402	7.44	2.46	14.87	16.2	23.45	20.72	2.04
Dorchester	33,137	3.27	1.39	5.19	9.3	13.29	11.5	0.5
Kent	19,428	6.4	1.9	6.99	8.7	22.37	13.65	0.72
Allegany	66,676	7.35	2.87	15.56	32.4	12.79	14.68	1.5
Wicomico	105,090	9.71	2.8	14.15	15.8	10.86	21.8	1.06
Washington	157,205	4.28	1.4	8.57	17.6	10.57	14.36	1.3
Baltimore County	851,159	6.59	2.22	10.84	17.6	7.73	13.12	1.45
Montgomery	1,053,094	6.47	1.76	9.44	11.8	12.91	11.87	1.29
Howard	338,242	3.32	1.24	7.08	13.8	6.66	11.56	1.14
St. Mary's	115,538	2.57	0.91	5.53	5.2	11.27	4.09	0.59
Anne Arundel	598,201	4.28	1.79	10.71	11.4	7.55	11.28	1.46
Somerset	24,448	5.14	2.06	3.03	3.9	20.39	12.21	0.38
Cecil	105,793	2.82	1.02	1.52	4.2	4.66	19.77	0.18
Garrett	28,558	8.5	2.33	8.84	10.9	11.41	8.14	1.27
Caroline	33,564	1.82	0.67	1.55	5.3	23.72	5	0.45
Frederick	296,364	3.74	1.03	5.82	9.5	9.93	8.62	0.93
Harford	266,656	3.12	1.08	8	11.6	4.68	7.25	0.84
Prince George's	954,320	3	0.96	5.27	7.3	12.43	8.09	0.76
Carroll	177,618	5.19	1.32	7	11.3	2.41	7.17	0.87
Worcester	54,622	5.63	1.69	5.38	8.0	3.58	11.79	0.36
Charles	172,319	2.58	0.77	4.11	7.0	8.4	5.37	0.6
Calvert	95,449	3.24	0.71	4.21	6.7	14.93	5.18	0.7
Queen Anne's	52,323	0.74	0.38	2.22	7.6	4.76	5.53	0.35

Appendix C: Demographic Estimates by BH Occupation and County, 2023

	ANNE ARUNDEL					BALTIMORE COUNTY				
	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE
2023 POPULATION	**10%**	**63%**	**19%**	**5%**	**3%**	**7%**	**52.0%**	**31%**	**7%**	**3%**
Clinical and Counseling Psychologists	3.6%	71.2%	17.8%	4.9%	2.5%	3.3%	67.3%	20.5%	6.5%	2.4%
Marriage and Family Therapists	5.0%	55.2%	33.7%	3.0%	3.1%	4.8%	50.5%	37.9%	4.0%	2.8%
Occupational Therapists	2.57%	72.86%	13.89%	7.94%	2.73%	2.10%	69.26%	16.47%	10.01%	2.16%
Rehabilitation Counselors	4.3%	36.3%	54.2%	1.1%	4.1%	3.9%	31.0%	60.6%	2.0%	2.5%
Counselors and Therapists	4.6%	47.1%	43.0%	2.6%	2.7%	4.2%	38.9%	50.8%	3.3%	2.7%
Mental Health and Substance Abuse Social Workers	5.1%	47.5%	42.1%	1.9%	3.3%	4.9%	41.7%	48.6%	2.4%	2.4%
Social and Human Service Assistants	6.5%	35.7%	52.7%	1.9%	3.3%	5.5%	29.1%	60.2%	2.7%	2.6%
Community Health Workers	6.5%	40.4%	47.1%	2.9%	3.1%	5.5%	34.2%	53.5%	4.0%	2.7%
Physician Assistants	5.8%	65.7%	17.4%	8.0%	3.1%	4.3%	63.6%	20.4%	9.0%	2.7%
Registered Nurses	3.5%	55.2%	29.1%	9.3%	2.9%	2.5%	52.1%	33.0%	10.4%	1.9%
Nurse Practitioners	2.8%	70.0%	18.7%	6.1%	2.4%	2.3%	66.0%	22.3%	7.3%	2.1%
Psychiatrists	3.7%	57.7%	15.9%	19.5%	3.2%	3.0%	52.2%	18.3%	24.0%	2.5%
Psychiatric Technicians	7.9%	39.8%	43.0%	4.2%	5.1%	4.8%	31.3%	56.6%	4.4%	3.0%
Licensed Practical and Licensed Vocational Nurses	3.8%	34.4%	55.7%	3.7%	2.5%	2.8%	30.6%	61.1%	4.1%	1.5%
Nursing Assistants	4.5%	22.8%	67.3%	3.4%	2.0%	2.9%	19.4%	73.0%	3.2%	1.4%
Psychiatric Aides	5.0%	20.4%	70.0%	1.5%	3.1%	3.5%	18.2%	73.7%	2.0%	2.6%
Total	4.90%	44.20%	42.50%	3.40%	4.90%	4.20%	38.30%	49.20%	4.30%	4.00%

Appendix C: Demographic Estimates by BH Occupation and County, 2023

	HARFORD					HOWARD				
	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE
2023 POPULATION	**7%**	**52%**	**31%**	**7%**	**3%**	**8%**	**47%**	**21%**	**21%**	**4%**
Clinical and Counseling Psychologists	2.4%	81.5%	10.9%	3.6%	1.6%	4.2%	66.7%	17.1%	9.7%	2.4%
Marriage and Family Therapists	4.2%	65.6%	25.3%	2.5%	2.4%	5.7%	54.0%	30.5%	6.7%	3.1%
Occupational Therapists	1.75%	81.26%	9.27%	5.68%	2.03%	2.61%	64.46%	16.47%	13.81%	2.65%
Rehabilitation Counselors	5.1%	38.9%	51.5%	1.5%	3.1%	4.9%	32.5%	56.7%	2.9%	2.9%
Counselors and Therapists	3.9%	58.4%	32.9%	2.1%	2.7%	5.7%	43.7%	41.6%	5.8%	3.3%
Mental Health and Substance Abuse Social Workers	4.7%	61.4%	30.0%	1.4%	2.5%	6.5%	46.8%	39.6%	3.8%	3.3%
Social and Human Service Assistants	6.0%	42.1%	47.4%	1.8%	2.7%	7.4%	32.9%	51.6%	5.1%	2.9%
Community Health Workers	5.4%	48.4%	41.0%	2.4%	2.7%	7.5%	37.3%	45.6%	6.4%	3.3%
Physician Assistants	3.5%	75.8%	11.0%	7.0%	2.6%	7.6%	57.3%	20.1%	12.3%	2.7%
Registered Nurses	2.4%	69.4%	18.7%	7.3%	2.2%	3.8%	48.7%	31.1%	13.9%	2.5%
Nurse Practitioners	1.8%	79.7%	11.6%	5.0%	2.0%	3.9%	61.6%	22.1%	10.1%	2.3%
Psychiatrists	2.8%	69.7%	9.6%	15.6%	2.3%	4.2%	48.0%	15.4%	29.6%	2.7%
Psychiatric Technicians	6.5%	55.6%	30.9%	3.0%	4.0%	8.0%	36.3%	43.0%	8.4%	4.2%
Licensed Practical and Licensed Vocational Nurses	3.3%	48.2%	42.6%	3.3%	2.6%	4.3%	28.8%	58.7%	6.3%	2.0%
Nursing Assistants	3.9%	41.4%	48.8%	3.4%	2.5%	4.7%	17.3%	70.0%	5.8%	2.1%
Psychiatric Aides	6.1%	39.0%	50.5%	1.6%	2.8%	5.0%	20.4%	68.5%	2.9%	3.3%
Total	4.30%	55.20%	33.60%	2.90%	4.10%	5.80%	41.80%	41.20%	6.80%	4.50%

