State of Oregon

Behavioral Health Talent Council Final Report

February 2026

State of Oregon

Behavioral Health Talent Council
Final Report

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Letter From Chair and Vice Chairs

Governor Kotek and behavioral health partners, it has been an honor to serve as Chair and Vice-Chairs of the Behavioral Health Talent Council. Oregon's behavioral health workforce crisis is one of the most pressing challenges facing our state, and we are grateful for your leadership in taking bold action to address it.

Over the past 8 months, the Council has worked tirelessly to develop a comprehensive action plan to strengthen and expand Oregon's behavioral health workforce. This report represents the collective expertise of twenty-two Council members, input from countless frontline providers across the state, and is grounded in research from the Higher Education Coordinating Commission's Behavioral Health Talent Assessment. We have drafted seventeen action plans that address each stage of the workforce pipeline - from education and training, to licensing and credentialing, and recruitment and retention.

Thank you for commissioning the talent assessment, consolidating years of fragmented research and filling critical gaps, then establishing this Council and empowering us to be honest about barriers and bold in identifying solutions. Thank you to staff from the Higher Education Coordinating Commission, Oregon Health Authority, and the Governor's Office who provided tireless support. To our Council members, subcommittee leads, and subject matter experts - thank you for bringing your knowledge and lived experience. And to the frontline behavioral health workers, students, educators, and partners who shared their voices - thank you for trusting us with your stories. Your insights shaped every action plan in this report.

We recognize that many of our recommendations intersect with broader policy questions about healthcare financing, regulatory frameworks, and resource allocation during a challenging budget environment for the State of Oregon. Some can be implemented immediately through administrative action; others will require legislative changes or new investments. The work of balancing competing priorities and determining the pathway forward rests with you and the Legislature. This report represents a new phase of sustained effort, not the end of the crisis. We are committed to partnering with you in the work of implementation that is yet to come.

We must take care of the people who take care of us. The professionals who show up every day to help Oregonians in crisis deserve workplaces that support them and systems that allow them to provide quality care. Every day that passes, Oregonians go without timely care and more skilled professionals leave the field - but every action you take will bring us closer to a system in which Oregonians can access care when they need it, and professionals have the support they deserve.

With gratitude and commitment,

Aimee Kotek Wilson, MSW
Chair, Behavioral Health Talent Council

Eli Kinsley, MSW, LCSW Vice-Chair, Licensing and Credentialing

Julie Ibrahim, LPC Vice-Chair, Recruitment and Retention

Robin Sansing, MSW, LCSW Vice-Chair, Education and Training

Executive Summary

Before the Governor took office, many entities had conducted research on the behavioral health workforce crisis; although important, the work was fragmented across disciplines and lacked a comprehensive, unified analysis. By commissioning the Higher Education Coordinating Commission to conduct the Behavioral Health Talent Assessment (the assessment), Governor Kotek took initiative and centralized all of the valuable research, data, and stakeholder input into one comprehensive resource. The assessment pulled together existing research, performed new analysis, and found that the crisis is being driven by the following factors:

- A shortage of workers to do the work, especially in rural areas;
- Challenges recruiting and retaining workers to organizations that serve Oregon Health Plan members;
- High turnover driven by unsustainable working conditions: heavy administrative burdens, safety concerns, overwhelming caseloads and trauma exposure without adequate support, compensation that doesn't reflect the complexity of the work, and limited opportunities for professional development and advancement.

The assessment included over sixty recommendations to address the crisis and laid the groundwork for the council to develop actionable strategies grounded in comprehensive research.

With a clear and comprehensive understanding of the problem and what was needed to fix it, the Governor established the Behavioral Health Talent Council (the Council), chaired by First Lady Aimee Kotek Wilson to develop an action plan by January 31, 2026, to address Oregon's workforce crisis. The Council included twenty-two members with expertise critical to developing effective action plans:

- Direct service providers,
- Administrators serving low-income clients,
- Licensing authorities,
- Workforce development professionals, and
- Educational program leaders

> "The composition of the BHTC was crucial to its success: We represented the full spectrum of people connected to this workforce, from peer support specialists to front-line professionals to educators and administrators at all levels. Hearing directly from people closest to many of the issues revealed specific ways that our systems are failing our people and communities but also pointed us toward concrete strategies and solutions."
>
> **Alice Gates**, MSW, PhD
> Associate Professor at the OHSU-PSU School of Public Health
> and Director of the Rural Public Health Practice Initiative

The Council established three subcommittees with membership across sectors - placing some members outside their primary areas of experience to break down silos and foster innovative solutions. Each subcommittee was assigned recommendations from the talent assessment and charged with developing detailed action plans to advance those recommendations, including strategies, milestones, timelines, and potential legislative changes and investments needed to implement the recommendations:

1. **Recruitment and retention**, chaired by Julie Ibrahim, developed five action plans with twenty-five unique strategies to support workers so they stay in the field, especially those serving the highest acuity and lowest income clients. The action plans aim to reduce administrative burden and other barriers to care delivery, increase access to clinical supervision, improve workplace safety, provide culturally specific supports and professional development opportunities, and chart a pathway toward better compensation models for the future of the profession.
2. **Licensing and credentialing**, chaired by Eli Kinsley, developed four action plans with fourteen unique strategies to ensure qualified individuals ready to serve Oregonians can receive their licenses and credentials without unnecessary delay. These action plans remove barriers in licensing and credentialing processes while maintaining the high standards of the state's licensing and credentialing bodies.
3. **Education and training**, chaired by Robin Sansing, developed eight action plans with thirty-five unique strategies to grow the workforce with a focus on profession types where the state has current or projected shortages. The action plans ensure Oregon has the right educational and training pathways, that those pathways are accessible and effectively prepare people for the work, and that they connect people to job opportunities that fit their skills and interests.

The individual action plans developed by the subcommittees were considered by the full council, where the full council membership provided additional insight and feedback. Together, the action plans advanced by the council work to:

1. Prevent the loss of behavioral health workers at high risk of turnover as outlined in the behavioral health talent assessment;
2. Improve recruitment and retention outcomes for providers who serve Oregon Health Plan members;
3. Address the shortage of behavioral health workers as outlined in the behavioral health talent assessment; and
4. Increase the cultural competency, preparedness, and diversity of the workforce.

To further inform the council's work, the First Lady and Governor's Office completed and reported back to the full council on: eighteen site visits across the State; ten meetings with culturally specific providers; seven round tables with frontline workers, students, and partners; meetings with behavioral health students; a tribal coordination meeting with the sovereign tribes in Oregon; and ongoing coordination with legislative workgroups focused on behavioral health. Individuals on the frontline of this crisis were essential to informing the workforce recommendations that will actually work for providers and the Oregonians they serve. Student voices were integral to ensuring that these recommendations fit the workforce of tomorrow. These efforts yielded considerable alignment with the feedback shared and the action plans developed by the council. Where feedback was received about an action plan that had been advanced by the full council and was not already included, it is noted in the report for the Governor's future consideration.

Upon submission of this report for consideration, the Governor will evaluate the council's recommended action plans, including any additional recommendations from culturally specific organization outreach, tribal coordination, workforce outreach, and legislative work groups.

Behavioral Health Talent Council Members

Name	Role	Affiliation
Aimee Kotek Wilson, MSW	Council Chair	First Lady of Oregon
Eli Kinsley, LCSW, CADC III, CGAC II	Council Vice-chair	Director of Operations, Bridgeway
Julie Ibrahim, LPC	Council Vice-chair	CEO, New Narrative
Robin Sansing, MSW, LCSW	Council Vice-chair	BHI Director, Southern Oregon University
Alice Gates, PhD, MSW	Council Member	Associate Professor, Oregon Health and Sciences University-Portland State University
Bethany M. Wallace, MSW, LCSW	Council Member	Assistant Professor of Practice Portland State University
Clarissa Carson, PMHNP-BC, MSN, APRN	Council Member	Rogue Community Health
Ebony Clarke, LCSW, MSW	Council Member	Behavioral Health Division Director, Oregon Health Authority
Jamie Vandergon, LPC	Council Member	CEO, Trillium Family Services
Janie Gullickson, MPA, CRM II, PSS	Council Member	Executive Director, The Peer Company
Julia Mines, QMHP, CRM	Council Member	Executive Director, Miracles Club
Julia Pontoni, MPA	Council Member	Workforce Investments Director, Higher Education Coordinating Commission
Liz O'Connor, QMHA	Council Member	Triager, Cascadia Project Respond
Mary Peterson, PhD	Council Member	Provost, George Fox
Monica Vines, MA, LPC	Council Member	Program Director, Central Oregon Community College
Rachel Prusak, MSN, APRN, FNP	Council Member	Executive Director, Oregon State Board of Nursing
Rick Treleaven, LCSW	Council Member	CEO, BestCare Treatment Services, Inc.
Shyra Merila Simmons, LPC	Council Member	Executive Director, Clatsop Behavioral Healthcare
Sommer Wolcott, LPC, CRC	Council Member	Executive Director, OnTrack Rogue Valley
Tammi S. Paul, MA	Council Member	Executive Director, Oregon Family Support Network
Todd Younkin	Council Member	Executive Director, Mental Health Regulatory Agency
Van Burnham, CRM	Council Member	Executive Director, Mental Health and Addiction Certification Board of Oregon

Behavioral Health Talent Council Staff

Name	Affiliation
Jennifer Purcell	Higher Education Coordinating Commission
Shalee Hodgson	Higher Education Coordinating Commission
Bret Golden	Oregon Health Authority
Cissie Bollinger	Oregon Health Authority
Kristen Donheffner	Oregon Health Authority
Kristy Alberty	Oregon Health Authority
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Sabrina Raqueño-Angel	Oregon Health Authority
Tim Nesbitt	Oregon Health Authority
Yudi Liu	Oregon Health Authority
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April Rohman	Office of Governor Tina Kotek
Chad Albright	Office of Governor Tina Kotek
Hanna Seay	Office of Governor Tina Kotek
KC LeDell	Office of Governor Tina Kotek
Sarah Means	Office of Governor Tina Kotek
Taylor Smiley Wolfe	Office of Governor Tina Kotek

Understanding the Crisis

Too many Oregonians cannot get the care they need - not because services don't exist, but because Oregon doesn't have enough professionals to provide them.

Workers are leaving the field, citing unsustainable working conditions: heavy administrative burdens, safety concerns, overwhelming caseloads and trauma exposure without adequate support, compensation that doesn't reflect the complexity of the work, and limited opportunities for professional development and advancement. When professionals are overwhelmed, everyone suffers - clients don't get the attention they need, and skilled workers leave the field entirely. This crisis hits hardest in our rural and BIPOC communities, and among organizations serving low-income and high acuity clients, where recruitment and retention challenges are most severe.

This is Oregon's behavioral health workforce crisis, and it demands comprehensive, urgent and sustained action.

Growing Demand, Insufficient Supply: Oregon has struggled for years to train and credential enough behavioral health professionals. The COVID-19 pandemic accelerated this crisis dramatically - waitlists ballooned from two weeks pre-pandemic to two months for youth and up to six months for adults in 2021, (CareOregon, 2021). While recent efforts have reduced wait times, many Oregonians still wait weeks for care, particularly new patients seeking services.

High Risk of Turnover: The Talent Assessment surveyed 14 behavioral health profession types and found that 9 have alarmingly high turnover risk - more than two-thirds of workers intend to quit. The professions at greatest risk include addiction counselors (92%), psychiatrists (76%), psychiatric nurse practitioners (73%), and certified alcohol and drug counselors (71%) (Adv25). When experienced workers leave, the burden on remaining staff intensifies, creating a cycle of burnout and attrition.

Barriers to Entry and Advancement: The path into the field is unclear and unnecessarily complicated. Fragmented educational pathways, complex licensing, limited supervision access, duplicative credentialing, and inadequate financial support prevent qualified people from entering the profession. These barriers disproportionately affect BIPOC and multilingual providers, limiting workforce diversity.

Structural Inequities: Rural and culturally specific organizations struggle disproportionately to recruit and retain professionals. Organizations serving Oregon Health Plan members and high-acuity populations face acute staffing challenges, creating a two-tiered system where those who need care most wait longest.

Landscape

Summary of Reports Informing the Oregon Behavioral Health Talent Assessment

The Governor directed the Higher Education Coordinating Commission (HECC) to conduct the Behavioral Health Talent Assessment to ensure the State had a single, comprehensive assessment of the workforce crisis, consolidating years of fragmented and siloed research. The assessment houses a comprehensive review of nine key reports provided by the HECC and other sources, establishing a consistent and data informed baseline for understanding workforce gaps, systemic barriers, and educational challenges. These reports collectively highlight the post-COVID surge in behavioral health (BH) service demand, persistent workforce shortages, and structural inequities across Oregon's health care system.

Reports Incorporated

1. Effects of the Pandemic on Oregon's Healthcare Workforce, EcoNW, November 2020: Captures pandemic-driven staffing shortages and burnout trends across health care sectors. (ECONorthwest, 2020)
2. Investing in Culturally and Linguistically Responsive BH Care, Research Justice Institute at the Coalition of Communities of Color, January 2022: Recommends strategies for improving access and equity in BH services. (Color, 2021)
3. Evaluation of Health Care Provider Incentive Programs, Oregon Health Authority, January 2023: Reviews effectiveness of scholarships, loan repayment, and other incentives. (Authority O. H., Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon, 2023)
4. Postsecondary Healthcare Education Shortage in Oregon, Oregon Longitudinal Data Collaborative, April 2023: Examines capacity constraints in nursing and BH programs; Oregon ranks last nationally in nursing graduates per capita. (Jesse Heligso, 2023)
5. Health Care Trends in Oregon, FutureReady Oregon, September 2023: Provides labor market data on vacancies, wage trends, and employment patterns. (Department, 2023)
6. Substance Use Disorder Financial Analysis, Public Consulting Group, April 2024: Assesses adequacy of BH financing structures and cost barriers. (Group, 2024)
7. Oregon 2024 Talent Assessment, SRI International, May 2024: Offers statewide insights into workforce and education system coordination, including BH. (International, 2024)
8. Oregon's Licensed Health Care Workforce Supply, Oregon Health Authority, November 2024: Details provider distribution, highlighting rural shortages and urban concentration. (Authority H. C., 2024)
9. The Diversity of Oregon's Licensed Health Care Workforce, Oregon Health Authority, January 2025: Analyzes racial, ethnic, and linguistic representation; identifies underrepresentation of BIPOC professionals. (Authority H. C., 2025)

This landscape review informed the Talent Assessment's methodology, shaping survey design, predictive analytics, and recommendations by identifying alignment between existing research and new findings, gaps in workforce data and educational pathways, and strategic priorities for recruitment, retention, and equity-focused interventions.

