How the U.S. Can Solve a Shortage of Mental-Health Professionals

Some 130 million Americans live in areas that don't have enough mental-health workers. We asked three experts for solutions.

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Many sufferers of mental-health issues can't find the help they need. Often there just aren't enough providers.

More than a third of the U.S. population, about 130 million people, live in areas that have a dearth of mental-health workers. Residents of underserved areas have roughly a quarter of the providers they need, in aggregate, the Kaiser Family Foundation says. The shortage is even more acute in rural areas. About 80% of rural counties lack access to a single psychiatrist, according to a report by the U.S. Senate Committee on Finance, citing data from the Health Resources and Services Administration.

The pandemic brought the shortage of mental-health services into sharp focus as more adults sought help to deal with the stress and disruption of their daily lives. Children suffered immensely, too, as prolonged school closures weren't only psychologically damaging, but also caused many children's mental-health conditions to go unnoticed because teachers and school psychologists are a primary source of referrals.

How can more people be encouraged to pursue careers in mental health? And how can the existing system be improved to help more people?

To help answer those questions, The Wall Street Journal asked three experts to join in an online video roundtable discussion: Kyle Grazier, a Richard Carl Jelinek professor of health services management and policy and professor of psychiatry at the University of Michigan, Ann Arbor; Charles Ingoglia, president and chief executive, National Council for Mental Wellbeing; and Keris Jän Myrick, vice president for partnerships with the mental-health advocacy organization Inseparable, a board member for the National Association of Peer Supporters and host of the podcast Unapologetically Black Unicorns.
Here is an edited transcript of their discussion.

WSJ: Are there ways to quickly boost the mental-health system's capacity?

MR. INGOGLIA: I represent about 3,200 clinics around the country, and as I talk to CEOs about why their staff members are leaving, one reason is they can earn more elsewhere. But paperwork is also right up at the top of the list—the amount of assessments, outcome measures and progress notes required. So anything we can do to reduce administrative burden and increase pay would be helpful.

DR. GRAZIER: There is evidence that if providing mental-health support to other people is viewed as a valuable and viable career path, more people are attracted to it. There are now several pilots in high schools and community colleges providing certification and licensing for students who want to pursue a career in the field. But state licensing laws make it really difficult for individuals, even with a bachelor's degree in social work, to practice to the full extent of their ability.

MS. MYRICK: People with serious mental conditions, like depression, anxiety, schizophrenia or bipolar disorder, can learn life skills that help them hold steady jobs, find secure housing and participate in community activities, like going to their local church or taking yoga classes at a YMCA. But too often, professionals who assisst these patients in the public system—practitioners paid by Medicaid, Medicare or the Department of Veterans Affairs—don't focus enough on recovery. That is not only harmful to patients, who become increasingly isolated, but it also leads to shortages of service within the public health system. More people are now entering the public system than leaving it to live more independent lives. It's like a balloon that just keeps getting bigger.

WSJ: Can drawing on people with different types of credentials and backgrounds help solve the shortage?

MS. MYRICK: The peer workforce—people who experienced mental-health or substance-use conditions and then are trained to support others—is one group. Peers have been through the process themselves, so they can help provide support. Peers help people cope and navigate the health system; they teach digital literacy and help find housing or employment. Having positive interactions with people who have experienced mental-health or substance-use conditions also helps reduce the stigma that is often associated with people who experience these ailments.

There are 49 states with peer certification through Medicaid, but peers are not widely used in the private sector. That is starting to change. Outcomes for peer initiatives include increased engagement with treatment and reduction in high-cost services, such as emergency-room treatment and hospitalizations.

DR. GRAZIER: There are effective programs in a growing number of high schools where mental-health clinicians train teachers and other staff members to screen and quickly assess students' mental-health needs and then, if needed, connect them via telehealth with primary-care and mental-health providers for additional care. This training model expands the capacity of existing mental-health workers to reach vulnerable adolescents.

MS. MYRICK: Another group that is helping; barbers in Black communities. The Confess Project trains Black barbers to provide emotional support to people in their communities who are experiencing mental distress. So, if people are feeling down or anxious and just need to talk, they can easily find a listening ear without waiting in a long line as they might in a health clinic. The barbers are taught to identify signs of mental-health conditions or harmful substance use and help refer people to mental-health professionals. That might prevent someone from ending up in the emergency room.

WSJ: Could changing how providers are reimbursed help ease the worker shortage?

MR. INGOGLIA: People on Medicare, older Americans, have a hard time accessing mental-health or substance-abuse treatment, because counselors, marriage and family therapists, substance-use professionals and peers are all excluded from Medicare. Covering such services through Medicare would make 225,000 additional providers available to Medicare recipients. It would also help in rural areas where these types of providers are a decent portion of the mental health workforce.

Allowances for cross-state licenses worked during the pandemic. Why can't we have more of that? Right now if I am providing telehealth in 10 states, I have to be licensed in all of those 10 states. If I am going to be prescribing psychiatric medications, I need to have a separate DEA number in every one of those states. That can take three to six months once you get licensed. State licensing boards also have different requirements for the amount of independent practice and supervision that is required for licensure. Can we standardize that and perhaps shorten it?

DR. GRAZIER: During the pandemic, New Jersey met an enormous portion of its mental-health needs just by allowing licensed providers from other states, who are just as capable of providing high-quality care, to help New Jersey residents.

MS. MYRICK: Each state also has its own, nontransferable certification for the peer workforce. The other issue is a lack of clarity from the Centers for Medicare and Medicaid Services. CMS says peers need a high-school diploma or equivalency. Equivalency has been interpreted very literally as a GED, but some states realize they can create their own definition. That opens the workforce up to peers, who may not have a high-school diploma or a GED because that is exactly the time when the mental health conditions hit. This could also help more marginalized groups.

WSJ: Are there other ways to attract people into the profession?

MR. INGOGLIA: We need to have a rational reimbursement system. A report several years ago showed that a primary-care physician delivering the same intervention as a psychiatrist gets paid more. We see that kind of differential across our system.

MS. MYRICK: When I worked in the public-health system, some community-health workers, including promotoras [specially trained but not professional healthcare workers] in the Latinx community, and peers, weren't earning enough money to afford housing, yet they were working for local government.

DR. GRAZIER: It is tough to get people to stay in jobs that are very difficult with low pay when they can't advance their own well-being. In mental health there are not the same kinds of established educational pathways that lead to higher job titles, more responsibility and greater pay. In nursing, high-school students can be certified assistants and college programs provide certifications. Once someone works in a health system, there are scholarships and financial aid to get more training and additional degrees certification that broaden the scope of how and where you can practice. A system where there are different access points and ways to advance is enormously helpful to attract people to the field and give them options when they are feeling burned out.

MR. INGOGLIA: We also need to figure out ways to make entry into the field easier, like providing more scholarships. Often, schools offering degrees in mental health require unpaid internships in the field as a graduation requirement. Turning these into paid internships could make these degrees more attractive. As a graduate student in social work, I worked 20 hours a week and did 20 hours a week as an unpaid intern on top of my classes. For lower-income students who need more paid working hours, my path is likely untenable.

MS. MYRICK: I like minority fellowship programs. Many times peers are coming from the public mental-health system and are carrying a lot of debt—unpaid medical bills, student loans and credit-card debt. It's hard to take time off for a continuing-education training course unless a county or state is picking up the cost of education.