Appendix C: Demographic Estimates by BH Occupation and County, 2023

	CAROLINE					CECIL				
	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE
2023 POPULATION	**9%**	**74%**	**13%**	**1%**	**3%**	**5%**	**82%**	**8%**	**1%**	**3%**
Clinical and Counseling Psychologists	3.8%	73.5%	18.6%	2.2%	1.9%	2.0%	83.2%	10.9%	2.1%	1.8%
Marriage and Family Therapists	3.9%	59.6%	34.7%	0.8%	1.0%	2.7%	71.2%	22.3%	1.2%	2.6%
Occupational Therapists	1.3%	82.4%	7.6%	6.6%	2.1%	1.9%	79.2%	9.8%	7.2%	2.0%
Rehabilitation Counselors	8.5%	45.5%	41.9%	1.9%	2.3%	3.2%	55.0%	37.4%	1.3%	3.1%
Counselors and Therapists	3.9%	53.1%	39.1%	1.8%	1.9%	3.1%	65.5%	26.8%	1.6%	3.0%
Mental Health and Substance Abuse Social Workers	4.2%	52.8%	39.4%	1.5%	2.1%	4.0%	66.4%	25.3%	1.1%	3.2%
Social and Human Service Assistants	6.8%	44.2%	45.7%	1.3%	2.0%	4.7%	52.2%	38.5%	1.2%	3.4%
Community Health Workers	6.7%	44.0%	44.3%	2.3%	2.7%	5.7%	52.9%	35.9%	2.2%	3.3%
Physician Assistants	8.5%	78.8%	9.7%	1.7%	1.3%	4.5%	73.9%	6.8%	13.0%	1.8%
Registered Nurses	2.9%	67.0%	23.5%	4.6%	2.1%	2.4%	70.5%	19.1%	6.2%	1.9%
Nurse Practitioners	3.9%	82.7%	10.8%	1.6%	1.0%	1.9%	80.3%	8.3%	7.9%	1.6%
Psychiatrists	5.3%	75.3%	8.4%	9.8%	1.2%	2.0%	77.5%	8.1%	10.1%	2.3%
Psychiatric Technicians	3.9%	51.9%	40.0%	1.8%	2.4%	4.1%	61.2%	28.3%	2.1%	4.2%
Licensed Practical and Licensed Vocational Nurses	3.2%	49.6%	43.8%	1.6%	1.8%	3.8%	51.1%	39.4%	3.5%	2.2%
Nursing Assistants	2.9%	37.3%	56.2%	1.5%	2.1%	5.0%	42.8%	46.7%	3.4%	2.1%
Psychiatric Aides	4.7%	25.9%	65.8%	1.2%	2.4%	7.2%	35.4%	51.0%	2.9%	3.5%
Total	6.10%	48.00%	41.10%	1.80%	3.00%	3.60%	62.20%	28.30%	1.80%	4.10%

Appendix C: Demographic Estimates by BH Occupation and County, 2023

	DORCHESTER					KENT				
	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE
2023 POPULATION	**7%**	**62%**	**28%**	**1%**	**3%**	**5.20%**	**77.60%**	**13.40%**	**1.50%**	**2.30%**
Clinical and Counseling Psychologists	2.2%	72.7%	19.6%	3.2%	2.3%	3.1%	67.5%	25.6%	1.8%	2.0%
Marriage and Family Therapists	2.5%	54.0%	42.3%	0.6%	0.6%	3.3%	49.5%	44.7%	0.5%	2.0%
Occupational Therapists	1.6%	74.8%	15.9%	6.3%	1.4%	0.8%	86.0%	8.3%	3.7%	1.3%
Rehabilitation Counselors	2.9%	47.1%	47.5%	0.7%	1.7%	4.0%	39.5%	52.9%	0.7%	2.8%
Counselors and Therapists	3.1%	52.5%	42.5%	0.8%	1.2%	2.2%	40.5%	55.5%	0.6%	1.2%
Mental Health and Substance Abuse Social Workers	3.0%	55.4%	39.4%	0.8%	1.3%	2.7%	41.1%	53.7%	0.8%	1.7%
Social and Human Service Assistants	3.7%	42.5%	51.4%	0.9%	1.5%	5.3%	39.7%	51.2%	1.2%	2.5%
Community Health Workers	4.4%	43.7%	48.8%	1.5%	1.6%	5.8%	42.3%	48.1%	1.7%	2.2%
Physician Assistants	2.4%	74.1%	17.2%	5.1%	1.2%	5.0%	79.3%	12.2%	2.4%	1.1%
Registered Nurses	4.2%	58.0%	29.1%	6.7%	2.1%	1.9%	72.0%	20.6%	4.3%	1.3%
Nurse Practitioners	1.2%	76.2%	18.9%	3.0%	0.7%	2.1%	81.0%	14.5%	1.6%	0.8%
Psychiatrists	1.0%	72.9%	13.0%	12.2%	0.8%	2.1%	72.5%	23.4%	1.3%	0.6%
Psychiatric Technicians	5.2%	38.9%	51.1%	3.2%	1.6%	4.9%	51.1%	39.9%	1.6%	2.5%
Licensed Practical and Licensed Vocational Nurses	4.2%	42.7%	50.6%	1.2%	1.4%	1.5%	46.9%	49.0%	0.8%	1.8%
Nursing Assistants	4.0%	30.3%	62.4%	1.5%	1.8%	2.0%	34.5%	60.3%	1.0%	2.2%
Psychiatric Aides	5.1%	26.6%	62.5%	2.6%	3.2%	4.9%	19.7%	68.8%	2.9%	3.8%
Total	3.50%	47.10%	45.30%	1.60%	2.40%	3.70%	42.80%	49.20%	1.40%	3.00%

Appendix C: Demographic Estimates by BH Occupation and County, 2023

	QUEEN ANNE'S					SOMERSET				
	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE
2023 POPULATION	**5.20%**	**85.20%**	**5.90%**	**1.30%**	**2.40%**	**4.50%**	**52.00%**	**39.40%**	**0.90%**	**3.20%**
Clinical and Counseling Psychologists	2.2%	83.0%	11.0%	2.9%	0.9%	1.9%	65.4%	26.0%	2.6%	4.2%
Marriage and Family Therapists	3.3%	77.9%	16.3%	1.8%	0.6%	3.3%	40.8%	51.6%	0.8%	3.6%
Occupational Therapists	1.5%	84.8%	5.9%	5.9%	1.9%	1.6%	74.3%	13.1%	8.2%	2.8%
Rehabilitation Counselors	4.7%	51.1%	37.0%	1.6%	5.6%	3.7%	31.1%	59.0%	0.8%	5.4%
Counselors and Therapists	3.5%	66.7%	26.7%	2.1%	1.1%	3.3%	41.2%	51.3%	1.5%	2.7%
Mental Health and Substance Abuse Social Workers	3.8%	66.0%	27.4%	1.4%	1.3%	4.2%	37.6%	53.6%	1.0%	3.7%
Social and Human Service Assistants	5.6%	48.4%	41.1%	1.9%	3.0%	5.5%	28.8%	60.6%	1.4%	3.8%
Community Health Workers	5.4%	50.9%	38.8%	2.4%	2.6%	5.5%	33.0%	56.1%	1.9%	3.5%
Physician Assistants	5.2%	76.4%	14.0%	3.3%	1.1%	3.2%	73.4%	17.5%	3.1%	2.8%
Registered Nurses	2.5%	68.6%	21.1%	5.9%	2.1%	2.0%	54.2%	36.5%	4.5%	2.7%
Nurse Practitioners	2.3%	80.5%	13.8%	2.7%	0.9%	1.7%	73.3%	20.4%	2.4%	2.2%
Psychiatrists	3.1%	71.0%	11.6%	13.1%	1.3%	2.2%	72.5%	15.3%	7.4%	2.6%
Psychiatric Technicians	6.8%	56.8%	29.8%	3.6%	2.9%	2.5%	37.9%	56.1%	1.4%	2.1%
Licensed Practical and Licensed Vocational Nurses	3.4%	54.0%	39.2%	1.9%	1.4%	2.0%	31.1%	63.6%	1.3%	2.1%
Nursing Assistants	4.6%	35.9%	54.6%	2.9%	2.0%	1.8%	18.7%	76.3%	1.0%	2.1%
Psychiatric Aides	4.8%	25.4%	65.6%	1.6%	2.6%	9.7%	38.8%	45.8%	2.1%	3.6%
Total	4.10%	60.20%	30.10%	2.40%	3.20%	3.80%	35.90%	53.80%	1.40%	5.10%