Summary of Legislative Work Groups

In addition to studies on the crisis, the Legislature established multiple work groups to address specific, high-priority workforce challenges: reducing administrative burden, stabilizing behavioral health providers serving Oregon Health Plan members, and addressing workforce needs for youth providers and substance use disorder (SUD) providers. These legislative priorities were reinforced in the Behavioral Health Talent Assessment, which identified these priorities as data-informed gaps. The work of these workgroups informed the comprehensive workforce action plan outlined in this report. The Talent Council was charged with tying together this critical work by addressing all elements contributing to the workforce crisis: recruitment and retention, licensing and credentialing, and education and training pathways. The Governor commissioned the Talent Assessment to create a data-informed baseline for all behavioral health workforce efforts, laying the foundation for meaningful, comprehensive action plans and decisive action.

To ensure that the council's final report was comprehensive and aligned with the efforts of multiple legislative work groups, the council worked to coordinate efforts by reviewing and incorporating existing recommendations into subcommittee work, meeting with the work groups, and reviewing their final reports which were due one month prior to the Talent Council's final report. This process clearly identified where recommendations aligned with the Council's work and which additional recommendations the Governor should consider alongside the Council's action plans.

Legislative Work Groups Overview

House Bill 2235 (2023): required the Oregon Health Authority (OHA) to convene a workgroup to study major barriers to workforce recruitment and retention in Oregon's publicly financed behavioral health system and produce a report of their recommendations for improvement.

- Membership: Peer mentors, clinical social workers, certified alcohol and drug counselors (CADC), qualified mental health associates (QMHA), qualified mental health professionals (QMHP), community mental health providers (CMHPs), coordinated care organizations (CCOs), associations representing behavioral health service consumers, associations representing behavioral health providers, community-based organizations (CBOs).
- Final Report - Recommendations for Stabilizing Oregon's Public Behavioral Health System: HB 2235 Workgroup Final Report. (Authority O. H., Stabilizing Oregon's Public Behavioral Health System HB 2235 Workgroup Final Report, 2025)

House Bill 4092 (2024): required OHA to contract with the Oregon Council for Behavioral Health (OCBH) to facilitate a workgroup to study the impact of state laws on providers' ability to do their jobs and report their findings and recommendations to reduce administrative burden.

- Membership: consumers, labor stakeholders, Coordinated Care Organizations (CCOs), Community Mental Health Programs (CMHPs), Culturally Specific organizations (CSOs), Advocacy organizations, county governments, Community Based Organizations (CBOs), hospitals, OHA, Tribes, Oregon Judicial Department, Mental Health Regulatory Agency (MHRA), Mental Health and Addiction Certification of Oregon (MHACBO).
- Final Report -Tackling Administrative Burden in Behavioral Health: HB 4092 Workgroup Report to Oregon Legislature. (Workgroup, 2025)

House Bill 4151 (2024): directs the System of Care Advisory Council (SOCAC) to establish a subcommittee on the youth behavioral health workforce and produce a report of their recommendations.

- Membership: Youth, Coordinated Care Organizations (CCOs), substance use disorder (SUD) treatment centers, behavioral health providers, community based organizations (CBOs), schools, high school and technical education programs, culturally specific organizations (CSOs), Mental Health Regulatory Agency (MHRA), Board of Licensed Social Workers (BLSW), Early Learning System Director, System of Care Advisory Council (SOCAC) council members
- Final Report - Youth Behavioral Health Workforce Subcommittee: Final Report to the System of Care Advisory Council. (Council, 2025)

Alcohol & Drug Policy Commission (ADPC): charged with improving access to evidence-based, evidence-informed and culturally-informed substance use prevention, treatment, and recovery support services by establishing state policies.

- Membership: Consumers, prevention specialists, Certified Alcohol and Drug Counselors (CADCs), substance use disorder (SUD) researchers, epidemiologists, Tribes, County commissioners, Tribes, SUD treatment providers and prevention specialists, health insurance providers, hospitals, addiction medicine providers, housing recovery providers, social service providers, district attorneys, police, defense attorneys, parole and probation departments.
- Final Report - ADPC Strategic Priorities 2026-2030. (Commission A. a., 2025)

For more information about the specific recommendations that emerged from these legislative efforts, their alignment with the council's action plans, and additional recommendation for the Governor's consideration, please see Appendix F.

The Behavioral Health Talent Assessment

A Comprehensive Analysis of Oregon's Behavioral Health Workforce Shortage

Approach

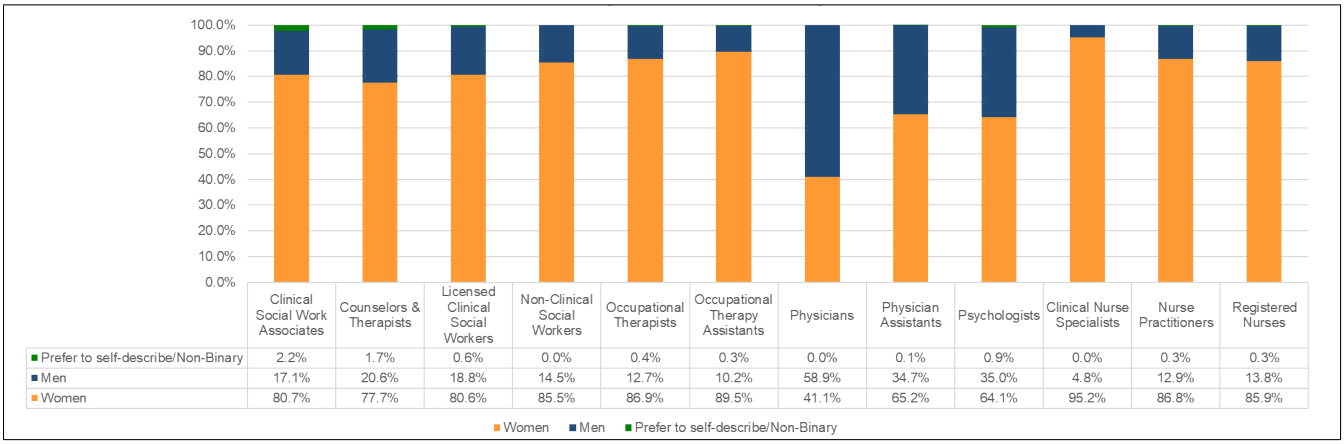
The Oregon Behavioral Health Talent Assessment commissioned by the Higher Education Coordination Commission at the request of the Governor is grounded in a comprehensive review of existing literature, includes new data analysis, and was informed by frontline workers and a multi-stakeholder steering committee including representatives from: healthcare, behavioral healthcare, workforce development nonprofits, colleges and universities, and public sector agencies focused on behavioral health, and workforce development.

Workforce and Demand Analysis

The talent assessment reviewed existing literature on gaps in access to behavioral health services based on population specific needs, demographic characteristics of the workforce compared to the general population, and geographic differences in access to care. These assessments identified the following gaps (Adv25):

- In alignment with national trends, Oregon is experiencing a shortage of child behavioral health specialists;
- There is critical need for more substance use disorder (SUD) providers, including certified prevention specialists and qualified mental health professionals.
- The workforce crisis is particularly acute in rural and frontier counties, where 32 of 36 counties lack even one licensed, in person mental health provider per 1,000 residents.
- The field is predominantly female, but women are underrepresented in higher paying roles.
- There is a significant underrepresentation of rural providers, Latinx, American Indian or Alaska Native, Black, and Pacific Islander providers.

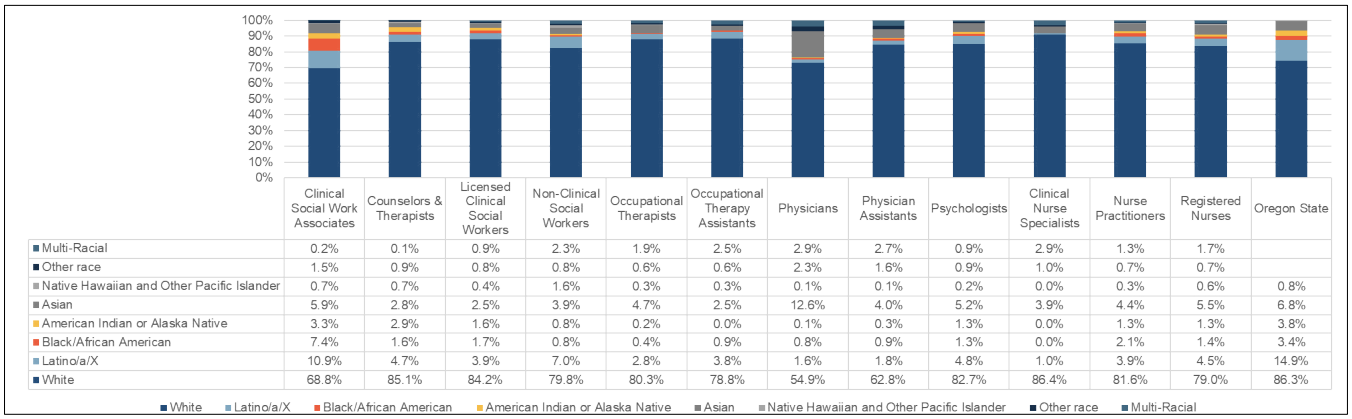
Graphic 1. Gender of Practicing Behavioral Health Workforce in Oregon, 2022



	Clinical Social Work Associates	Counselors & Therapists	Licensed Clinical Social Workers	Non-Clinical Social Workers	Occupational Therapists	Occupational Therapy Assistants	Physicians	Physician Assistants	Psychologists	Clinical Nurse Specialists	Nurse Practitioners	Registered Nurses
Prefer to self-describe/Non-Binary	2.2%	1.7%	0.6%	0.0%	0.4%	0.3%	0.0%	0.1%	0.9%	0.0%	0.3%	0.3%
Men	17.1%	20.6%	18.8%	14.5%	12.7%	10.2%	58.9%	34.7%	35.0%	4.8%	12.9%	13.8%
Women	80.7%	77.7%	80.6%	85.5%	86.9%	89.5%	41.1%	65.2%	64.1%	95.2%	86.8%	85.9%

(Adv25p. 15)

Graphic 2. Race and Ethnicity of Practicing Behavioral Health Workforce in Oregon, 2022



	Clinical Social Work Associates	Counselors & Therapists	Licensed Clinical Social Workers	Non-Clinical Social Workers	Occupational Therapists	Occupational Therapy Assistants	Physicians	Physician Assistants	Psychologists	Clinical Nurse Specialists	Nurse Practitioners	Registered Nurses	Oregon State
Multi-Racial	0.2%	0.1%	0.9%	2.3%	1.9%	2.5%	2.9%	2.7%	0.9%	2.9%	1.3%	1.7%	
Other race	1.5%	0.9%	0.8%	0.8%	0.6%	0.6%	2.3%	1.6%	0.9%	1.0%	0.7%	0.7%	
Native Hawaiian and Other Pacific Islander	0.7%	0.7%	0.4%	1.6%	0.3%	0.3%	0.1%	0.1%	0.2%	0.0%	0.3%	0.6%	0.8%
Asian	5.9%	2.8%	2.5%	3.9%	4.7%	2.5%	12.6%	4.0%	5.2%	3.9%	4.4%	5.5%	6.8%
American Indian or Alaska Native	3.3%	2.9%	1.6%	0.8%	0.2%	0.0%	0.1%	0.3%	1.3%	0.0%	1.3%	1.3%	3.8%
Black/African American	7.4%	1.6%	1.7%	0.8%	0.4%	0.9%	0.8%	0.9%	1.3%	0.0%	2.1%	1.4%	3.4%
Latino/a/X	10.9%	4.7%	3.9%	7.0%	2.8%	3.8%	1.6%	1.8%	4.8%	1.0%	3.9%	4.5%	14.9%
White	68.8%	85.1%	84.2%	79.8%	80.3%	78.8%	54.9%	62.8%	82.7%	86.4%	81.6%	79.0%	86.3%

(Adv25p. 13)

Cultural Competency

When people feel like their provider understands them, they are more likely to continue seeking care. To achieve the vision of ensuring that everyone who needs it has access to mental health and addiction care, it is critical to ensure that the workforce can provide culturally competent care. It is critical to support building and retaining a workforce that reflects the rich and deep cultures of Oregonians. Although everyone can and should be trained to provide culturally competent care, the workforce should also reflect the communities being served. The talent assessment identified an underrepresentation of both rural providers and Latinx, American Indian or Alaska Native, Black, and Pacific Islander providers.

Shortages of Critical Profession Types

The talent assessment assessed the supply and demand of twelve critical behavioral health profession types to project future shortages or surpluses of specific profession types. Without supply and demand data for community health workers, marriage and family therapists, mental health and substance abuse social workers, occupational therapy aides, psychiatric aides, or psychiatric technicians, the talent assessment was unable to project gaps in these position types in the talent assessment.

Table 1. Supply and Demand for Selected BH Occupations

Occupation	Estimated Supply 2024	Estimated Supply Growth	Projected Supply 2034	Estimated Demand 2024	Estimated Demand Growth	Projected Demand 2034	Projected Supply (minus) Demand 2034
Addiction Counselors	2220	-80	2140	2160	770	2930	-790
Adult Psychiatrists	520	-30	490	690	230	920	-430
Child & Adolescent Psychiatry	140	30	170	160	30	190	-20
Child, Family, and School Social Workers	1520	-260	1260	1820	580	2400	-1140
Health Care Social Workers	1040	1050	2090	1100	490	1590	500

Occupation	Estimated Supply 2024	Estimated Supply Growth	Projected Supply 2034	Estimated Demand 2024	Estimated Demand Growth	Projected Demand 2034	Projected Supply (minus) Demand 2034
Mental Health Counselors	1330	100	1430	1680	590	2270	-840
Occupational Therapists	1380	380	1760	1810	170	1980	-220
Occupational Therapy Assistants	310	100	410	580	60	640	-230
Psychiatric Nurse Practitioners	410	240	650	260	90	350	300
Psychiatric Physician Assistants	30	50	80	50	10	60	20
Psychologists	2100	780	2880	1470	420	1890	990
School Counselors	1970	1070	3040	1690	390	2080	960

(Adv25p. 24)

The talent assessment identified projected shortages of addiction counselors, adult psychiatrists, child and adolescent psychiatrists, child family and school social workers, occupational therapists, and occupational therapy assistants.