Appendix C: Demographic Estimates by BH Occupation and County, 2023

	TALBOT					WICOMICO				
	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE
2023 POPULATION	**8.20%**	**76.00%**	**12.20%**	**1.40%**	**2.20%**	**6.20%**	**60.00%**	**27.30%**	**3.20%**	**3.30%**
Clinical and Counseling Psychologists	2.6%	78.8%	14.4%	2.7%	1.6%	2.4%	74.6%	16.0%	4.6%	2.3%
Marriage and Family Therapists	4.1%	68.0%	24.7%	1.2%	2.0%	2.8%	52.1%	41.2%	1.9%	1.9%
Occupational Therapists	1.8%	80.6%	9.7%	5.8%	2.1%	1.5%	81.4%	9.7%	5.4%	2.0%
Rehabilitation Counselors	3.4%	45.0%	48.4%	1.5%	1.8%	3.4%	41.8%	49.9%	1.7%	3.3%
Counselors and Therapists	3.2%	55.7%	36.8%	2.1%	2.3%	2.9%	46.6%	46.1%	2.1%	2.3%
Mental Health and Substance Abuse Social Workers	3.0%	55.6%	37.7%	1.7%	2.0%	3.4%	48.3%	43.7%	1.9%	2.7%
Social and Human Service Assistants	4.8%	50.0%	42.0%	1.0%	2.2%	5.2%	36.9%	53.6%	1.8%	2.6%
Community Health Workers	5.4%	49.4%	40.7%	1.8%	2.7%	5.0%	42.7%	47.4%	2.3%	2.7%
Physician Assistants	2.8%	76.5%	13.1%	5.3%	2.4%	2.6%	78.8%	11.3%	5.0%	2.3%
Registered Nurses	2.6%	59.6%	26.4%	8.8%	2.6%	1.8%	71.8%	18.6%	5.6%	2.0%
Nurse Practitioners	1.4%	78.4%	14.5%	3.9%	1.8%	1.4%	80.6%	12.3%	3.9%	1.8%
Psychiatrists	1.5%	73.3%	10.5%	13.2%	1.5%	1.7%	71.0%	9.4%	16.1%	1.8%
Psychiatric Technicians	6.3%	51.3%	34.1%	4.4%	3.8%	5.0%	35.1%	54.7%	3.0%	2.2%
Licensed Practical and Licensed Vocational Nurses	2.0%	37.5%	56.9%	2.1%	1.5%	2.6%	46.7%	46.4%	2.3%	2.0%
Nursing Assistants	3.3%	22.8%	69.4%	2.7%	1.8%	3.2%	34.4%	57.6%	2.4%	2.4%
Psychiatric Aides	2.6%	29.9%	62.9%	2.4%	2.2%	2.1%	16.9%	78.9%	1.0%	1.2%
Total	3.40%	51.20%	39.50%	2.30%	3.60%	3.40%	46.30%	42.90%	2.50%	5.00%

Appendix C: Demographic Estimates by BH Occupation and County, 2023

	WORCESTER					CALVERT				
	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE
2023 POPULATION	**3.90%**	**80.10%**	**12.00%**	**1.70%**	**2.20%**	**5.40%**	**74.70%**	**14.00%**	**2.00%**	**3.80%**
Clinical and Counseling Psychologists	2.0%	79.1%	14.2%	3.2%	1.6%	2.6%	80.8%	11.4%	3.3%	1.8%
Marriage and Family Therapists	2.5%	67.7%	26.2%	1.7%	1.9%	4.6%	71.4%	20.0%	2.5%	1.5%
Occupational Therapists	1.5%	82.4%	8.5%	5.3%	2.2%	1.8%	80.2%	9.1%	6.3%	2.6%
Rehabilitation Counselors	3.8%	43.8%	48.2%	1.1%	3.1%	18.3%	37.3%	39.3%	2.7%	2.4%
Counselors and Therapists	3.4%	51.5%	40.8%	2.0%	2.3%	4.9%	55.8%	34.6%	2.2%	2.5%
Mental Health and Substance Abuse Social Workers	4.3%	49.7%	41.4%	1.8%	2.8%	5.4%	54.0%	36.3%	1.6%	2.7%
Social and Human Service Assistants	5.1%	43.3%	47.2%	1.9%	2.6%	8.4%	37.8%	48.9%	1.9%	2.9%
Community Health Workers	5.1%	45.2%	44.7%	2.4%	2.7%	6.6%	41.7%	45.8%	2.3%	3.6%
Physician Assistants	2.3%	84.2%	8.7%	3.1%	1.7%	2.8%	77.7%	12.4%	3.9%	3.2%
Registered Nurses	1.6%	79.0%	14.6%	3.4%	1.3%	2.2%	72.5%	18.0%	4.6%	2.6%
Nurse Practitioners	1.1%	85.1%	9.9%	2.6%	1.2%	1.4%	79.6%	13.3%	3.2%	2.4%
Psychiatrists	1.4%	76.4%	8.3%	12.3%	1.6%	2.6%	70.2%	12.8%	11.5%	2.9%
Psychiatric Technicians	6.4%	46.1%	40.4%	3.0%	4.1%	6.8%	52.8%	33.0%	3.0%	4.4%
Licensed Practical and Licensed Vocational Nurses	2.1%	48.7%	46.5%	1.4%	1.3%	2.7%	47.1%	42.9%	4.6%	2.7%
Nursing Assistants	2.2%	37.5%	57.6%	1.1%	1.5%	3.5%	36.7%	51.9%	4.6%	3.3%
Psychiatric Aides	1.5%	30.7%	66.8%	0.5%	0.5%	5.4%	25.4%	65.8%	1.1%	2.3%
Total	3.70%	50.00%	39.60%	2.00%	4.60%	9.60%	46.40%	36.40%	2.80%	4.80%