Recruitment and Retention Challenges

In addition to identifying specific profession type shortages, the talent assessment also detailed widely known challenges to recruitment and retention in the behavioral health sector. Recruitment and retention challenges, especially acute for community mental health providers serving Oregon Health Plan members, result in an understaffed workforce that directly results in decreased options and quality of care for Oregonians seeking behavioral health services.

Table 2. Challenges to Recruitment and Retention in the BH Sector

Recruitment	Retention
• Low wages • Limited career development opportunities • Lack of clear career pathways • Cultural and linguistic barriers • Disparities in cultural and linguistic representation in field • Geographic imbalances (urban vs. rural) • Poor infrastructure and traumatic work environments	• Low wages • Limited career development opportunities • Lack of clear career pathways • Cultural and linguistic barriers • Disparities in cultural and linguistic representation in field • Geographic imbalances (urban vs. rural) • Poor infrastructure and traumatic work environments
• Background check barriers	• Administrative burden • Staff reductions (post-COVID-19) • Increased competition

(Adv25p. 22)

Another way of understanding retention challenges is assessing the risk of turnover for the behavioral health workforce. The talent assessment identified significant risk of turnover for behavioral health professionals measured as intent to quit this month. Intent to quit is highest for addiction counselors (CADC-III), psychiatrists, psychiatric nurse practitioners, and certified alcohol and drug counselors.

Table 3. Survey-Based Percentages of Intent to Quit this Month (n=248)

BH Position Title	% Intending to Quit Job This Month
Addiction Counselor (CADC-III)	92%
Certified Alcohol and Drug Counselor	71%
Certified Prevention Specialist	68%
Community Health Worker	18%
Medical Doctor	86%
Mental Health Counselor	8%
Other	9%
Psychiatric Nurse Practitioner	73%
Psychiatrist	76%
Qualified Mental Health Associate	20%
Qualified Mental Health Professional	40%

(Adv25p. 25)

Elaborating on the retention challenges identified in Table 2, the talent assessment emphasized these factors contributing to intent to quit and subsequent workforce attrition:

- Limited Career Advancement: Lack of clear pathways for professional growth discourages long-term commitment to the field.
- Organizational Challenges: Fragmented systems, inconsistent supervision, and inadequate onboarding contribute to dissatisfaction.
- Compensation and Benefits: Behavioral health professionals often earn significantly less than peers in other healthcare fields, making retention difficult.
- Safety Concerns: Staff report feeling unsafe in certain work environments, particularly when serving high-acuity clients without adequate support.
- Caseload Pressures: Overwhelming workloads and administrative burdens lead to burnout and emotional fatigue.

Impact on Access and Outcomes

The shortage of behavioral health professionals has far-reaching consequences for individuals, families, and communities. Delays in care exacerbate mental health conditions, increase reliance on emergency departments, and contribute to higher rates of hospitalization and incarceration. For Oregon's most vulnerable populations – including those in rural areas, communities of color, individuals with complex needs, and those on the Oregon Health Plan – the lack of timely access to culturally competent care deepens health inequities. Specifically, the talent assessment found high turnover destabilizes care teams, leading to:

- Disrupted Continuity of Care: Frequent staff changes hinder therapeutic relationships and treatment progress.
- Increased Wait Times: Vacant positions delay access to services, particularly in rural and frontier counties already facing severe provider shortages.
- Higher Costs: Recruiting and training replacements is expensive and diverts resources from direct care.
- Burnout Among Remaining Staff: As vacancies persist, remaining employees shoulder heavier workloads, perpetuating the cycle of attrition.

Recommendations

The talent assessment includes over sixty recommendations to address the behavioral health workforce crisis, including recommendations to:

1. Retain the workforce of today by improving retention strategies, with a focus in areas with the greatest need like rural areas;
2. Reduce barriers for the individual who have completed education or training programs and are seeking a license or credential to enter the workforce;
3. Increase the overall number, quality, and cultural competency of behavioral professionals by increasing and improving educational and training pathways; and
4. Address disparities in access to care by improving both recruitment and retention for providers serving Oregon Health Plan members generally, and with a focus in rural areas.

The Solution

The Behavioral Health Talent Assessment identified what needs to change. This report outlines how to make these changes.

The action plans that follow transform the HECC's Behavioral Health Talent Assessment's research-backed recommendations into implementation strategies. Each plan includes the problem being addressed, specific implementation steps, responsible agencies, timelines, resource requirements, and expected outcomes - giving the Governor the tools to take decisive, calculated action on the workforce crisis. These solutions are grounded in evidence and shaped by frontline experience, so that these recommendations actually work for providers and the Oregonians they serve.

The Council's recommendations address the wide spectrum of workforce challenges through immediate actions, mid-term strategies, and long-term investments. Some can be implemented through administrative action; others require legislative changes or further exploration. Several recommendations identify complex policy challenges requiring additional research and stakeholder engagement beyond the Council's timeframe - these are not deprioritized items but clearly defined steps for continued work beyond January 2026, outlined in Appendix G.

This report represents a new phase of sustained effort, not the end of the crisis. The behavioral health workforce crisis developed over decades and will require long-term commitment to fully address. However, these action plans represent a comprehensive, coordinated effort to address the crisis - and it charts a clear path from where we are to where we need to be.

Action Plan Executive Summary

Recruitment and Retention

1. Improve client care and reduce turnover by eliminating unnecessary and duplicative administrative burden.
2. Improve recruitment and retention by improving safety for frontline workers, growing and retaining supervisors, embedding supportive services for the workforce and mentorship within behavioral health organizations.
3. Grow a more culturally responsive workforce and recruit and retain behavioral health talent by funding education, offering paid internships, incentives for supervision and peer support development.
4. Reduce pay disparities, recruit and retain specialized workforce, and maintain competitive salaries through biennial rate adjustments.
5. Improve recruitment and retention of behavioral health providers in rural and underserved communities.

> "The Behavioral Health Talent Council was unlike any committee I've served on. We brought together higher education, government, community organizations, and frontline workers to address the workforce crisis with a truly comprehensive, equity-focused approach—developing solutions from high school career awareness through advanced training and workforce retention. This Council focused upstream and created aspirational yet achievable strategies that span the entire behavioral health workforce continuum."
>
> **Janie Gullickson**, MPA: HA, CRM II, PSS
> Executive Director of The Peer Company

Licensing and Credentialing

1. Grow and support the behavioral health workforce by providing clear pathways to licensure, connecting the existing workforce to advancement opportunities, and improving customer service to navigate these processes.
2. Bolster the workforce by increasing access to primary entry points into the behavioral health field and reducing barriers for entry-level workers to access more career growth opportunities.
3. Grow a culturally competent workforce by supporting applicants in gaining the skills and knowledge they need to achieve their licensing requirements, and making the licensure process more equitable, efficient, and timely.
4. Increase accessibility to the behavioral health field for people with lived experience by simplifying and streamlining our peer credentialing systems, improving the background check system, and providing the resources to navigate it.

Education and Training

1. Grow the workforce and the cultural competency of the workforce by strengthening and aligning behavioral health education pathways.
2. Increase transparency about licensure requirements to more effectively prepare students to succeed during the licensure process.
3. Attract a robust talent pool to education and training programs by effectively communicating the value and pathway to a career in behavioral health.
4. Expand equitable access to behavioral health services across rural, frontier, and culturally distinct communities through targeted workforce initiatives and community-based service models.
5. Broaden and strengthen behavioral health partnerships among education, employers, and community organizations to expand coordinated, high-quality career experiences and training opportunities statewide.
6. Increase equitable entry and completion in community college behavioral health pathways, with special attention to BIPOC, rural, immigrant, and linguistically diverse students, by mapping barriers and launching new supports.
7. Expand clear, inclusive behavioral health pathways that help more Oregonians, including BIPOC, rural, and lived-experience learners, enter and complete degrees that lead to meaningful careers.
8. Expand equitable opportunities for Oregon students to explore, enter, and progress through behavioral health career pathways, starting early and spanning high school through advanced degrees.

Recruitment and Retention

The Problem: Behavioral health professionals serving low income clients and working in community behavioral settings do profoundly complex, emotionally demanding work - often with the highest acuity clients- while earning significantly less than colleagues working with other populations and in similarly educated health disciplines. Individuals served by community behavioral health can have significantly higher needs due to chronic homelessness and lack of access to long term treatment supports. Similar to the client population, many behavioral health workers struggle to afford to live in the communities they serve. They face high administrative burdens, productivity pressures that conflict with clinical judgment, and regular trauma exposure without sufficient support. New graduates carry debt loads they struggle to repay on behavioral health salaries. Mid-career clinicians leave due to burnout and lack of career advancement opportunities. Experienced providers retire early or shift to private practice, leaving community organizations to serve the highest-acuity clients with a lack of experienced providers. Oregon cannot recruit its way out of this crisis - retention is the most urgent and cost-effective strategy.

Oregon's Progress: The executive branch administered over $85 million in behavioral health workforce investments from the legislature between 2021 and 2025 (HB 2949, SB 5525, and HB 2024). The legislature provided parameters for how these funds were invested and directed a wide range of investment tools to stabilize the workforce. At the legislature's direction, these investments funded hiring and retention bonuses, scholarships, tuition assistance, clinical supervision, housing and childcare stipends, and apprenticeships. Information about how legislatively directed workforce investments from HB2949 (2021) were allocated can be found here. These investments were administered to address high priority workforce challenges experienced by community mental health providers. However, without a baseline assessment of recruitment and retention patterns in community mental health, it is not possible to assess whether these investments moved the needle overall. The state needs a better understanding of recruitment and retention challenges for providers serving Oregon Health Plan Members to more effectively track the impact of future workforce investments.

The Oregon Council for Behavioral Health, which represents 70 private and non-profit behavioral health providers of behavioral health providers, and which reports on their recruitment and retention challenges, is expected to release an updated report in February 2026, shortly after the Behavioral Health Talent Council submits this final report to the Governor. As a next step (see Next Steps section) the council recommends that the Governor's Office review and consider that report and create a baseline for retention in community mental health (similar to the HECC talent assessment) to better measure progress over time. Tracking turnover among public providers can help identify where support is needed. High turnover can create service gaps and fragmented care for those in the most need, driving up cost while driving down outcomes.

The Behavioral Health Talent Council's recommendations are focused on ensuring that future investments in workforce are effective, data driven, and tied to measurable outcomes that move the needle on the workforce crisis.

The Action Plans: The Recruitment and Retention subcommittee developed action plans to support, strengthen, and retain Oregon's existing behavioral health workforce, with a focus on those serving rural communities, the highest-acuity populations, and individuals on the Oregon Health Plan. These plans seek to expand access to clinical supervision and professional development opportunities, support worker safety and emotional wellbeing, address compensation issues, diversify the workforce through equity-focused strategies, reduce administrative burden, and prepare workplace culture for the next generation of behavioral health workers.

Administrative Burden (Action Plan RR.1)

Improve client care and reduce turnover by eliminating unnecessary and duplicative administrative burden.

Strategies:

RR 1.1 Create standardized charting and documentation templates. Implement AI technology for chart documentation which addresses privacy regulation (HIPAA and 42 CFR), and identify the most effective procurement pathways for deploying these health technologies.

Responsible Agency: *OHA*

RR 1.2 Streamline rules, reporting and compliance. Revise OHA rules and policies regarding documentation, reporting, and audit requirements for simplification and parity across disciplines. Streamline clinical documentation by revising the 309 Administrative rules to meet federal minimum necessary requirements.

Select a centralized credentialing platform that all CCOs are required to use for elimination of duplicative processes.

Utilize AI to identify all required reports for behavioral health providers and then eliminate low-value and duplicative reporting. Redefine audits to focus on client-centered outcomes. Contract with a third-party organization to provide technical assistance to organizations that need assistance as evidenced by deficient audits, safety concerns or other triggers. Modernize fidelity program requirements, customize for rural communities and eliminate fidelity specific audits.

Responsible Agency: *OHA*

RR 1.3 Define and protect dedicated admin time for workforce. Define and protect paid administrative time in OHA contracts and/or agency staffing models.

Responsible Agency: *OHA*

RR 1.4 Create a centralized grant administration system improvement for OHA. Implement a centralized cross agency unit within OHA for grant administration and ownership of all required reports. Centralized reporting ownership will eliminate duplication and ensure high value reporting. OHA will report on administrative burden to a governing body comprising of provider organizations, CCOs, CMHPs, and consumer advocates, with biennial reports submitted to the legislature and the Governor.

Responsible Agency: *OHA*

Complete action plan in Appendix H.

In addition to the strategies outlined in this action plan, the Behavioral Health Talent Council recommends:

- That the Governor's Office should explore opportunities to address challenges with electronic health records (EHR), including aligning medical and BH systems more effectively to improve care and reduce burden on workforce that has to search through records to understand their full medical and BH picture.

> "One of the most immediate challenges we face is duplicative credentialing. Community Mental Health Programs regularly hire qualified, licensed professionals who are ready to work but are delayed for weeks or months because they must be validated through OHA and then credentialed through multiple billing entities. During that time, we are paying staff who cannot yet see clients while waitlists continue to grow. This takes a particular toll on rural, smaller providers like my organization."
>
> **Rick Treleaven**, LCSW
> Chief Executive Officer of BestCare Treatment Services

Workforce Supports (Action Plan RR.2)

Improve recruitment and retention by ensuring safety, growing and retaining supervisors, and embedding supportive services and mentorship within behavioral health organizations.

Strategies:

RR 2.1 Invest in supervisors. Grow our clinical supervisors within Oregon's publicly funded behavioral health system through statewide training, legislative advocacy for employee based personal tax credits for clinical supervisors, and providing free continuing education units for supervisors in publicly funded community mental health settings.

Responsible Agency: *OHA*

RR 2.2 Workplace safety. Conduct organizational workforce safety evaluations to address areas of concern proactively; develop workforce safety best practice guidelines that align with organizational safety plans; and provide grant funding for safety technology like cameras and alert/panic button systems that lead to a response.

Responsible Agency: *OHA*, *OSHA*

RR 2.3 Cultural Representation in the Field. Establish mentorship pathways for culturally specific staff and supervisors through a statewide network of culturally specific providers

Responsible Agency: *OHA*

RR 2.4 Supporting workforce. To support organizational wellness, contract with statewide organizations like Riverside Trauma and the Oregon Wellness Program for postvention services following traumatic events. Promote legislation to make improper restraint and seclusion a licensing matter rather than a child abuse investigation and provide guidelines on recommended caseload sizes for key roles.