Appendix C: Demographic Estimates by BH Occupation and County, 2023

	CHARLES					MONTGOMERY				
	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE
2023 POPULATION	**7.90%**	**31.60%**	**52.80%**	**3.40%**	**4.30%**	**20.50%**	**40.90%**	**19.40%**	**16.00%**	**3.20%**
Clinical and Counseling Psychologists	4.3%	67.7%	20.1%	4.9%	3.0%	10.6%	59.7%	17.3%	10.1%	2.2%
Marriage and Family Therapists	5.1%	55.5%	33.9%	2.9%	2.6%	10.4%	50.2%	30.3%	6.2%	3.0%
Occupational Therapists	2.7%	68.9%	16.7%	8.5%	3.1%	6.3%	58.5%	19.0%	13.4%	2.7%
Rehabilitation Counselors	3.0%	35.2%	56.5%	1.4%	3.9%	8.8%	30.5%	54.0%	4.2%	2.5%
Counselors and Therapists	4.3%	37.1%	53.8%	2.0%	2.8%	10.5%	36.1%	45.4%	5.3%	2.8%
Mental Health and Substance Abuse Social Workers	4.4%	39.0%	51.9%	1.8%	2.9%	10.7%	37.9%	44.4%	4.4%	2.6%
Social and Human Service Assistants	5.7%	27.6%	62.1%	1.8%	2.9%	12.0%	28.0%	52.4%	4.9%	2.7%
Community Health Workers	5.7%	31.2%	57.1%	3.0%	3.0%	11.6%	31.3%	48.0%	6.2%	2.9%
Physician Assistants	6.2%	57.2%	24.1%	8.9%	3.7%	13.8%	47.9%	20.7%	14.5%	3.0%
Registered Nurses	3.2%	51.7%	33.1%	9.3%	2.8%	7.0%	40.4%	35.6%	14.5%	2.5%
Nurse Practitioners	3.1%	61.3%	25.7%	7.1%	2.8%	7.7%	53.6%	24.0%	12.1%	2.7%
Psychiatrists	3.6%	50.7%	20.7%	21.9%	3.1%	8.0%	37.8%	15.3%	36.7%	2.2%
Psychiatric Technicians	10.6%	36.8%	42.4%	4.8%	5.5%	20.9%	27.6%	38.4%	9.3%	3.9%
Licensed Practical and Licensed Vocational Nurses	3.6%	28.7%	61.9%	3.7%	2.1%	7.3%	23.2%	61.9%	5.7%	2.0%
Nursing Assistants	3.9%	17.3%	73.6%	3.2%	2.0%	8.7%	13.6%	70.5%	5.4%	1.8%
Psychiatric Aides	3.4%	17.7%	75.3%	1.6%	2.1%	9.0%	15.4%	68.2%	5.1%	2.2%
Total	4.50%	36.50%	51.10%	3.10%	4.90%	10.30%	33.60%	44.40%	7.00%	4.70%

Appendix C: Demographic Estimates by BH Occupation and County, 2023

	PRINCE GEORGE'S					ST. MARY'S				
	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE
2023 POPULATION	**21.40%**	**11.20%**	**61.00%**	**4.10%**	**2.40%**	**6.20%**	**71.80%**	**15.30%**	**3.00%**	**3.80%**
Clinical and Counseling Psychologists	7.7%	48.9%	31.8%	8.6%	3.0%	3.3%	73.5%	15.8%	4.6%	2.7%
Marriage and Family Therapists	7.4%	44.3%	40.8%	4.6%	3.0%	3.7%	66.3%	24.7%	3.2%	2.1%
Occupational Therapists	4.4%	54.8%	27.4%	10.6%	2.9%	1.9%	78.4%	10.5%	6.2%	3.0%
Rehabilitation Counselors	5.6%	20.9%	68.8%	2.3%	2.5%	4.0%	53.5%	38.8%	0.8%	2.8%
Counselors and Therapists	7.5%	32.6%	53.3%	3.6%	2.9%	3.8%	54.0%	37.0%	2.2%	3.0%
Mental Health and Substance Abuse Social Workers	7.9%	33.1%	53.3%	2.7%	3.0%	4.2%	52.2%	38.3%	2.1%	3.3%
Social and Human Service Assistants	8.9%	21.4%	64.0%	3.0%	2.7%	5.8%	41.2%	48.0%	1.9%	3.2%
Community Health Workers	8.9%	24.2%	60.2%	3.6%	3.1%	5.5%	41.1%	46.6%	2.7%	4.1%
Physician Assistants	10.6%	40.5%	33.4%	12.0%	3.5%	5.6%	64.2%	16.0%	9.9%	4.3%
Registered Nurses	4.6%	34.9%	47.5%	10.4%	2.7%	2.7%	62.7%	22.6%	8.6%	3.4%
Nurse Practitioners	5.6%	44.5%	37.2%	9.5%	3.1%	2.1%	74.0%	14.4%	6.5%	3.0%
Psychiatrists	5.9%	37.6%	24.4%	28.8%	3.3%	4.6%	69.5%	9.9%	11.1%	4.9%
Psychiatric Technicians	13.9%	22.1%	53.3%	7.0%	3.7%	5.8%	47.5%	39.3%	3.0%	4.4%
Licensed Practical and Licensed Vocational Nurses	4.9%	19.9%	69.5%	3.8%	2.0%	3.1%	39.4%	50.2%	4.4%	2.8%
Nursing Assistants	4.8%	10.5%	79.8%	3.2%	1.7%	3.2%	30.5%	59.6%	3.8%	2.9%
Psychiatric Aides	4.9%	13.0%	77.9%	2.2%	2.0%	4.5%	27.5%	63.6%	1.6%	2.9%
Total	7.30%	27.30%	56.30%	4.60%	4.40%	4.20%	53.80%	34.70%	2.90%	4.50%

Appendix C: Demographic Estimates by BH Occupation and County, 2023

	ALLEGANY					CARROLL				
	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE
2023 POPULATION	**2.30%**	**86.40%**	**7.50%**	**1.10%**	**2.70%**	**4.90%**	**85.90%**	**4.20%**	**2.60%**	**2.40%**
Clinical and Counseling Psychologists	1.5%	84.3%	9.3%	2.9%	2.0%	2.5%	79.4%	11.4%	4.2%	2.5%
Marriage and Family Therapists	3.0%	80.5%	13.4%	1.8%	1.2%	4.1%	66.9%	23.5%	2.8%	2.6%
Occupational Therapists	0.8%	90.9%	3.3%	3.6%	1.4%	1.6%	80.2%	8.9%	6.4%	2.9%
Rehabilitation Counselors	2.8%	73.9%	19.0%	0.3%	4.1%	6.0%	48.0%	41.4%	1.8%	2.8%
Counselors and Therapists	2.8%	72.8%	19.4%	1.7%	3.3%	3.8%	59.5%	31.9%	2.2%	2.6%
Mental Health and Substance Abuse Social Workers	3.5%	68.5%	23.0%	1.5%	3.5%	4.3%	59.7%	31.5%	1.8%	2.7%
Social and Human Service Assistants	4.0%	59.9%	31.3%	1.2%	3.5%	5.7%	47.2%	42.7%	1.9%	2.5%
Community Health Workers	3.5%	66.3%	25.5%	2.1%	2.7%	5.9%	52.7%	36.5%	2.4%	2.4%
Physician Assistants	1.0%	91.0%	2.6%	4.2%	1.2%	3.1%	80.6%	8.5%	6.0%	1.8%
Registered Nurses	0.9%	89.4%	5.1%	3.2%	1.3%	2.0%	75.3%	14.8%	6.2%	1.7%
Nurse Practitioners	0.6%	91.5%	3.5%	3.3%	1.0%	1.6%	82.9%	9.5%	4.5%	1.5%
Psychiatrists	1.5%	67.7%	12.3%	16.5%	2.0%	2.6%	63.8%	11.0%	19.9%	2.6%
Psychiatric Technicians	4.2%	67.6%	20.6%	3.3%	4.3%	7.3%	46.2%	35.4%	5.8%	5.3%
Licensed Practical and Licensed Vocational Nurses	1.4%	81.6%	13.5%	1.7%	1.8%	2.7%	55.8%	36.4%	3.3%	1.8%
Nursing Assistants	1.9%	77.8%	16.2%	1.6%	2.5%	3.6%	45.1%	45.8%	3.4%	2.1%
Psychiatric Aides	5.5%	20.5%	68.0%	1.6%	4.3%	5.1%	22.4%	65.3%	3.0%	4.3%
Total	2.70%	73.30%	18.20%	2.00%	3.80%	4.20%	56.70%	31.40%	3.30%	4.30%