Responsible Agency: *OHA*

Complete action plan in Appendix H.

In addition to the strategies outlined in this action plan, the Behavioral Health Talent Council recommends:

- That the Governor's Office reach out to the family of Haley Rogers about naming or dedicating a future bill or program in her honor.
- That the Governor's Office work with the legislature to ensure that legislative concepts requiring behavioral health providers to adopt safety plans align with best practices adopted by the Oregon Health Authority, in congruence with this action plan.

> "I attended the roundtable with the First Lady and AFSCME union members who shared with us their experiences regarding safety in the workplace. I was so impressed by the courage of these front-line workers and the heart they have for their patients, in spite of the unsafe conditions they often encounter, particularly in field work. This meeting was pivotal for me in committing to improving safety for our behavioral health workforce."
>
> **Julie Ibrahim**, LPC
> Vice Chair of the Recruitment and Retention Subcommittee and CEO of New Narrative

Culturally Responsive Workforce Incentives and Cost of Education (Action Plan RR.3)

Grow a more culturally responsive workforce and recruit and retain behavioral health talent by funding education and offering paid internships, incentives for supervision, and peer support development.

Strategies:

RR 3.1 Grow-your-own regional career roadmaps. Collaborate with local agencies, licensing and credentialing boards, and tribes to develop region-specific behavioral health career roadmaps aligned with community cultural values and local service needs.

Responsible Agency: *OHA*

RR 3.2 Incentivize specialized workforce roles. Prioritize workforce grants to create financial incentives for roles in crisis response, rural areas, and culturally/linguistically specific services in publicly funded behavioral health settings with service commitments.

Responsible Agency: *OHA*

RR 3.3 Preceptor incentives for PMHNPs operating in rural/culturally specific orgs. Fund incentives for preceptors to accept and supervise students and fund preceptors' organizations to backfill PMHNP's time in smaller organizations that cannot take a PMHNP offline.

Responsible Agency: *OHA*

RR 3.4 Expand access to supervision and licensure support. Fund supervision stipends, develop group supervision models, and subsidize clinical supervision through grant opportunities.

Responsible Agency: *OHA*

RR 3.5 Incentivize career advancement through funding for education. Fund behavioral health scholarships, loan forgiveness, and grants for certifications tied to a service commitment in the publicly financed behavioral health sector.

Responsible Agency: *OHA*

RR 3.6 Incentivize Continuing Education (CE). Fund Continuing Education (CE) grants for licensed staff who need financial assistance to pursue continuing education.

Responsible Agency: *OHA*, *HECC*

RR 3.7 Paid student internships. Fund paid internships for students in behavioral health workforce education programs.

Responsible Agency: *OHA*

RR 3.8 Operationalize Peer Support Programs. Establish a statewide program to provide free technical assistance to organizations on operationalizing peer support.

Responsible Agency: *OHA*

RR 3.9 Culturally Specific Leadership Development. OHA will contract with culturally specific organizations for the purpose of providing mentorship and leadership wellness support to culturally specific organizations, particularly those that are experiencing stress due to federal policy decisions. Supporting culturally specific leaders to better support front line staff and strengthen organizational structures.

Responsible Agency: *OHA*

Complete action plan in Appendix H.

In addition to the strategies outlined in this action plan, the Behavioral Health Talent Council recommends:

- That the Governor's Office should explore aligning requirements for in-person versus virtual clinical supervision, with a focus on flexibility for culturally specific providers.

> "There was a moment in our Recruitment and Retention subcommittee that fundamentally shifted my thinking. A colleague shared that she was chastised by her supervisor for using a culturally appropriate intervention aligned with her community's values. When supervisors don't share or understand the cultural framework of the clinician or community, we perpetuate harm, undermine trust, and lose incredible talent. This highlighted for me the urgent need for culturally appropriate supervision in behavioral health. We cannot address retention without elevating diverse leadership at every level."
>
> **Clarissa Carson**, PMHNP-BC, MSN, APRN
> Psychiatric Mental Health Nurse Practitioner at Rogue Community Health

Compensation (Action Plan RR.4)

Reduce pay disparities, recruit and retain specialized workforce, and maintain competitive salaries through biennial rate adjustments.

Strategies:

RR 4.1 Define and implement updated rate methodology for high-acuity, community based providers. Develop criteria and methodology for identifying high-acuity service providers and apply enhanced reimbursement rates.

Responsible Agency: *OHA*, *Medicaid*

RR 4.2 Incentivize specialized workforce roles. Modernize and update Medicaid behavioral health payment processes to incentivize providers offering crisis services or culturally specific services, and in rural areas

Responsible Agency: *OHA*, *HECC*, *CCO*

RR 4.3 Develop progressive reimbursement model. Develop a legislative concept for biennial rate adjustments tied to inflation or cost indices.

Responsible Agency: *OHA*, *Medicaid*

RR 4.4 Supporting existing infrastructure. Develop a funding framework that does not promote significant investment in new services without providing rate adjustments based on inflation or cost indices for existing behavioral health infrastructure

Responsible Agency: *OHA*, *Medicaid*

RR 4.5 Establish crisis stabilization billing codes. Implement new billing codes for short-term crisis stabilization services (4–24 hours) for Medicaid and commercial payors

Responsible Agency: *OHA*, *Medicaid*, *DCBS*

Complete action plan in Appendix H.

Recruitment and Retention Incentives Underserved Communities (Action Plan RR.5)

Improve recruitment and retention of behavioral health providers in rural and underserved communities.

Strategies:

RR 5.1 Support childcare access. Create a statewide childcare subsidy or tax credit for behavioral health providers with dependents in rural areas.

Responsible Agency: *OHA*

RR 5.2 Fund relocation and housing stipends. Develop a grant or stipend program for relocation and housing support for new hires in rural and remote areas.

Responsible Agency: *OHA*

RR 5.3 Align incentives with workforce. Use existing workforce shortage and unmet need data to prioritize funding investments.

Responsible Agency: *OHA*

Complete action plan in Appendix H.

In addition to the strategies outlined in this action plan, the Behavioral Health Talent Council recommends:

- That the Governor's Office comprehensively explore opportunities to improve access and affordability to child-care to determine the most effective and equitable funding mechanism, including but not limited to a tax credit funding structure.
- That the Governor's Office explore legislation or administrative action to align definitions of "behavioral health workforce" to ensure psychologists, psychiatrists, PMNHPs, and other profession types are consistently and accurately referenced as part of the behavioral health workforce and associated incentive programs.

Licensing and Credentialing

The Problem: The majority of the behavioral health workforce must be licensed or credentialed—sometimes multiple times—for their positions. Unnecessary barriers in licensing and credentialing prevent qualified individuals from achieving or maintaining credentials and perpetuate workforce disparities.

Oregon's Progress: When Governor Kotek took office, she directed licensing and credentialing agencies to improve customer service and reduce barriers. Agencies have made measurable progress. The Board of Licensed Professional Counselors and Therapists and the Board of Psychology now consistently process applications within 1-2 days - well under their targets - despite steadily rising application volumes over the past three years. Both boards have also seen significant increases in customer satisfaction survey results. During the same period, the Board of Licensed Social Workers eliminated its application backlog and implemented policies to reduce wait times for licensees with application questions.

The Action Plans: The Licensing and Credentialing subcommittee developed action plans to streamline the processes by which behavioral health professionals attain and maintain credentials, making these processes more accessible, equitable, and efficient while maintaining quality standards. These plans seek to remove unnecessary barriers, increase transparency around requirements, reduce disparities especially for BIPOC and multilingual providers, and ensure credentialing processes support rather than hinder workforce growth.

Communicating Pathways and Requirements (Action Plan LC.1)

Grow and support the behavioral health workforce by providing clear pathways to licensure, connecting the existing workforce to advancement opportunities, and improving customer service to navigate these processes.

Strategies:

LC 1.1 Behavioral Health Career Crosswalk. Create a Behavioral Health Career Crosswalk that contains accurate, accessible, and up-to date information about behavioral health career pathways and requirements.

Responsible Agency: *OHA*

LC 1.2 Behavioral Health Workforce Resource Hub. Create a centralized Behavioral Health Workforce Resource website to provide an easily accessible, one-stop source of information for behavioral health workers and behavioral health employers for information about entering, advancing in, and supporting the workforce. (See also: ET 1.3)

Responsible Agency: *OHA in partnership with HECC and Licensing Bodies*

LC 1.3 Real-Time Customer Service for Licensees. Establish real-time chat-based customer service for Oregon's behavioral health licensing boards to help workers remove obstacles to gaining and maintaining their licenses.

Responsible Agency: *Licensing Bodies*

Complete action plan in Appendix H.

Entry-Level Behavioral Health Positions (Action Plan LC.2)

Bolster the workforce by increasing access to primary entry points into the behavioral health field and reducing barriers for entry-level workers to access more opportunities.

Strategies:

LC 2.1 Entry-level Behavioral Health Credentialing. Create an entry-level behavioral health credential, reflecting that the recipient has received the trainings required by OHA rules to be able to practice within the position.

Responsible Agency: *OHA and MHACBO*

LC 2.2 Revise Billing Structures to Support Team-Based Care. Review and revise billing structures for behavioral health providers to determine if changes can be made to make it more feasible for providers to hire entry-level, non-licensed support staff.

Responsible Agency: *OHA*

Complete action plan in Appendix H.

Supporting Licensees and Reducing Barriers (Action Plan LC.3)

Grow a culturally competent workforce by supporting applicants in gaining the skills and knowledge they need to achieve their licensing requirements, and making the licensure process more equitable, efficient, and timely.

Strategies:

LC 3.1 Update the Licensing Database for Licensing Agencies. Invest in an updated licensing database for MHRA and BLSW, as the current database is outdated and significantly impeding the efficiency of both agencies.

Responsible Agency: *MHRA and BLSW*

LC 3.2 Bolster Staffing at Licensing Agencies. Increase staffing at MHRA and BLSW to allow for quicker processing of licenses and more robust customer service for people seeking to be licensed.

Responsible Agency: *MHRA and BLSW*

LC 3.3 Create Alternative Pathways to Licensure. Direct MHRA and BLSW to implement alternative pathways to licensure for people who have been unable to pass the exam but are able to demonstrate full proficiency through other methods.

Responsible Agency: *MHRA and BLSW*

LC 3.4 Support Licensees with Test Preparation. Continue existing investments in test preparation and explore additional avenues to help potential licensees prepare for testing.

Responsible Agency: *Licensing bodies*

LC 3.5 Increase Access to Meaningful Supervision and Mentorship. Explore avenues to reduce pressure on clinical supervisors to focus on providing billable services rather than providing meaningful support and preparation.

Responsible Agency: *OHA*

Complete action plan in Appendix H.

In addition to the strategies outlined in this action plan, the Behavioral Health Talent Council recommends:

- That the Governor's Office should explore including documentation as countable clinical hours for the behavioral health workforce.
- That the Licensing Boards should expand access to clinical supervision by drafting rules permitting masters-level associates to be supervised by any appropriate, qualified mental health professional.

> "As an Indigenous provider who is a licensed clinical social worker, I know first-hand the challenges passing a psychometric standardized exam. This became evident when I did not pass the social work licensing exam on my first attempt. I admit I felt defeated and demoralized, feelings that I am sure many others felt before me, especially other indigenous providers, and people of color in general. For myself, this was evidence to support that licensing exam pass rates show clear racial and cultural disparities. Many struggle to pass the exam, yet they demonstrate proficiency in the field every day. To address these disparities, there need to be alternative pathways to demonstrate competency. Creating an alternative pathway does not lower standards; they recognize that a single exam isn't the only way to measure if someone can provide quality care. Alternative pathways can help to address this issue and maintain quality standards of the profession."
>
> **Eli Kinsley**, LCSW, CADC III, CGAC II
> Director of Operations, Bridgeway Community Health

> "The lack of clinical supervisors is one of the biggest bottlenecks in growing our workforce. Community Mental Health Programs train future clinicians, but restrictive supervision rules limit how many we can support at once. Particularly in rural communities, we have qualified supervisors ready to provide supervision—they just don't hold the specific license type required for the associate."
>
> **Rick Treleaven**, LCSW
> Chief Executive Officer of BestCare Treatment Services

Supporting Lived Experience in the Workplace (Action Plan LC.4)

Increase accessibility to the behavioral health field for people with lived experience by simplifying and streamlining our peer credentialing systems, improving the background check system, and providing the resources to navigate it.

Strategies:

LC 4.1 Consolidate peer credentials with duplicative trainings and add certifications/ micro-credentials for more specialized areas of practice. New peer credentialing model based on MHACBO recommendation.

Responsible Agency: *MHACBO*

LC 4.2 Examine opportunities to merge credentialing for SUD/MH peers, improve accessibility to credentialing and training for people working in both fields, and eliminate extraneous requirements. Joint recommendations from OHA and MHACBO to streamline peer credentialing.

Responsible Agency: *OHA*, *MHACBO*

LC 4.3 Convene a committee to improve background check process for behavioral health workers. Recommendations for background check process improvements, including new process for Integrated Co-Occuring Disorders (ICOD) providers.

Responsible Agency: *ADPC*

LC 4.4 Create a toolkit and guide for people with lived experience navigating the background check process. Toolkit and guide should be publicly available and widely accessible.

Responsible Agency: *ADPC*, *OHA*, *Department of Human Services - Background Check Unit (BCU) Licensing agencies*

Complete action plan in Appendix H.

In addition to the strategies outlined in this action plan, the Behavioral Health Talent Council recommends:

- That the Governor's Office should explore strategies to reduce barriers to being dual credentialed (substance use and mental health) for both individual BH professionals and organizations providing services, with a focus on youth providers
- That the Governor's Office should explore strategies to encourage and support existing youth mental health providers to receive SUD credentials.

> "Our peer services credentialing system is unnecessarily complicated. Solutions include revising and streamlining the certification and background check processes and updating the foundational training requirements for mental health and substance use disorder and recovery because so many of us have the personal lived experience of both areas as do many of the people we serve. These changes remove the obstacles while maintaining quality standards and fidelity to the peer profession, recognizing that lived experience is expertise and helps develop and build the peer workforce Oregon desperately needs."
>
> **Janie Gullickson**, MPA: HA, CRM II, PSS
> Executive Director of The Peer Company

Education and Training

The Problem: For years, Oregon has struggled to train enough behavioral health professionals to meet demand. Educational pathways are fragmented and unclear. Students lack adequate financial support and wraparound services. Training capacity is constrained by a limited number of qualified clinical supervisors and practicum or other hands-on training opportunities, particularly in rural and underserved communities. Programs don't always align with workforce needs or prepare graduates to provide culturally competent care. Career opportunities in behavioral health are poorly communicated, and alternative pathways into the field are limited.

Oregon's Progress: Although there is still significant work to do, the ratio of behavioral health professionals has improved since Governor Kotek took office in 2023, signaling the number of people receiving education and training, and licensing and credentialing has improved. When the Governor took office in 2023, there was 1 mental health professional for every 170 Oregonians. Now, there is 1 mental health professional for every 130 Oregonians. The Mental Health in America report (America, 2025) summarizes behavioral health workforce by NPI numbers which includes clinical associates but not qualified mental health associates and peers. While overall provider ratios have improved, workforce shortages persist by region, specialty, and population served. This underscores the need for continued action to improve education, training and recruitment and retention into those workforce shortage gaps.

The Action Plans: The Education and Training subcommittee developed action plans to expand, strengthen, and align behavioral health education and training pathways for behavioral health professionals across clinical, peer, and community-based roles. These plans aim to make careers in behavioral health more accessible, and equitable, and prepare professionals to effectively serve all Oregonians - especially those enrolled in the Oregon Health Plan, in rural communities, and among culturally diverse populations. These action plans seek to expand alternative and non-traditional pathways to licensure, improve educational program quality and alignment with workforce needs, strengthen student support systems, advance recruitment and retention of diverse students and early-career professionals, and enhance communication about behavioral health career opportunities.

Developing Clear Pathways (Action plan ET.1)

Grow the workforce and the cultural competency of the workforce by strengthening and aligning behavioral health education pathways.

Strategies:

ET 1.1 Strengthen and align behavioral health education pathways. Conduct a cross-agency review of current BH academic pathways; gap analysis report with recommendations for improving coordination and equity in enrollment and completion.

Responsible Agency: *HECC, OHA, ODE*

ET 1.2 Develop and pilot an inclusive high school behavioral health curriculum. Draft and pilot a behavioral health elective or module in at least two districts (urban and rural) including mentorship components.

Responsible Agency: *ODE, OHA*

ET 1.3 Improve and transfer pathways and credit mobility. Updated, standardized transfer maps for Associate of Arts Oregon Transfer/ Associate of Science Oregon Transfer psychology and social work, approved and shared with community colleges and universities.

Responsible Agency: *HECC*

ET 1.4 Expand accessible career pathway information. Create a public, no-cost Behavioral Health Career Pathway Guide included in a comprehensive Behavioral Health Resource Hub showcasing clear steps, transferable credits, and career options.

Responsible Agency: *HECC, OHA*

Complete action plan in Appendix H.

> "As a professor, I work with many early-career professionals who are passionate about behavioral health and eager to enter the field, but who struggle to navigate licensing, credentialing, and supervision requirements. Too often, the information they need is hard to find and difficult to make sense of. A centralized resource hub will offer clear, accessible guidance and help remove unnecessary barriers. This is exactly the kind of practical support that is critical to helping us grow and sustain our behavioral health workforce."
>
> **Robin Sansing**, MSW, LCSW
> Behavioral Health Initiative Director,
> Southern Oregon University Licensed Clinical Social Worker

Transparency About Licensure Requirements (Action Plan ET.2)

Increase transparency about licensure requirements to more effectively prepare students to succeed during the licensure process.

Strategies:

ET 2.1 Develop and launch multilingual licensure toolkit. Develop a multilingual, culturally responsive toolkit outlining time commitments, costs, and supervision requirements for BH licensure; distributed online and in print.

Responsible Agency: *OHA, Licensing boards, HECC*

ET 2.2 Establish interim licensure information portal. Create a basic centralized online portal hosting licensure information, toolkits, FAQs, and guidance updates; accessible, mobile-friendly site.

Responsible Agency: *OHA, Licensing Boards*

ET 2.3 Build cross-agency workgroup and education partnerships. Establish cross-agency licensure transparency workgroup launched; integration of licensure guidance into advising systems at select community colleges.

Responsible Agency: *OHA, HECC, Licensing Board, Community Colleges*

ET 2.4 Pilot mentorship and navigation supports. Establish a mentorship/navigation pilot program targeting BIPOC, rural, and multilingual candidates; evaluation framework for tracking participation and outcomes.

Responsible Agency: *OHA, HECC, CBO*

Complete action plan in Appendix H.

Improve Communications and Transparency (Action Plan ET.3)

Attract a robust talent pool to education and training programs by effectively communicating the value and pathway to a career in behavioral health.

Strategies:

ET 3.1 Develop and launch a statewide behavioral health marketing campaign. Launch a multilingual, culturally responsive marketing campaign and outreach materials answering, "What is Behavioral Health?" featuring broad career pathways and diverse workforce representation

Responsible Agency: *HECC, OHA, ODE*

ET 3.2 Establish and disseminate best practices in career guidance. Create and distribute a behavioral Health Career Guidance Toolkit including skill assessments, mentoring templates, and informational interview resources for schools and workforce programs

Responsible Agency: *HECC, ODE*

ET 3.3 Create and standardize clear behavioral health language. Initiate statewide adoption of consistent, plain-language definitions for Behavioral Health fields and roles vetted through partner working groups

Responsible Agency: *OHA, HECC, Licensing Boards*

ET 3.4 Develop and launch an accessible behavioral health resource hub. Establish a cross-agency public online portal consolidating marketing materials, guidance tools, and BH definitions in multiple languages with user-testing for accessibility

Responsible Agency: *HECC, OHA*

Complete action plan in Appendix H.

Culturally Responsive Services (Action plan ET.4)

Expand equitable access to behavioral health services across rural, frontier, and culturally distinct communities through targeted workforce initiatives and community-based service models.

Strategies:

ET 4.1 Identify and address rural and cultural service gaps. Conduct statewide mapping and equity analysis of rural, frontier, and culturally distinct communities to identify behavioral health service and workforce, publish regional dashboards to inform funding priorities and program development.

Responsible Agency: *OHA, HECC, Community based partners*

ET 4.2 Expand culturally specific workforce pathways. Develop and expand culturally responsive pipelines through coordinated efforts of higher education institutions, MHACBO, community colleges, peer training programs, and community-based providers. Deliver aligned curriculum and supervision training reflecting cultural and regional needs.

Responsible Agency: *HECC, OHA, MHACBO, Community partners*

ET 4.3 Incentivize and sustain rural multicultural practice. Launch targeted recruitment campaigns, loan repayment, and housing incentives for bilingual, bicultural, and lived-experience providers serving in rural and frontier regions. Establish regional mentorship and supervision networks for community-based practitioners.

Responsible Agency: *OHA, HECC, Workforce boards, CCOs*

ET 4.4 Strengthen community based innovative service models. Pilot and evaluate mobile tele-behavioral health and community wellness services mode delivered through schools, faith centers and trusted local organizations. Integrate data tracking into the behavioral health resource hub to measure access, equity, and provide retention

Responsible Agency: *OHA, HECC, tribal partners, Workforce boards, CBOs*

Complete action plan in Appendix H.

In addition to the strategies outlined in this action plan, the Behavioral Health Talent Council recommends:

- That the Higher Education Coordinating Commission further explore ways to educate and train supervisors to support staff in working sustainably with high-acuity populations.

Enhancing Partnerships and Collaboration (Action Plan ET.5)

Broaden and strengthen behavioral health partnerships among education, employers, and community organizations to expand coordinated, high-quality career experiences and training opportunities statewide.

Strategies:

ET 5.1 Pilot early behavioral health career experiences. Implement two regional pilots (rural and urban) offering early BH exposure through job shadowing, mentorship, and student wellness ambassador roles. Include alignment with existing CTE frameworks, trauma-informed supervision, and evaluation for statewide scaling.

Responsible Agency: *OHA, ODE, HECC, school districts, Community Colleges, Tribal*

ET 5.2 Strengthen partnerships between employers and higher education. Develop and implement standardized partnership frameworks connecting higher education, employers, and training providers to expand paid internships, apprenticeships, and rural/tribal placements.

Responsible Agency: *HECC, OHA, Oregon workforce*

ET 5.3 Establish an Oregon behavioral health career consortium. Launch a statewide consortium coordinating messaging, recruitment, and career promotion under a unified brand. Produce multilingual marketing materials and conduct 2– 3 career events with employer and peer-workforce representation.

Responsible Agency: *OHA, HECC, ODE, Community Colleges, Workforce boards*

ET 5.4 Advance equitable pathways and credit for prior learning. Develop statewide CPL guidance recognizing peer and workforce training for academic credit; pilot CPL articulation agreements across 3 institutions; monitor equity participation and outcomes through HECC/OHA data systems.

Responsible Agency: *HECC, OHA, MHACBO, Community Colleges, Workforce boards*

Complete action plan in Appendix H.

Community College Collaboration (Action Plan ET.6)

Increase equitable entry and completion in community college behavioral health pathways, with special attention to BIPOC, rural, immigrant, and linguistically diverse students, by mapping barriers and launching new supports.

Strategies:

ET 6.1 Analyze and understand enrollment patterns. Conduct a statewide analysis report on behavioral health enrollment trends and equity gaps in community colleges, with partner input.

Responsible Agency: *HECC, OHA, Community Colleges, CBOs*

ET 6.2 Develop and pilot inclusive on-ramps. Pilot pathways and entry points, including dual credit, CTE, CPL, and peer/lived-experience onramps, with co-designed curriculum and support models.

Responsible Agency: *ODE, HECC, OHA, Community Colleges, high schools*

ET 6.3 Strengthen articulation and course credit mobility. Establish new or revised articulation agreements, transfer maps, and statewide advising tools that clarify credit and CPL movement from community colleges to universities.

Responsible Agency: *HECC, OHA, Oregon Transfer Council, Community Colleges*

ET 6.4 Expand local partnerships and capacity. Develop a network of local partnerships in targeted regions providing mentorship, placements, ESL/developmental education supports, and holistic outreach.

Responsible Agency: *Community Colleges, HECC, Workforce boards, employers, tribal*

ET 6.5 Ensure equity driven accountability and continuous improvement. Require routine cross-agency reporting on enrollment, transfer, CPL use, and completion, disaggregated by region/ equity group and tied to improvement cycles

Responsible Agency: *HECC, OHA, Community Colleges, Workforce boards*

Complete action plan in Appendix H.

Expand Degree Pathways and Completion (Action Plan ET.7)

Expand clear, inclusive behavioral health pathways that help more Oregonians, including BIPOC, rural, and lived-experience learners, enter and complete degrees that lead to meaningful careers.

Strategies:

ET 7.1 Strengthen and align behavioral health degree pathways. Direct cross-agency review of current behavioral health academic pathways; gap analysis identifying areas for coordination and equity improvements, including Credit for Prior Learning (CPL)

Responsible Agency: *HECC, OHA, ODE*

ET 7.2 Develop and pilot inclusive high school to career pathways. Conduct the collaborative design and pilot of behavioral health CTE courses and dual credit modules integrating CPL and mentorship in diverse districts/colleges

Responsible Agency: *ODE, HECC, OHA, CTE directors/ districts*

ET 7.3 Promote collaboration credit mobility and data sharing. Establish enhanced transfer pathways, articulation agreements, and initial cross-agency data sharing protocols with CPL utilization tracked

Responsible Agency: *HECC, OHA, ODE, Oregon Transfer Council*

ET 7.4 Expand focused recruitment and supports. Establish frramework for targeted recruitment, scholarships, mentoring, and CPL support tailored to BIPOC, rural, and lived experience students

Responsible Agency: *Colleges, HECC, OHA, ODE*

ET 7.5 Foster accountability for completion and workforce outcomes. Create a prototype data dashboard for public reporting of enrollment, completion, CPL use, and licensure outcomes disaggregated by key equity factors

Responsible Agency: *HECC, OHA, Workforce Council*

Complete action plan in Appendix H.

In addition to the strategies outlined in this action plan, the Behavioral Health Talent Council recommends:

- That the agencies implementing this action plan should focus specifically on expanding pathways for psychologists and psychiatric nurse practitioners.

Career Exploration and Professional Development (Action Plan ET.8)

Expand equitable opportunities for Oregon students to explore, enter, and progress through behavioral health career pathways, starting early and spanning high school through advanced degrees.

Strategies:

ET 8.1 Broaden and align career exploration. Pilot statewide CCL-aligned behavioral health career days, job shadowing, and roadmap for internships and observation with confidentiality/ safety guidance

Responsible Agency: *HECC, ODE, ESD, Workforce boards, CBOs*

ET 8.2 Clarify roles, certification and credentialing pathways. Establish comprehensive, accessible guidance and integrated advising on behavioral health certifications/licensure (CADC, QMHA, LPC, peer roles, etc.)

Responsible Agency: *HECC, ODE, ESD, Workforce boards, CBOs*

ET 8.3 Enhance professional development and retention. Develop modular, portable professional development in evidence-based practice, documentation, digital skills, self-care, team based care; launch rural/peer mentorship

Responsible Agency: *HECC, OHA, credentialing and licensure organizations, community colleges, universities, CBOs*

ET 8.4 Support rural and community based programs. Provide technical assistance, resource grants, and engagement initiatives for rural/ culturally specific agencies to expand BH learning opportunities

Responsible Agency: *OHA, HECC, CBOs, Workforce boards*

ET 8.5 Continuous communication and feedback. Establish advisory groups, student/ practitioner surveys, and forums, collaborating with credentialing and licensure organizations, for ongoing pathway, certification, and training improvement

Responsible Agency: *HECC, ODE, Workforce boards, credentialing and licensure organizations*

Complete action plan in Appendix H.

Engagement and Feedback

Summary

In addition to the incredible expertise of the behavioral health talent council members, the talent council's recommendations were informed by significant expertise outside of the council itself. The First Lady, Vice Chairs, and the Governor's Office sought additional feedback to ensure that the action plans and final council report centered the voice of frontline workers and would address the needs of every Oregonian, including Oregonians seeking and providing culturally specific care. Additionally, the First Lady invited the nine sovereign tribes of Oregon for coordination – and eight of the nine sovereign tribes shared feedback with the full council for the purpose of the council's final report honoring tribal sovereignty and uplifting the unique needs and strategies of Oregon's tribal nations.

Each council meeting was livestreamed, and recordings were posted online with an email to provide feedback, to facilitate an avenue for all frontline workers, behavioral healthcare consumers, and members of the public to provide input on the work and recommendations of the council.