Appendix C: Demographic Estimates by BH Occupation and County, 2023

	FREDERICK					GARRETT				
	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE
2023 POPULATION	**12.30%**	**66.20%**	**11.60%**	**6.70%**	**3.20%**	**1.50%**	**95.60%**	**1.00%**	**0.50%**	**1.40%**
Clinical and Counseling Psychologists	4.2%	80.0%	9.5%	4.4%	1.9%	1.6%	82.9%	11.8%	2.0%	1.7%
Marriage and Family Therapists	6.1%	69.1%	18.8%	3.2%	2.8%	2.3%	74.3%	21.7%	0.4%	1.3%
Occupational Therapists	3.1%	79.3%	8.5%	6.5%	2.5%	1.5%	87.4%	5.0%	4.6%	1.5%
Rehabilitation Counselors	5.9%	55.9%	33.1%	1.7%	3.5%	3.2%	53.7%	38.7%	0.8%	3.7%
Counselors and Therapists	5.4%	59.8%	29.5%	2.7%	2.7%	3.1%	67.1%	26.0%	1.7%	2.1%
Mental Health and Substance Abuse Social Workers	5.7%	61.2%	28.7%	1.9%	2.6%	4.0%	58.0%	33.4%	1.7%	2.9%
Social and Human Service Assistants	8.5%	48.7%	37.6%	2.3%	3.0%	4.5%	57.3%	34.5%	1.3%	2.4%
Community Health Workers	7.8%	51.5%	34.6%	3.0%	3.0%	5.3%	54.2%	35.3%	2.4%	2.7%
Physician Assistants	5.9%	76.5%	8.7%	6.3%	2.6%	2.0%	87.9%	4.9%	3.7%	1.5%
Registered Nurses	3.8%	70.7%	17.4%	6.1%	2.0%	2.1%	71.5%	16.5%	7.6%	2.3%
Nurse Practitioners	3.2%	79.7%	10.0%	4.9%	2.2%	1.0%	90.1%	5.0%	2.7%	1.1%
Psychiatrists	3.9%	66.9%	9.2%	17.7%	2.3%	0.9%	89.7%	2.2%	6.5%	0.8%
Psychiatric Technicians	11.5%	52.0%	27.1%	4.5%	4.9%	6.6%	53.1%	32.7%	4.4%	3.2%
Licensed Practical and Licensed Vocational Nurses	5.2%	49.8%	39.7%	3.3%	2.0%	0.9%	87.3%	9.5%	1.0%	1.2%
Nursing Assistants	6.8%	38.9%	49.0%	3.2%	2.1%	1.8%	76.5%	18.0%	1.7%	2.0%
Psychiatric Aides	4.1%	29.8%	61.9%	2.0%	2.1%	4.8%	26.3%	64.1%	1.6%	3.1%
Total	6.30%	55.80%	29.80%	3.20%	5.00%	3.20%	60.50%	29.60%	2.00%	4.70%

Appendix C: Demographic Estimates by BH Occupation and County, 2023

	WASHINGTON					CITY OF BALTIMORE				
	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE	HISPANIC	WHITE	BLACK	ASIAN	OTHER/TWO OR MORE
2023 POPULATION	**7.70%**	**73.80%**	**13.00%**	**2.10%**	**3.40%**	**6.60%**	**27.10%**	**61.00%**	**2.80%**	**2.60%**
Clinical and Counseling Psychologists	2.6%	82.3%	10.0%	3.2%	1.9%	3.7%	57.8%	29.7%	5.8%	3.0%
Marriage and Family Therapists	4.1%	68.1%	23.4%	1.8%	2.5%	4.8%	38.4%	51.4%	2.6%	2.8%
Occupational Therapists	2.1%	84.6%	6.2%	5.1%	2.0%	2.3%	66.7%	20.4%	8.4%	2.1%
Rehabilitation Counselors	3.3%	67.0%	25.4%	1.0%	3.3%	4.2%	30.6%	59.5%	1.3%	4.3%
Counselors and Therapists	4.1%	68.8%	22.4%	2.1%	2.6%	4.2%	31.2%	59.6%	2.7%	2.3%
Mental Health and Substance Abuse Social Workers	4.6%	69.8%	21.8%	1.4%	2.4%	5.1%	34.0%	56.2%	2.1%	2.6%
Social and Human Service Assistants	5.6%	58.3%	31.3%	1.5%	3.3%	6.3%	26.3%	62.6%	2.1%	2.7%
Community Health Workers	5.3%	60.4%	28.8%	2.3%	3.2%	6.0%	29.6%	58.7%	3.1%	2.6%
Physician Assistants	3.2%	83.0%	5.6%	6.4%	1.8%	4.3%	57.9%	24.7%	10.5%	2.5%
Registered Nurses	2.4%	81.9%	10.0%	4.0%	1.6%	2.7%	49.9%	34.7%	10.8%	1.9%
Nurse Practitioners	1.7%	85.9%	6.3%	4.7%	1.4%	2.5%	60.4%	27.0%	8.0%	2.1%
Psychiatrists	2.4%	71.2%	5.1%	19.9%	1.4%	3.1%	47.7%	20.6%	25.8%	2.8%
Psychiatric Technicians	5.6%	64.0%	24.1%	3.0%	3.3%	5.0%	28.2%	59.9%	4.1%	2.8%
Licensed Practical and Licensed Vocational Nurses	3.5%	67.2%	25.4%	2.3%	1.7%	3.0%	25.8%	66.5%	3.0%	1.6%
Nursing Assistants	5.3%	57.7%	32.8%	2.2%	2.0%	3.4%	17.6%	74.3%	3.3%	1.5%
Psychiatric Aides	5.1%	25.2%	64.3%	1.5%	3.9%	4.2%	16.9%	74.6%	1.6%	2.7%
Total	4.30%	66.00%	23.40%	2.20%	4.20%	4.50%	33.60%	53.50%	4.20%	4.20%

Appendix D: Estimates of Workers Needed in Maryland, 2028, 2033, and 2043*

		BY 2028			BY 2033			BY 2043		
OCCUPATION	ESTIMATED WORKERS (2023)	NET NEW WORKERS NEEDED	REPLACEMENT WORKERS NEEDED	TOTAL ADDITIONAL WORKERS NEEDED	NET NEW POSITIONS NEEDED	REPLACEMENT WORKERS NEEDED	TOTAL ADDITIONAL WORKERS NEEDED	NET NEW WORKERS NEEDED	REPLACEMENT WORKERS NEEDED	TOTAL ADDITIONAL WORKERS NEEDED BY 2033
Social and Human Services Assistants	8,732	4,029	4,000	8,029	3,017	8,456	11,473	2,901	18,931	21,832
Counselors and Therapists	7,583	5,784	3,748	9,532	10,756	8,622	19,378	16,237	20,386	36,623
Psychiatric Aides and Technicians	1,496	938	802	1,740	1,421	1,743	3,164	2,098	4,140	6,238
Social Workers in BH Settings	2,799	1,651	1,024	2,675	2,210	2,209	4,419	2,884	1,024	3,908
Psychologists (Clinical and Counseling)	1,266	745	315	1,060	993	680	1,673	1,280	315	1,595
Psychiatrists	1,196	105	164	269	220	342	562	480	746	1,226
Nursing Assistants	1,094	379	771	1,150	-168	1,525	1,357		2,986	2,986
Licensed Practical Nurses	339	173	134	307	159	281	440	128	621	749
Registered Nurses (Inc. Adv. Practice)	2,126	1,002	590	1,592	664	1,221	1,885	171	2,621	2,792
Nurse Practitioners	313	260	78	338	588	181	769	1,172	502	1,674
Occupational Therapists	2,747	1061	779	1,840	534	1,590	2,124	-463	3,314	2,851
Rehabilitation Counselors	2,105	602	789	1,391	-761	1,528	767		2,864	2,864
Community Health Workers	2,548	1,322	1,300	2,622	1,272	2,736	4,008	1,108	6,076	7,184
Physician's Assistants	269	171	71	242	263	155	418	389	374	763
Total	34,613	18,222	14,565	32,787	21,168	31,269	52,437	28,385	64,900	93,285

** Based estimates and trends of unmet need for BH services, Maryland population growth, occupational growth rates, and occupational replacement rate estimates as described in Section 2, projected out five, ten, and twenty years from the 2023 baseline year.*

****Cells without data indicate insufficient or unreliable data to make estimates.***

.Appendix E: NAICS Classification Used for Wage and Education Data Analysis

Of the 1012 unique six-digit North American Industry Classification System (NAICS) codes currently in use, the following 57 were classified as "Likely" or "Possible" as employing an individual in a job working to meet the Behavioral Health needs of Maryland residents.

NAICS CODE	NAICS TITLE	LIKELIHOOD EMPLOYED IN BEHAVIORAL HEALTH
621112	Offices of Physicians, Mental Health Specialists	Likely
621330	Offices of Mental Health Practitioners (except Physicians)	Likely
621399	Offices of All Other Miscellaneous Health Practitioners	Likely
621420	Outpatient Mental Health and Substance Abuse Centers	Likely
621491	HMO Medical Centers	Likely
622210	Psychiatric and Substance Abuse Hospitals	Likely
623210	Residential Intellectual and Developmental Disability Facilities	Likely
623220	Residential Mental Health and Substance Abuse Facilities	Likely
621340	Offices of Physical, Occupational and Speech Therapists, and Audiologists	Possible
624110	Child and Youth Services	Possible
624230	Emergency and Other Relief Services	Possible
624310	Vocational Rehabilitation Services	Possible
541214	Payroll Services	Possible
541612	Human Resources Consulting Services	Possible
561311	Employment Placement Agencies	Possible
561312	Executive Search Services	Possible
561320	Temporary Help Services	Possible
561330	Professional Employer Organizations	Possible
611110	Elementary and Secondary Schools	Possible
611210	Junior Colleges	Possible
611310	Colleges, Universities, and Professional Schools	Possible
611410	Business and Secretarial Schools	Possible
611430	Professional and Management Development Training	Possible
611620	Sports and Recreation Instruction	Possible
611699	All Other Miscellaneous Schools and Instruction	Possible
611710	Educational Support Services	Possible
621111	Offices of Physicians (except Mental Health Specialists)	Possible
621410	Family Planning Centers	Possible
621493	Freestanding Ambulatory Surgical and Emergency Centers	Possible
621498	All Other Outpatient Care Centers	Possible
621610	Home Health Care Services	Possible
621910	Ambulance Services	Possible
621999	All Other Miscellaneous Ambulatory Health Care Services	Possible
622110	General Medical and Surgical Hospitals	Possible
622310	Specialty (except Psychiatric and Substance Abuse) Hospitals	Possible

NAICS CODE	NAICS TITLE	LIKELIHOOD EMPLOYED IN BEHAVIORAL HEALTH
623110	Nursing Care Facilities (Skilled Nursing Facilities)	Possible
623311	Continuing Care Retirement Communities	Possible
623312	Assisted Living Facilities for the Elderly	Possible
623990	Other Residential Care Facilities	Possible
624120	Services for the Elderly and Persons with Disabilities	Possible
624190	Other Individual and Family Services	Possible
624210	Community Food Services	Possible
624221	Temporary Shelters	Possible
624229	Other Community Housing Services	Possible
624410	Child Care Services	Possible
813920	Professional Organizations	Possible
921150	American Indian and Alaska Native Tribal Governments	Possible
921190	Other General Government Support	Possible
922110	Courts	Possible
922140	Correctional Institutions	Possible
922150	Parole Offices and Probation Offices	Possible
923110	Administration of Education Programs	Possible
923120	Administration of Public Health Programs	Possible
923130	Administration of Human Resource Programs (except Education, Public Health, and Veterans' Affairs Programs)	Possible
923140	Administration of Veterans' Affairs	Possible
925110	Administration of Housing Programs	Possible
925120	Administration of Urban Planning and Community and Rural Development	Possible

Appendix F: Maryland Longitudinal Data System Center Data Overview

The **Maryland Longitudinal Data System Center** (MLDS Center) is the State of Maryland's central repository for student and workforce data. The MLDS Center develops and maintains the MLDS to provide analyses, produce relevant information, and inform choices to improve student and workforce outcomes in the State of Maryland.

MLDS Data

The MLDS connects data from across Maryland's education, child & youth services, and workforce agencies. These data are subject to strict data management, security, and privacy requirements. The MLDS may only report aggregated, de-identified data. All research conducted by the MLDS Center focuses on what happens to students before and after critical transitions between education and workforce pathways. All research and analysis using the MLDS is cross-sector.

Below is an overview of the available data within the System that was included in the analysis completed for the Maryland Health Care Commission's Behavioral Health Workforce Needs Assessment, ***Section 3: Post-Secondary Degree Completion Trends***.

Education Data

The MLDS contains education data on all students from Maryland public high schools, students attending Maryland public, state-aided independent and private institutions of higher education, and adults completing GED® Testing or the National External Diploma Program® (NEDP®). Education data begin with the 2007-2008 academic year. The MLDS does not contain education data on students in private high schools in Maryland. The MLDS contains limited data on out-of-state college enrollment and graduation for Maryland public high school graduates.

Wage Data

The MLDS System contains workforce data from quarterly Unemployment Insurance (UI) filings beginning with the first fiscal quarter of 2008 for individuals with a Maryland educational record (see the MLDS Data Inventory for a definition of educational record). UI filings are only available for Maryland employees who work for an in-state employer required to file UI and have a Maryland education record. Examples of employers that are not required to file UI include the federal government (including the military), certain non-profits, and self-employed and independent contractors. Individuals working in temporary employment, including federal

postsecondary work-study programs, are also not subject to UI filings. These omissions mean it is incorrect to assume that individuals not counted as “employed” are unemployed.

The UI wages reported reflect the compensation paid during a fiscal quarter, rather than when the compensation was earned. UI wages reflect the sum of all compensation, including bonuses, commissions, tips, and other forms of compensation. The UI wage data do not distinguish between part-time and full-time employment, hourly and salaried wages, regular wages and commissions, bonuses, and other incentive pay. The UI wage data provided do not indicate the number of days or the number of hours a person worked in a fiscal quarter.

UI filings for a fiscal quarter may be incomplete. Employers may have filed UI wages after the data have been transmitted to the MLDS Center or have omitted individuals from their file. Missing wage data and/or corrections to previously reported wages may be provided in subsequent fiscal quarters. While there is no time limit on correcting UI filings, most changes (additions and/or corrections) are completed within one fiscal quarter. The analysis completed for the Healthcare Workforce Crisis Commission includes UI wage data with at least one fiscal quarter of subsequent UI data reported; therefore, errors in wage visibility and wage amounts due to corrections and late filings have been minimized.

Wage data in the MLDS include North American Industry Classification System (NAICS) codes for employers. This system classifies employers by sector rather than identifies the specific jobs performed by employees. For example, NAICS 62 is Health Care and Social Assistance, and NAICS 6221 is General Medical and Surgical Hospitals. Individuals who are doctors, hospital administrators, dietitians, and janitorial staff at a hospital would all have this same NAICS code. Employers select the sector and may change their sector designation at any time

Appendix G: Letter Received from the Maryland Assembly on School-Based Health Care

masbhc
MARYLAND ASSEMBLY ON
SCHOOL-BASED HEALTH CARE
education + health = success

Maryland Association of School Health Nurses
MASHN

To: Maryland Health Care Commission and Trailhead Strategies

From: Maryland Assembly on School-Based Health Care and Maryland School Nurses Association

RE: **Recommendations for Maryland Behavioral Health Workforce Needs Assessment**

Date: July 25, 2024

Thank you for allowing us providing feedback into the behavioral health needs assessment study in support of implementation of HB 418/SB 283 - *Mental Health - Workforce Development - Fund Established* from the 2023 session. The legislation provides the framework of a program to support recruitment and retainment of behavioral health professions, given the dire shortage facing nearly all Maryland communities.