> "The council, and the experts and frontline voices consulted, represented the diversity within Oregon. The regional perspectives that were shared have changed how I think about pipeline development and career pathways that are responsive to the needs of communities and build on the strengths and resources within each community."
>
> **Alice Gates**, MSW, PhD
> Associate Professor at the OHSU-PSU School of Public Health
> and Director of the Rural Public Health Practice Initiative

BHTC Meetings

Throughout the Behavioral Health Talent Council's work to develop action plans, the Council received briefings from subject matter experts in the following topic areas to provide council members with a deeper dive on the unique challenges and successful strategies of the following:

- Licensing and Credentialing Boards: Mental Health and Addiction Certification Board of Oregon (MHACBO). Mental Health Regulatory Agency (MHRA), Board of Licensed Social Workers (BLSW), Oregon State Board of Nursing (OSBN);
- Substance Use and Addiction Treatment Providers;
- Mental Health Providers;
- Peers, including youth and family peers;
- Youth providers;
- Culturally specific providers.

All council meetings were livestreamed and recorded. Please visit the Behavioral Health Talent Council website for more information.

Tribal Coordination

The staff of the Behavioral Health Talent Council reviewed the Tribal Health Strategic Plan to facilitate alignment between the behavioral health workforce priorities of Oregon's sovereign Tribes and the work of the council subcommittees. Staff worked throughout the council to support alignment with the priorities of Tribes, and the First Lady and Governor's Office intentionally coordinated with Oregon's Tribes to get feedback on whether those efforts to align were successful.

After the council's action plans, informed by the Tribal Health Strategic Plan, had been advanced by the council. the leadership and staff of the Governor's Office invited representatives from Oregon's nine sovereign Tribes to meet and discuss the work of the Behavioral Health Talent Council and how it can best align with and support the Tribes' own strategic vision for providing behavioral health services to their communities.

The First Lady, Talent Council staff, and the OHA Tribal Affairs Director met with representatives from eight of Oregon's nine sovereign Tribes on January 7th, 2025. Governor's office staff presented on the work that had been done by the Council up to that point, including alignment of the work of the Talent Council with the Oregon Tribal Health Strategic Plan for 2025-2030. The Tribal representatives, the First Lady, and the Talent Council staff then discussed the gaps identified in the Talent Assessment, the needs of Tribal behavioral health workers, and successful strategies that the Tribes have already implemented to support their workforce.

For more information and feedback from the coordinating meeting with Oregon's sovereign tribes, please see Appendix C.

Culturally Specific Organization Engagement

Governor's Office staff coordinated meetings with ten organizations that either provide culturally specific behavioral health services in Oregon or support providers of culturally specific behavioral health services. Governor's office staff sat down with representatives of each organization to review the work of the Talent Council and receive feedback to incorporate into the Talent Council's final report.

List of Organizations:

- Adelante Mujeres
- AHO! Wellness Tech
- Asian Health and Service Center
- Avel Gordly Center for Healing
- Capaces
- Dian's Well
- Latino Network
- NARA NW
- Oregon Change Clinic
- Prism Health

For more information on feedback from culturally specific organizations, please see Appendix D.

Front-Line Worker Engagement

The council directly engaged with frontline behavioral health workers. As the Chair of the Council, First Lady Aimee Kotek Wilson visited behavioral health organizations across the state - from facilities struggling with severe workforce shortages to those that have implemented innovative strategies to recruit and retain staff. The First Lady, council members and Governor's office staff met with workers, attended and hosted roundtables, and encouraged frontline voices to continue providing feedback on the work of the council.

The majority of recommendations shared by frontline workers are reflected in the action plans that reduce administrative burden, support the workforce, reduce licensing and credentialing barriers, and create more professional advancement opportunities. All recommendations received by frontline workers are outlined for the Governor's consideration in Appendix E.

Legislative Workgroup Alignment

The Behavioral Health Talent Council prioritized engagement with legislatively directed behavioral health workforce work groups who were drafting reports of recommendations in their own parallel processes to ensure alignment between the action plans and legislative work group final reports. As a result of the engagement throughout the council's process, of the fifty four recommendations from four legislative workgroups:

- Twenty-two are directly in alignment and represented in the talent council's action plans;
- Twenty recommendations are related to workforce but are not in a BHTC action plan.
- Twelve recommendations were not related to workforce and are therefore not included.

This analysis is further detailed in Appendix F and recommendations related to workforce that are not included in an action plan are still submitted as part of the council's report to the Governor for consideration.

Next Steps

This report is submitted to the Governor for consideration. The action plans developed by subcommittees are comprehensive and substantively aligned with the feedback the council received from frontline workers, Oregon's tribes, and culturally specific and responsive organizations. However, the Council recommends that the Governor consider the totality of the action plans and additional recommendations outlined in the engagement section and appendices to inform next steps.

The Governor will review and determine which action plans, strategies, and recommendations to advance by directing her team or the executive branch to move them forward. The Governor's Office will inform the Behavioral Health Talent Council of the outcome of the Governor's initial review and may consult with the council on an as needed basis moving forward. The Governor's Office will produce an annual report for the public and members of the council on the progress of implementing the action plans.

To ensure progress towards addressing the crisis is grounded in comprehensive and accurate data, the Governor should consider directing the Higher Education Coordinating Commission (HECC) to update the behavioral health talent assessment that informed the work of this council with the most current data and information on workforce shortages by the end of 2026. HECC should explore the feasibility of getting more specific data on recruitment and retention challenges for providers serving Oregon Health Plan members and should explore expanding the scope of profession types evaluated in the assessment to include as many behavioral health professional types as possible. In addition to an update to the assessment by the end of 2026, HECC should conduct a full assessment on a regular basis to ensure workforce efforts continue to be data informed.

Finally, the Governor has already decided to advance a bill in the 2026 legislative session that includes recommendations from the Behavioral Health Talent Council (HB 4083, Cutting Red Tape for Behavioral Health Workers). The bill includes the following policy and administrative changes:

- **Streamline Credentialing for Behavioral Health Workers:** Currently, workers are required to be credentialed through the Oregon Health Authority (OHA), as well as separately through each entity that their provider bills for their services. This causes unnecessary delays that keep qualified professionals from serving patients who are waiting for care and requires providers to pay workers who are not yet able to provide care. This bill will require OHA to adopt a centralized payer credentialing process for behavioral health workers, allowing qualified workers to begin providing care sooner and reducing administrative burden on providers.
- **Reduce Administrative Burden to Give Workers More Time to Care for Patients:** Behavioral health workers report that Behavioral health workers report that increasing administrative requirements – including duplicative reporting – take time away from patient care and contribute to burnout. This bill directs OHA to eliminate unnecessary administrative burden as part of their mission, and report to the Legislature and Governor every two years on steps they have taken to reduce administrative burdens on providers.

- **Implement Cross-License Supervision to Expand Access to Clinical Supervision:** Prospective master's level licensees need supervised hours to attain their license, but a lack of qualified clinical supervisors has created a bottleneck. Current rules for some behavioral health licensees allow for supervision by "any qualified mental health professional," while others are more restrictive. This bill directs the licensing boards to draft and implement rules allowing for any prospective master's level qualified mental health licensee to receive supervision from any qualified mental health licensed professional, regardless of whether they and their supervisor possess the same type of license. This will reduce barriers for qualified workers obtaining their license.

The Governor's Office will work to advance this bill in partnership with the Behavioral Health Talent Council members.

Council members testified on HB 4083, "Cutting Red Tape for Behavioral Health Workers", in the 2026 legislative session - the first bill to include recommendations from the council.

Appendices

Appendix A. Council Member Bios

Aimee Kotek Wilson, MSW, First Lady of Oregon

Aimee Kotek Wilson has been the First Lady of Oregon since 2023, having supported and worked alongside her wife, Governor Tina Kotek, for more than 20 years. The First Lady received her MSW from Portland State University. Prior to stepping back from her work as a social worker to take on her public role as First Lady, she worked for a community mental health provider working with high acuity clients. The First Lady has recent direct experience of navigating the education-to-credentialing-to-work continuum for behavioral health professionals. The First Lady also worked as a political campaign strategist, a union advocate, and senior staff in the legislative and executive branches. She has traveled to every corner of Oregon to meet with behavioral health providers, bringing their voices directly into the policy process. She now chairs the Governor's Behavioral Health Talent Council and continues to be a champion for both providers and consumers of mental health and addiction services.

Eli Kinsley, LCSW, CADC III, CGAC II, Director of Operations at Bridgeway Community Health

Eli Kinsley is a descendant of the Hopi and Turtle Mountain Chippewa/Cree tribe, and an enrolled member of the Tohono O'. Odham Nation. He is a graduate of Chemeketa Community College where he received an associate degree in addiction studies. He went on to Portland State University (PSU) where he completed a bachelor's and master's in social work degree. He is currently employed with Bridgeway Community Health as the Director of Operations, is an adjunct instructor in PSU's School of Social Work, as well as the owner of a private practice, Midewin Counseling and Consulting. He is a Licensed Clinical Social Worker and credentialed Certified Alcohol and Drug Counselor (CADC III) and Certified Gambling Addiction Counselor (CGAC II). He currently sits on the Marion County Sheriff's Office Community Advisory Board and a board member of Transformative Justice Community (TJC). He primarily provides services in Marion and Polk Counties.

Julie Ibrahim, LPC, CEO of New Narrative

Julie is the CEO for New Narrative, a non-profit mental health agency providing comprehensive mental health treatment, housing, and peer support services for adults with severe and persistent mental health challenges in Multnomah and Washington Counties. Julie is also a Board Member on the Tri-County Behavioral Health Providers Association (TCBHPA), as well as a Board Member on the Oregon Council for Behavioral Health (OCBH). Her experience and qualifications include over 30 years of leading and coaching business teams and individuals in two Fortune 500 companies and, in the past decade, two mental health agencies. She has built a career that includes a broad range of clinical and business experience including leadership of large department, clinic, and business operations, budgets, personnel and projects. Julie is also a Licensed Professional Counselor (LPC) in the State of Oregon where she has been providing mental health counseling for the past 12 years.

Robin Sansing, MSW, LCSW, Behavioral Health Initiative Director at Southern Oregon University

Robin Sansing is a Licensed Clinical Social Worker with leadership experience in higher education, behavioral health systems, and workforce development. Robin serves at Southern Oregon University as Director of the Behavioral Health Initiative where she leads regional efforts focused on workforce development, community partnership building, and applied research. Robin has maintained a private clinical practice since 2012, providing psychotherapy services alongside systems-level leadership work. Her work is grounded in community-based approaches and a commitment to strengthening Oregon's behavioral health workforce.

Dr. Alice Gates, MSW, PhD, Associate Professor at the OHSU- PSU School of Public Health

Alice is an Associate Professor at the OHSU-PSU School of Public Health and Director of the Rural Public Health Practice Initiative, where she leads statewide efforts to strengthen Oregon's public health workforce. Her work focuses on aligning graduate curriculum with community and workforce needs and building academic–practice partnerships that support "grow-your-own" strategies across Oregon. Dr. Gates brings more than two decades of experience in community-engaged practice and higher education leadership. She previously served as a Professor of Social Work and Program Director at the University of Portland. Her early career included work with PCUN, Oregon's farmworker union, and Virginia Garcia Memorial Health Center, where she supported initiatives integrating behavioral health and primary care. Dr. Gates earned her BA in Sociology from Grinnell College and holds an MSW and PhD in Sociology and Social Work from the University of Michigan.

Bethany Wallace (she/her), MSW, LCSW, Assistant Professor at the School of Social Work at PSU

Behtany is an Assistant Professor of Practice and Practicum Specialist in the School of Social Work at Portland State University. She earned her BS from the University of Oregon and her MSW from the University of Michigan, where she received a Child Welfare Fellowship. Bethany spent 12 years at Trillium Family Services in progressively responsible roles, including Child and Family Therapist, Clinical Manager, and Director of Quality Improvement. Since joining the PSU School of Social Work in 2019 and becoming full-time faculty in 2023, Bethany has supervised and supported bachelor's and master's level practicum students statewide, with a primary focus on Marion, Polk, and Linn-Benton counties. She teaches MSW practicum seminars and foundational courses, emphasizing the integration of theory and practice. Bethany is a doctoral student at the University of Kentucky's DSW program, focusing on leveraging lived experience to strengthen social work education, supervision, and practice.

Clarissa Carson, PMHNP-BC, MSN, APRN, Psychiatric Mental Health Nurse Practitioner at Rogue Community Health

Clarissa Carson, MSN, APRN, PMHNP-BC, is a board-certified Psychiatric Mental Health Nurse Practitioner with advanced training in nursing and psychiatry. She provides comprehensive psychiatric care at Rogue Community Health, serving a 500-square-mile region of Southern Oregon with a focus on trauma-informed care and patient-centered practice. Mrs. Carson serves on the Executive Committee of the Oregon Wellness Program and previously represented ICU nurses through the Oregon Nurses Association, contributing to key contract advancements. Her background includes multiple professional honors, prior board certification as an ICU nurse, and longstanding commitment to improving behavioral health access for Oregon communities.

Ebony Clarke, LCSW, MSW, Behavioral Health Director at Oregon Health Authority

Ebony Clarke is a seasoned behavioral health executive with over 25 years of leadership experience in publicly funded and nonprofit behavioral health systems. As the Behavioral Health Director for the Oregon Health Authority (OHA) appointed in February 2023, and former Director of the Multnomah County Health Department, she has been a driving force in shaping policy, bringing forward accountability, advancing equity-centered care, and strengthening behavioral health services across Oregon. Ebony has dedicated her career to developing comprehensive and responsive services, and leading large-scale organizational initiatives. Ebony holds a Bachelor of Arts in Community and Human Services from the University of Oregon and a Master of Social Work from Portland State University. With a steadfast commitment to building a comprehensive continuum of care, Ebony's mission is to ensure equitable access to high-quality behavioral health services that promote healing and well-being for individuals, families, and communities rooted in lived experience.

Jamie Vandergon, LPC, CEO of Trillium Family Services

Jamie serves as CEO of Trillium Family Services. With more than 22 years of experience in behavioral health, Jamie leads Oregon's largest provider of mental health services for youth and families, offering care across the full continuum—from community based prevention to state hospital inpatient services. Jamie has held multiple leadership roles across Trillium, guiding the growth and expansion of programs that strengthen outcomes for Oregon's children and families. A passionate advocate for youth mental health, Jamie is a recognized voice for trauma-informed systems, mental health equity, and the belief that mental health is health. Jamie began her career in community-based children's mental health at Johns Hopkins Hospital and joined Trillium in 2002 as a school-based Child & Family Therapist. She holds a Master of Science in Psychology from Loyola University Maryland and is a Licensed Professional Counselor in Oregon.