The Maryland Assembly on School-Based Health Care (MASBHC) and the Maryland Association of School Health Nurses (MASHN) have joined together to prepare these comments. We would like to collaborate with the Maryland Health Care Commission, the Maryland Department of Health, and other stakeholders as the findings of the Behavioral Health Workforce Needs Assessment become the basis for implementation of the legislation.

The report highlights certain settings where behavioral health providers shortages are particularly acute. **We recommend that the Maryland Health Care Commission (MHCC) add school settings to the final report.** With the addition of school settings, the Assessment would be consistent with other programs initiated by the Maryland General Assembly, Department of Health, and Maryland State Department of Education:

- In 2022, the Maryland General Assembly enacted *SB 440/HB 425 - Commission to Study the Health Care Workforce Crisis in Maryland – Establishment (Delegate Ariana Kelly/Senator Pam Beidle)*. The bill created a commission to study health professional shortages, citing primary and secondary schools as a specific area of focus;

- In 2023, the Maryland General Assembly enacted *HB 1219 - Maryland Educator Shortage Reduction Act of 2023 (Speaker Jones):* The legislation updated Blueprint requirements and expanded the state's loan repayment programs specifically to provide support to behavioral health providers in school settings;

- Under the Behavioral Health Commission, the Department of Health has created the Workgroup on Youth Behavioral Health, Individuals with Developmental Disabilities, and Individuals with Complex Behavioral Health Needs. The Department of Health recently contracted with Mannat to prepare a roadmap, with stakeholders' input, on creating a more responsive behavioral health system for youth. Although the roadmap is just in the planning states, it is reasonable to assume that it will encompass school health and other school-based services given the focus on youth. A major implementation issue will be the lack of behavioral health providers in schools. This will require partnership between the Maryland Department of Health and the Maryland State Department of Education, as both have jurisdiction over school health issues.

The Maryland General Assembly and Governor Moore's Administration has been laser-focused on improving behavioral health access for young people. With the addition of school settings in the findings of the Maryland Behavioral Health Workforce Needs Assessment, MHCC could align the findings of this report with other health professional shortage initiatives across Maryland.

If we can provide any additional information, please contact Robyn Elliott at relliott@policypartners.net.

cc: Delegate Heather Bagnall
Senator Malcolm Augustine

Appendix H: Letter Received from the Maryland Occupational Therapy Association

MOTA Maryland Occupational Therapy Association

PO Box 36401, Towson, Maryland 21286 ♦ mota-members.com

To: Maryland Health Care Commission

Subject: Maryland Behavioral Health Workforce Needs Assessment Draft

Date: August 2, 2024

Thank you for the opportunity to comment on the draft of the behavioral health workforce needs assessment required by Senate Bill 283 (Ch. 286) Mental Health - Workforce Development - Fund Established, from the 2023 legislative session. The Maryland Occupational Therapy Association (MOTA) appreciates the work MHCC and Trailhead Stratgies has done to ensue that the Behavioral Health Workforce Investment Fund will provide reimbursement for costs associated with educating, training, certifying, recruiting, placing, and retaining behavioral health professionals and paraprofessional. In 2023, MOTA advocated for Senate Bill 283 because of the shortage of behavioral health professionals. **MOTA is requesting that occupational therapists be included in the list of behavioral health providers in the assessment.**

Occupational therapy is rooted in behavioral health in both the history and current scope of practice of the profession. In the late 1800's, occupational therapy emerged as a profession in psychiatric hospitals. Clinicians had begun to recognize that behavioral health treatment needed to involve engaging patients in caring for themselves in activities of daily living. In 1917, the National Society for the Promotion of Occupational Therapy was established in the U.S. (later becoming the American Occupational Therapy Association). At the same time, occupational therapy emerged as a profession in the United Kingdom as their health system struggled to treat soliders and veterns with "shell shock", now called post-traumatic stress disorder. In today's practice environment, occupational therapists continue to provide behavioral health services as important members of clinician teams in multiple types of behavioral health programs.

Occupational therapists address barriers that individuals with mental and behavioral health conditions experience in the community by providing interventions that focus on enhancing existing skills; remediating or restoring skills; modifying or adapting the environment or activity; and preventing relapse. The entry-level graduate education of occupational therapists includes required behavioral health content including basic psychology and psychopathology as pre-

requisites, as well as overview of behavioral and mental health conditions, presentation and evidence-based assessment and intervention to improve functioning in daily life.

Entry-level graduate education is regulated by the Accreditation Council for Occupational Therapy Education (ACOTE) and also requires observations and supervised fieldwork in behavioral health settings and addressing those with mental health and/or substance use conditions.

The Maryland Board of Occupational Therapy Practice requires Maryland OT's to be certified with the National Board for Certification in Occupational Therapy (NBCOT)[1]. Part of the NBCOT exam includes evaluation, assessment, and case intervention items on mental and behavioral health. Additionally, the American Occupational Therapy Association's (AOTA) Standards of Practice for Occupational Therapy outlines requirements for occupational therapists for the delivery of occupational therapy services which recognizes mental health within their scope of practice.

Specifically, in mental health, occupational therapists help people with thought disorders and psychosis, depression, anxiety, post-traumatic stress disorder (PTSD), addiction, eating disorders and a range of co-occurring disorders to manage their conditions and regain their ability to take part in valued everyday activities that make up daily life. Occupational therapists help people with mental health conditions learn new ways of participating in work, school, and leisure activities by regaining or acquiring new skills, and adapting their environment in ways that make it easier for them to participate in various activities. Occupational therapy focuses on how the patient's mental state—their thoughts and emotions as well as the symptoms of mental illness, such as fatigue, loss of motivation and meaning, confusion, fearfulness and hypervigilance—are preventing them from participating fully a balanced life.

Occupational therapists operate as independent members of the interdisciplinary team supporting recovery and successful community tenure of people with behavioral health conditions across the lifespan. Their scope of practice addresses all aspects of function, and contributes to diagnosis and treatment. Occupational therapists work in direct service on behavioral health inpatient units as well as in licensed day hospitals, intensive outpatient programs, supported education, employment and housing and psychiatric rehabilitation programs. Occupational therapists also function as consultants to community based behavioral health programs to assist with identifying current capacity and supporting transitions between levels of care. This occurs through comprehensive assessment as well as individualized treatments that occur either individually or in groups.

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[1] COMAR 10.46.01.02E(7)

We appreciate the opportunity to submit the request to be included in the behavioral health workforce assessment. Our comments today are consistent with the information shared by occupational therapists at all of the town halls.

If we can provide any further information, please contact Michael Paddy at mpaddy@policypartners.net.

cc: Delegate Heather Bagnall
Senator Malcolm Augustine

Appendix I: Letter Received from the Maryland School Counselor Association

August 7, 2024

Maryland Health Care Commission and Trailhead Strategies
4160 Patterson Ave
Baltimore, MD 21215

RE: Maryland Behavioral Health Workforce Needs Assessment Draft – School Counselors Inclusion Request

Dear Maryland Health Care Commission and Trailhead Strategies,

The Maryland School Counselors Association (MSCA) is a professional organization of over 900 counselors who work with students in pre-kindergarten through twelfth grade in public, private, charter, and magnet school settings. MSCA appreciates the opportunity to provide comment on the draft of the Behavioral Health workforce needs assessment and thank the Commission and Trailhead Strategies for your work to inform the design of the Behavioral Health Workforce Investment Fund required by *SB 283 (Ch. 286) Mental Health - Workforce Development - Fund Established*.