Janie Gullickson MPA: HA, CRM II, PSS, Executive Director of The Peer Company

Janie is a person in long-term recovery and for her means she has not used alcohol or other drugs in over 17 years. Janie is in recovery from both addiction and serious mental health issues as well as homelessness, incarceration, and criminal justice involvement. She navigated all types of systems and institutions that can accompany such life experiences, from frequent hospitalizations to prison. Janie first began her work as a Peer Support Specialist/Recovery Mentor in 2011. Janie joined the peer-run organization The Peer Company, formerly the Mental Health & Addiction Association of Oregon (MHAAO), as a project assistant in 2014 and in May of 2017 Janie became The Peer Company's Executive Director. She also earned her Bachelor's Degree in Social & Behavioral Health Sciences from Linfield College in 2014 and her Master of Public Administration: Health Administration (MPA: HA) degree from Portland State University in June of 2017. Janie is passionate about behavioral health systems change, the fidelity of peer services, growing and developing the peer services workforce and advocacy in these realms.

Julia Mines QMHP, CRM, Executive Director of Miracles Club

Julia's story is one of resilience and transformation. Today, she is a mother of three, a grandmother, and a dynamic leader known for her confidence, empathy, and vibrant personality. Her ability to listen and understand stems from staying true to herself and her complex history. Despite her current success, Julia has faced significant adversity. She rebuilt her life after incarceration and a halfway house, using her past as a source of strength. Her journey includes earning a bachelor's degree, two master's degrees and multiple certifications, including: Master's Certificate in Human Services Management, Master's Certificate in Alcohol and Drug Counseling, Level II Certified Recovery Mentor, Qualified Mental Health Professional. Julia serves in leadership roles such as: Oregon Black, Brown Indigenous Coalition, State Commissioner on Oregon Alcohol and Drug Policy Commission. For over 20 years, she has worked with vulnerable populations, helping clients rebuild their lives. Today, she leads Miracles Club in Northeast Portland, continuing her mission to support recovering addicts. Her rise from hardship was fueled by grit, love, hope for her community, and devotion to family.

Julia Pontoni, MPA, Director of the Office of Workforce Investments at HECC

Julia Pontoni (she/her) is the Director of the Office of Workforce Investments at the Higher Education Coordinating Commission (HECC). In her role, Julia leads an office committed to ensuring that job-seeking Oregonians statewide have the knowledge, skills, and work-related training they need to secure self-sufficiency wage jobs and meet the needs of our employers – now and in the future. Julia previously held several other positions at the HECC focused on STEM education, adult educational attainment, and transfer between community college and university.

Before joining the HECC in the spring of 2017, Julia worked in Washington, DC for eight years, most of which she spent as a staffer in the U.S. House of Representatives. She also worked at the National Head Start Association and for the U.S. Department of State.

Born and raised in Portland, Julia earned a BA from Amherst College and MPA from the George Washington University.

Liz O'Connor Triage Manager, QMHA, Triage Manager at Cascadia Project Respond

Liz O'Connor is a Qualified Mental Health Associate (QMHA) with seven years of service at Cascadia Health. Currently, they serve as the "air traffic control" for Project Respond, Multnomah County's mobile crisis team. In this role, Liz triages calls, dispatches teams, and provides on-site support to urban populations. Committed to systemic change, Liz serves as a Union Steward for Local 1790, representing colleagues in negotiations and collaborating with stakeholders to strengthen Oregon's behavioral health infrastructure. Liz holds a Bachelor's in Social and Behavioral Studies and is pursuing a Master's in Social Work. A primary goal of their work is increasing safety for both community members and frontline responders. Ultimately, Liz bridges crisis response with policy to ensure equitable mental health care for all.

Mary Peterson, Ph.D., ABPP/CL, Provost and Vice President of Academic Affairs at George Fox University

Mary Peterson, PhD, is the Provost and Vice President of Academic Affairs at George Fox University. She is a board-certified clinical psychologist, former program director of the clinical psychology doctoral program, and dean of behavioral health sciences. She served on the board of directors for the Oregon Psychological Association for nine years, serving as Vice President and President. She was the regional Federal Education Advocate for the American Psychological Association. She received the Presidential Award for service to the community, specifically focusing on service to rural areas. In 2019, she secured a 1.4 m HRSA grant to serve rural communities affected by opioid epidemic. Her research and professional interests are in health psychology, and she served on the board and as chair of the Service Advisory Council for Providence Newberg Medical Center and is currently vice-chair of the Oregon Community Ministry Board for Providence Health Systems.

Monica Vines, MA, LPC, Professor and Program Director at Central Oregon Community College

Monica Vines is a licensed professional counselor with a master's degree in counseling psychology, with an emphasis in marriage, child and family counseling. She studied psychology, women's studies, and addiction studies in her undergraduate work. She began working in the mental health field in 1997 with primary focus on trauma, attachment, and diversity, equity and inclusion. She has been teaching at Central Oregon Community College since 2005 and has been the program director for Addiction Counseling and Behavioral Health since 2007. In her role at COCC she works with students who plan to enter the Addiction Counseling and Behavioral Health fields. Her goal is to foster most ethical, empathetic, self-aware helpers students can be when they enter the workforce. She serves on local/regional boards for addictions and human services and serves as a resource for her community on topics related to ethics, trauma, DEI, and attachment.

Rachel Prusak, MSN, APRN, FNP, Executive Director of the Oregon State Board of Nursing

Rachel has been serving as the Executive Director of the Oregon State Board of Nursing since the summer of 2023. With a master's degree in nursing and board certification as a family nurse practitioner, she has over 25 years of experience in frontline healthcare, dedicating her career to uplifting vulnerable communities. Before her role in the executive branch, Director Prusak distinguished herself as a state representative in the Oregon Legislature, where she served two terms. She also chaired the Oregon House Healthcare Committee during the COVID-19 pandemic, skillfully navigating the complexities of healthcare. Her leadership was vital in safeguarding public health and ensuring the well-being of the workforce. Rachel's journey underscores her strong belief in the essential role that nurses play in shaping the future of our behavioral healthcare system.

Rick Treleaven, LCSW, Chief Executive Officer of BestCare Treatment Services, Inc. and Community Mental Health Director for Jefferson County and Crook County

Community Mental Health Director for Jefferson County and Crook County. Rick is a licensed clinical social worker who has worked in the fields of addiction and mental health since 1982. He has provided clinical services with diverse groups of people, including youth, families, veterans, victims of abuse, and people with severe and persistent mental illnesses. He has worked at all levels of the field, as a volunteer, a therapist, a clinical supervisor, and as an administrator of programs. He has worked for BestCare since 1999 and has been the CEO since 2001. Rick is currently a member of the Oregon Opioid Settlement Board. He is a past president of the Oregon Council for Behavioral Health and a member of the Oregon Association of Community Mental Health Programs. BestCare provides behavioral health services in Crook, Jefferson, Deschutes, and Klamath counties, employing around 370 staff. Our employees include peers, CADCs and other certified staff, licensed behavioral health professionals, nurses, PA's, PMHNP, and physicians.

Shyra Merila Simmons, LPC, Executive Director of Clatsop Behavioral Healthcare

Shyra has served in leadership at CBH since 2016. Prior to moving to Clatsop County, Shyra worked in Colorado at Griffith Centers for Children in varying clinical leadership roles across the state. Shyra spent most of her direct service years working with families and youth experiencing acute behavioral health symptoms, providing intensive services, EMDR and home-based care. Shyra brings a social justice lens to her work in behavioral health and believes we have an obligation to own and address the inherent flaws in the behavioral health system that have historically marginalized and pathologized populations. Shyra serves on the HB 2235, Behavioral Health Workforce workgroup. Shyra is a member of the Association of Oregon Community Mental Health Programs and serves on their legislative committee. Shyra also serves on the Columbia Pacific CCO Clinical Advisory Panel. Shyra was appointed to the Alcohol and Drug Policy Commission in 2025.

Sommer Wolcott, LPC, CRC, Executive Director of Continuum Behavioral Health & Recovery Services

Sommer Wolcott is the Executive Director at Continuum Behavioral Health & Recovery Services (Formerly OnTrack Rogue Valley) and has been with OnTrack since October 2018. Sommer has worked in Oregon's non-profit behavioral health system for 25 years and holds an MS in Counseling Rehabilitation from Portland State University and a BS in Psychology from Western Oregon University, is a Licensed Professional Counselor (LPC) and Certified Rehabilitation Counselor (CRC). After spending 18 years working in the children's system. Sommer joined the new leadership team at OnTrack seeing the possibilities of integrating child, family, mental health and substance use treatment to support the entire family system and interrupt the in intergenerational cycle that leads to childhood aversity, poverty, addiction, and mental illness. Continuum is located in Southern Oregon serving Jackson and Josephine Counties with a full continuum mental health and substance use treatment, recovery services, and housing supports. Sommer serves on various local steering committees, the board of Jefferson Regional Health Alliance and is Vice President of the Board for Oregon Council for Behavioral Health.

Tammi Paul, MA, Executive Director of Oregon Family Support Network

Tammi S. Paul currently serves as the Executive Director for Oregon Family Support Network, a statewide, peer run organization that supports parents and caregivers raising children or youth with behavioral health or other complex health needs. Tammi is a certified Traditional Health Worker with a specialty of Family Support Specialist in the state of Oregon and has worked in higher education, special education law and holds a Master's degree in Intercultural Relations. Tammi currently serves as an appointment member of the Children's System Advisory Council (CSAC); Addictions and Mental Health Policy Advisory Council (AMHPAC); and serves as a faculty member for the Oregon ECHO (Extension for Community Healthcare Outcomes)

Program through OHSU. Tammi lives on a small farm in rural Oregon and is the parent of 3 youth (now young adults) who have all navigated mental health and developmental disabilities.

Todd Younkin, Executive Director of Mental Health Regulatory Agency

Todd Younkin is the Executive Director for the Mental Health Regulatory Agency, which supports and oversees Oregon's Boards of Psychology and Licensed Professional Counselors and Therapists. Todd's prior work experience includes positions in Montana state government as Legislative Staff, Workforce Information Director, and Director of Montana's umbrella agency for occupational licensing, overseeing more than 40 boards and programs, 100 license types, and 100,000 licensees.

Van Burnham, CRM, Executive Director of MHACBO

Van holds a bachelor's degree in accounting from the University of Mississippi and has spent the past 15 years specializing in behavioral health workforce credentialing. Van has collaborated with numerous certification boards across the country, helping to support their operations, legislative advocacy, and credentialing requirements. Van currently serves as Oregon's representative to the International Certification & Reciprocity Consortium (IC&RC), the national leader in substance use disorder examinations. In addition to credentialing work, Van has a robust background in data management and technology and works closely with behavioral health agencies and the Oregon Health Authority to assist in workforce data needs and analytics. Van serves as the Executive Director of the Mental Health & Addiction Certification Board of Oregon (MHACBO), where they manage statewide certification for non-licensed behavioral health workers (CADCs, QMHPs, CRMs), Van holds a Certified Recovery Mentor (CRM) credential. Van serves on the Board of Directors for IC&RC, the national leader in substance use disorder examinations. Van also serves on the Board of Directors for True Colors, a Portland-based nonprofit organization supporting LGBTQ+ youth and communities.

Appendix B. Council Values

The council intentionally adopted values that would inform their work early in their process to ground their work in shared values.

- Equity and Inclusion: Increasing the cultural competency and diversity of the workforce to serve all Oregonians fairly, especially communities most harmed by health inequities.
- Access to Care: Addressing the worker shortage to ensure that all people in Oregon can access timely and responsive behavioral health support.
- Support for the Workforce: Creating sustainable careers and supporting the well-being of both providers and the communities they serve, including focusing on competitive pay and work-life balance.
- Community-Informed Solutions: Utilizing a collaborative approach that brings together experts and honors the lived experiences of the behavioral health workforce and people who use services.
- Innovation: Developing new strategies and "practical, actionable solutions" to tackle the ongoing workforce crisis.
- Accountability and Stewardship: Committing to the responsible use of public resources to achieve measurable outcomes.

Appendix C. Tribal Coordination

Governor Kotek is committed to partnering with Oregon's nine sovereign Tribes and to coordinating and collaborating with the Tribes on policy initiatives that have the potential to affect them, which informed the council's Tribal engagement. The Behavioral Health Talent Assessment identifies a number of gaps in the support provided to Tribal behavioral healthcare providers, and specifically to American Indian and Alaska Native workers. Among them:

- "Underrepresentation of Latino/a/x/, American Indian or Alaska Native, Black, and Pacific Islander health care professionals… particularly in higher-paying roles."
- "Lack of appropriate training in schools and on the job for cultural responsivity, specifically for American Indian or Alaska Native, Latinx, and rural communities."
- "Rural workers have less access to training and workforce support services (e.g., internships, mentorship programs, career counseling, job placement services)."

The assessment also identified a critical shortage of mental health providers in Oregon's rural and remote counties, with 32 of 36 lacking even one in person, licensed mental health provider per 1,000 residents. In many rural communities, Tribal providers are the primary healthcare system available to both Tribal and non-Tribal community members.

The Talent Assessment presents several recommendations specific to supporting Tribal providers and providers in rural communities. They include:

- "Support statewide initiatives to minimize the urban/rural divides in education about and access into the BH field."
- "Offer region-specific BH career roadmaps to encourage a grow-your-own approach for Tribal, rural, and remote communities."
- "Subsidize housing, relocation, and childcare costs, particularly in rural areas with underserved communities."
- "Increase access to in-person and virtual BH resources in rural areas with culturally competent providers."

The Nine Tribes have also produced a five-year strategic plan to improve health outcomes for Tribal communities across Oregon, which was reviewed by Talent Council staff and incorporated into their work throughout the Council's processes. The Oregon Tribal Health Strategic Plan highlights the importance of supporting workforce as one of its central strategic pathways:

"Nurturing a healthy workforce – This pathway seeks to support the existing Tribal health workforce and promote its continued growth. This will be done by supporting accreditation programs, enhancing provider incentives for retention, continuing to offer Tribal-specific cohorts across the health field, and supporting mentorship opportunities and cross-training activities to connect one another in this work"

The Strategic Plan identifies three strategic outcomes to serve as clear indicators of progress under this pathway:

- Achieve measurable staff growth and retention across Tribal health care positions.
- Increase access to workplace wellness, training, and support.
- Increase knowledge transfer and workforce proficiency in identified core competencies.