MSCA appreciates the thorough evaluation of the behavioral health workforce assessment presented to the Commission in July. We would recommend the addition of school counselors to the list of behavioral health professionals in the final report for the needs assessments. School counselors are an integral part of the behavioral health team in schools, and they are the only behavioral health professional that interacts with every student in the school. This position gives them a unique vantage point to help identify students with behavioral health needs, provide short-term counseling, and coordinate services with other behavioral health professionals for long-term needs.

School counselors are licensed professionals who improve student success for all students by implementing a comprehensive school counselor program that complement other behavioral health providers. School counselors are licensed by the Maryland State Department of Education. They are often the first mental health professional a student sees; and under CMS policy, they may be reimbursed for behavioral health services in schools under Medicaid, like school psychologists, in states that have established school health billing programs.

In understanding the role of school counselors in behavioral health, it may be helpful to review the American School Counselor Association's (ASCA) white paper on "The School Counselor and Student Mental Health" (please see attached). School counselors are the only member of the behavioral health team that is charged with monitoring the need of all students in a school. School counselors recognize and respond to the need for mental health services that promote social/emotional wellness and development for all students. According to the ASCA,

school counselors "recognize mental health warning signs" and "provide short-term counseling and crisis intervention focused on mental health or situational concerns such as grief or difficult transitions." For longer-term counseling, school counselors provide care coordinating with other behavioral health professions. In addition, school counselors also advocate for the mental health needs of all students by offering instruction that enhances awareness of mental health (such as Start Talking Maryland lessons), appraisal and advisement addressing academic, and career and social/emotional development.

The Maryland General Assembly recognizes the importance of including school counselors in programs that address behavioral health professional shortages in schools. With *HB 1219 Maryland Educator Shortage Reduction Act of 2023*, our state legislature expanded the Janet Hoffman Loan Repayment Program to include behavioral health professionals. Under Education Article 18-1501, the bill defined mental health professionals as including school counselors.

MSCA requests the inclusion of school counselors in the needs assessment for SB 283 to be consistent with state policy established under HB 1219. According to the most recent Maryland Department of Health *Youth Risk Behavior Survey*, about one third of all students in Maryland reported feeling hopeless or sad between 2021 and 2022.[1] Yet, there is a workforce shortage and not enough school counselors to meet the continued increasing needs of students today. The Commission on Innovation and Excellence in Education's 2019 report adopted the nationally recommended ratio of 250 students per school counselor. However, per 2023-2024 MSDE data, many of our counties are significantly above the recommended ratio, the baseline student-counselor ratio in schools indicated that there are on average 307 students per school counselor with several schools having over 1,000 students per school counselor. Our members provided feedback at Trailhead's listening sessions on the impact of these shortages on the health and wellbeing of students across Maryland.

We ask for you to consider our request and for school counselors to be included moving forward. If we can provide an additional information, please contact Jocelyn I. Collins at jcollins@policypartners.net with a response and for any questions.

Sincerely,

Holly J. Kleiderlein

Holly J. Kleiderlein, NBCT
Legislative Chair, Maryland School Counselor Association

cc: Delegate Heather Bagnall
Senator Malcolm Augustine

[1] https://health.maryland.gov/phpa/ccdpc/Reports/Pages/YRBS-2022-2023.aspx

The School Counselor and Student Mental Health

(Adopted 2009, Revised 2015, 2020)

ASCA Position

School counselors recognize and respond to the need for mental health services that promote social/emotional wellness and development for all students. School counselors advocate for the mental health needs of all students by offering instruction that enhances awareness of mental health, appraisal and advisement addressing academic, career and social/emotional development; short-term counseling interventions; and referrals to community resources for long-term support.

The Rationale

Students' unmet mental health needs can be a significant obstacle to student academic, career and social/emotional development and even compromise school safety. Even so, most students in need do not receive adequate mental health supports (Centers for Disease Control and Prevention [CDC], 2013). Research indicates 20% of students are in need of mental health services, yet only one out of five of these students receive the necessary services (Erford, 2019). Furthermore, students of color and those from families with low income are at greater risk for mental health needs but are even less likely to receive the appropriate services (Panigua, 2013) despite increased national attention to these inequities (Marrast, Himmelsteim & Woolhandler, 2016).

Of school-age children who receive any behavioral and/or mental health services, 70%–80% receive them at school (Atkins et al., 2010). Preventive school-based mental health and behavioral services are essential. Without planned intervention for students exhibiting early-warning signs, setbacks in academic, career and social/emotional development can result during later school years and even adulthood.

The ASCA Student Standards: Mindsets & Behaviors for Student Success (ASCA, 2021) identify and prioritize the specific attitudes, knowledge and skills students should be able to demonstrate as a result of a school counseling program. School counselors use the standards to assess student growth and development, guide the development of strategies and activities and create a program that helps students achieve to their highest potential. This includes offering instruction that enhances awareness of mental health and short-term counseling interventions designed to promote positive mental health and to remove barriers to success.

The School Counselor's Role

School counselors focus their efforts on designing and implementing school counseling programs that promote academic, career and social/emotional success for all students. School counselors acknowledge they may be the only counseling professional available to students and their families. Thus, school counselors:

- Deliver instruction that proactively enhances awareness of mental health; promotes positive, healthy behaviors; and seeks to remove the stigma associated with mental health issues
- Provide students with appraisal and advisement addressing their academic, career and social/emotional needs
- Recognize mental health warning signs including
  - changes in school performance and attendance
  - mood changes
  - complaints of illness before school
  - increased disciplinary problems at school
  - problems at home or with the family situation (e.g., stress, trauma, divorce, substance abuse, exposure to poverty conditions, domestic violence)
  - communication from teachers about problems at school
  - dealing with existing mental health concerns
- Provide short-term counseling and crisis intervention focused on mental health or situational concerns such as grief or difficult transitions
- Provide referrals to school and community resources that treat mental health issues (suicidal ideation, violence, abuse and depression) with the intent of removing barriers to learning and helping the student return to the classroom
- Educate teachers, administrators, families and community stakeholders about the mental health concerns of students, including recognition of the role environmental factors have in causing or exacerbating mental health issues, and provide resources and information
- Advocate, collaborate and coordinate with school and community stakeholders to meet the needs of the whole child and to ensure students and their families have access to mental health services
- Recognize and address barriers to accessing mental health services and the associated stigma, including cultural beliefs and linguistic impediments
- Adhere to appropriate guidelines regarding confidentiality, the distinction between public and private information and consultation
- Help identify and address students' mental health issues while working within the:
  - ASCA Ethical Standards for School Counselors
  - ASCA Professional Standards & Competencies for School Counselors
  - National, state and local legislation, which guides school counselors' informed decision-making and standardizes professional practice to protect both the student and school counselor
- Seek to continually update their professional knowledge regarding the students' social/emotional needs, including best practices in universal screening for mental health risk
- Advocate for ethical use of valid and reliable universal screening instruments with concerns for cultural sensitivity and bias if state legislation or school board policy requires universal screening programs for mental health risk factors (ASCA, 2022)

Summary

Students' unmet mental health needs pose barriers to learning and development. Because of school counselors' training and position, they are uniquely qualified to provide instruction, appraisal and advisement and short-term counseling to students and referral services to students and their families. Although school counselors do not provide long-term mental health therapy in schools, they provide a school counseling program

designed to meet the developmental needs of all students. As a component of this program, school counselors collaborate with other educators and community service providers to meet the needs of the whole child.

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