The Plan also identifies eight action steps to support this pathway:

- Work with the Nine Tribes to define health care positions and categories of departments (administration, public, physical and behavioral health, oral/dental, eye care, traditional health)
- Create a comprehensive job description repository with standardized pay grade ranges.
- Implement an enhanced provider retention incentive system.

- Deliver a Tribal-specific, trauma-informed care and historical trauma training program with a 50% staff completion rate.
- Implement workforce wellness and self-care initiatives with measurable outcomes.
- Establish a trauma-informed mentorship program with impact metrics.
- Support training programs specifically for working in Tribal communities.
- Map Tribal-specific credentialing systems for behavioral health and public health workers.

All of these action steps are in alignment with the action plans put forth by the Behavioral Health Talent Council.

The Governor's Office invited the nine Tribes to meet to discuss the work that the Talent Council had done and the recommendations that they anticipated putting forward. Representatives from eight of the nine Tribes met in person with the First Lady, OHAs' Tribal Affairs Director, and staff from the Governor's Office. BHTC staff presented on the existing alignment between the Tribal Strategic Plan and the recommendations of the Talent Council and then solicited feedback from Tribal representatives. Find below a summary of the feedback that emerged from that conversation:

- Tribes have to be creative in finding BH workers. They often have to pay above market rate or contract with remote workers. It can be expensive for them.
- Workers are needed who can work with both adult and adolescent/youth populations.
- BH workers need to understand the effects of intergenerational trauma on all native clients they work with and be culturally competent to address that trauma.
- Flexible hours could help incentivize workers to work in rural settings, including allowing some workers to work part-time.
- Young people may not be interested in becoming BH workers and we must help to support more interest.
- It is important to continue focusing on prevention and valuing prevention specialists.
- The Tribes stick together and learn from each other. Best practices are adopted by other Tribes. This could be a model for the counties.
- The Community Health Aide Program (started in Alaska) is a fantastic program for creating an entry-level behavioral health work pipeline. It allows for "grow-your-own" model and teaches culturally sensitive care. More work needs to be done on billing to allow it to expand.
- Culturally sensitive training should include tools to work with members from all different Tribes, as all have different trauma to understand.
- Certified Recovery Mentors are an important part of the workforce and need better stepping stones to advance through the field.
- Behavioral health workers are still very underpaid compared to other masters-level positions. We have come a long way in recognizing that mental health is as important as physical health but pay has lagged.
- Administrative rules need to be reviewed and updated so that Tribes and other providers can properly bill for certain employees/ services.
- Mismatches in supervision are making it more difficult to hire in some settings, we need to expand the type of people who can provide supervision hours for both licensed staff and peers.
- There are still significant structural barriers to providing integrated mental health and substance use services, even though that is the most effective model. Providers have to do a lot of work to maintain firewalls between different services, and even people who don't work directly with clients (i.e. finance department) have to go through onerous background checks for mental health system. This burden is preventing expansion for some providers.

Appendix D. CSO Engagement

The Behavioral Health Talent Assessment identified a lack of access to culturally competent behavioral health services as a critical gap in Oregon's behavioral health system. This gap is largely driven by a shortage of culturally specific and multilingual behavioral health providers; it is crucial that we develop systems to educate, recruit, and support those providers if we want to meet the needs of our communities.

The First Lady and staff from the Behavioral Health Talent Council met with organizations that provide or support culturally specific behavioral health services to receive feedback on the work of the Talent Council and provide a forum for discussing the needs of the culturally specific behavioral health workforce. Below, find a summary of the themes and recommendations that emerged from those conversations.

Participants:

Adelante Mujeres: *Founded in 2002, Adelante Mujeres provides holistic education and empowerment opportunities to marginalized Latina women and families to ensure full participation and active leadership in the community. Through their Clinica Esperanza they provide inclusive, compassionate, and comprehensive mental health services to women and families in their community. They also serve as a training site for mental health practicum students.*

AHO! Wellness Tech: *AHO! Wellness Tech partners with organizations to help emerging and senior leaders to build Wellness-Conscious Leadership cultures grounded in traditional and multilingual practices, replacing burnout and survival mode with sustainable energy, emotional resilience, and aligned decision-making.*

Asian Health and Service Center: *First opened in 1983 in the basement of the Chinese Presbyterian Church with one and half employees, the Asian Health and Service Center provides physical and mental health services, public health and wellness programs, and community engagement opportunities for the Portland Metro region's growing Asian population. They provide culturally specific therapeutic services in Cantonese-Chinese, Mandarin-Chinese, Korean, Vietnamese, and English, and their vision is to reduce health inequity and improve health care quality for all Asians.*

Avel Gordly Center for Healing: *The Avel Gordly Center for Healing at the Oregon Health and Science University provides mental health services to all while also providing Afro-centric, culturally responsive and specific services. The Center uses trauma-informed practices and helps with healing in children, adults, couples, families, and community while engaging the community through teaching and training.*

Capaces: *The Capaces Leadership Institute strengthens the wellness, capacity, and political consciousness of individuals, organizations, movements, and community to eliminate social disparities. Their Alianza Poder Community Health Workers Hub certifies local BIPOC Community Health Workers and provides seed funding to expand CHW teams across partner organizations, enhancing community well-being and promoting health equity through culturally tailored training focused on social determinants of health and challenging community environments.*

Dian's Well: *Dian's Well Counseling specializes in serving trans and gender expansive adults living in Oregon. They are dedicated to providing quality mental health services, including therapy, groups, peer support, and more. They are social justice oriented and believe strongly in the tenets of cultural humility.*

Latino Network: *Latino Network is a Latine-led education organization, grounded in culturally specific practices and services, that lifts up youth and families to reach their full potential. Their Zenit Centro de Serenidad was founded to advance the mental health of Latines by increasing access to high-quality, culturally relevant treatment services. They are committed to expanding and diversifying the culturally specific mental health workforce to better serve Latine communities.*

NARA NW: *Founded in 1970 in Portland, Oregon, the Native American Rehabilitation Association of the Northwest, Inc. is an American Indian-owned, American Indian-operated, non-profit agency. Originally an outpatient substance abuse treatment center, NARA NW now operates a residential family treatment center, an outpatient treatment center, a child and family services center, a primary health care clinic, several adult mental health locations, a wellness center, and transitional housing for AI/AN participants.*

Oregon Change Clinic: *The Oregon Change Clinic is a culturally specific outpatient treatment facility for substance use recovery and mental health treatment. OCC specializes in working with Black, Indigenous, and People of Color (BIPOC) communities in Portland, Oregon. They also provide highly supported, temporary housing for clients in their Intensive Outpatient Treatment program.*

Prism Health: *Prism Health is a center of excellence for comprehensive, compassionate, and culturally affirming healthcare for everyone, addressing long-standing gaps in healthcare. Originally created to meet the evolving care needs of our LGBTQ+ community and beyond, their goal is to create a safe and affirming atmosphere that ensures everyone receives the comprehensive care they deserve.*

Themes and Recommendations

Note: *The majority of the recommendations that came out of these discussions were in alignment with existing Behavioral Health Talent Council Action Plans, and those recommendations have been listed here with references to those action plans. Recommendations that were not included in an existing plan have been listed at the bottom of this appendix and have been flagged for the Governor's Office for additional implementation planning.*

Educating Young People and Fighting Stigma

Many providers mentioned the challenge of addressing stigma in their communities against mental illness and mental health treatment. While the form that that stigma takes can vary from community to community, the common solution is to normalize talking about mental health from a young age and expose young people to opportunities for mental health careers from middle school onward.

- Support opportunities for young people to shadow behavioral health workers or otherwise gain real life experience in the field. **Included in action plans.**
- Offer early behavioral health education opportunities in multiple languages. **Included in action plans.**
- Continue to support educational programs that provide culturally responsive education in the face of federal pressure on those programs. **Included in action plans.**
- Educate supervisors/mentors in culturally humble and trauma-informed methods of supervision. Eliminate "suck it up" mentality. **Included in action plans.**

Supporting International/Out-of-State/Immigrant Workers

Often workers coming to the United States or to Oregon from elsewhere have vital skills and experience to the workforce, but there can be significant barriers to them being able to work in Oregon.

- Fund H1-B visas for behavioral health workers in Oregon. **Additional feedback.**
- Provide guidance on navigating licensure for people with out-of-state or out-of-country licenses/professional experience. **Included in action plans.**
- Streamline the variance process for licensing/credentialing. **Additional feedback.**

Building Community and Resilience in the Workforce

Having access to a meaningful community of peers and mentors is crucial to reducing burnout and building investment in the profession for workers. Isolation and uncertainty make the already-difficult work of behavioral health workers even more difficult; Knowing that you have people who can support you, answer questions, or just be a welcoming space for you can help people maintain strength and hope.

- Pilot inclusive behavioral health curricula with mentorship. **Included in action plans.**
- Pay increase for culturally specific clinical supervisors to recognize the value of what they teach and give them the opportunity to remain with organizations that share their values. **Included in action plans.**
- Restore funding for a coordinator for the Cultural Alliance. **Additional feedback.**
- Support the building of culturally specific spaces and communities for workers, including group chats, regular meetings, and retreats/trainings. **Included in action plans.**
- Provide continuous professional development funding, including funding to attend culturally specific conferences. **Included in action plans.**
- Create and/or support behavioral health councils/advisory groups for culturally specific workers. **Additional feedback.**

Expanding Pathways for Traditional Health Workers (THWs)/Community Health Workers (CHWs)

THW/CHW roles provide an opportunity for people to begin a career in the behavioral health field for people without master's degrees and can be an opportunity to bring bilingual workers and immigrants with training and experience in their previous countries into the workforce. Supporting organizations in incorporating THWs/CHWs into their teams would make it more feasible for organizations to employ these valuable workers in roles such as case management, while freeing up licensed personnel to operate at the top of their licenses.

Create more opportunities for THWs/CHWs, which in turn will create a pipeline into other licensures/positions. **Included in action plans.**

- Expand the services for which THWs and CHWs can bill. **Additional feedback.**
- Simplify billing processes for THWs and CHWs. **Additional feedback.**
- Create templates for approved traditional treatments that are effective but not regularly documented. **Additional feedback.**

Supporting Culturally Specific Organizations in Training and Retaining Their Workers

Culturally specific organizations often serve as a training ground for new workers, including recent immigrants, because of the depth of experience that the provide. However, due to the demands of the work and the relatively low pay that they can offer, those workers often end up leaving for larger organizations or private practice after getting their licensure.

- Continue to support CSOs financially through CLSS coding. **Additional feedback.**
- Create a how-to guide for culturally specific clinical supervision. **Included in action plans.**
- Provide funding to CSOs to sponsor staff to get their master's degrees in exchange for continuing to work with the organization for some period. **Included in action plans.**
- Provide additional incentives for behavioral health workers to work for culturally specific organizations (scholarships/loan forgiveness, pay differentials, retention bonuses) and make sure that existing incentives are distributed equitably. **Included in action plans.**
- Provide funding for smaller organizations to adopt workable Electronic Health Records systems. **Additional feedback.**

Expanding Access for Rural Communities

Providing culturally specific services to rural communities comes with its own unique challenges. Many of those communities are too

small to support culturally specific providers of their own, and members of some minority communities do not necessarily feel safe seeking out behavioral health treatment (or know who is safe to seek it from) in some rural communities.

- Support models for larger CSOs to partner with rural providers to provide support and training. **Included in action plans.**
- Create clearer maps of resources in rural areas and connect them to resources in urban areas that may not be available in rural areas. **Included in action plans.**

Supporting the Peer Workforce

Peers are particularly vital in delivering culturally specific behavioral health services, since they come from the communities they serve and are often able to communicate, build trust, and relate to clients in ways that people outside of the community cannot.

- Clearly communicate the value and role of peers in the behavioral health workforce (professionals with robust training and experience, not just "volunteers that used to be clients.") **Additional feedback.**
- Invest in a peer career pipeline starting in high school. **Included in action plans.**
- Integrate peers into policy development and curriculum-building for the peer workforce. **Additional feedback.**
- Create more peer-specific training and education that recognizes their unique role in behavioral health treatment. **Included in action plans.**
- Encourage clinicians to engage in peer coursework to give them a deeper understanding of the roles peers can play on their teams. **Additional feedback.**

Fostering a Bilingual/Multilingual Workforce

Bilingual/multilingual behavioral health workers are crucial to providing services to diverse communities. While employing translators or interpreters can help to bridge language gaps, these services can be expensive and inefficient at a time when provider hours are a crucial resource. Additionally, being able to speak directly with the provider helps to establish rapport and openness for the client.

- Expand the availability of Spanish-language behavioral health education. Many bilingual providers actually have to be able to speak Spanish with clients, then chart in English, and know clinical terms in both Spanish and English, which is challenging even for many bilingual people. **Included in action plans.**
- Encourage bilingual/multilingual people to enter the field through scholarships and other supports. **Included in action plans.**
- Provide support for bilingual/multilingual workers in their documentation. **Additional feedback.**

Supporting Culturally Specific Organizations through Crises in their Communities

Many minority communities have recently been targeted by the federal government, leading to increased trauma for those communities and increased acuity being treated by culturally specific providers. This in turn makes those providers more susceptible to burnout and compassion fatigue.

- Provide emergency funding for culturally specific providers whose communities are experiencing severe systemic trauma, to allow them to reduce the caseloads of their providers/provide more intensive services to their community members. **Additional feedback.**
- Support workforce wellness efforts through culturally specific organizations. **Included in action plans.**
- Provide legal rights training/other trainings for emergent situations. **Additional feedback.**
- Provide grants for securing spaces and keeping people safe. **Included in action plans.**

Recognizing and Valuing Behavioral Health Workers as a Crucial Part of our Community

Many people, particularly young people, never consider behavioral health careers because they see "caring professions" as underpaid and undervalued, with workers expected to accept poor conditions simply because they care about helping others. It is important to clearly show how vital behavioral health workers are, both through material support and elevation of their importance in our communities.

- Publicly recognize the importance of behavioral health workers, and specifically of culturally responsive behavioral health workers. **Additional feedback.**
- Fund and support bilingual/bicultural leadership capacity, not just pipelines into entry-level support roles. **Included in action plans.**
- Create more opportunities for behavioral health workers, including peers, to engage in policy-making discussions, providing education and training, and curriculum development (this will also help with burnout by letting those workers take some time away from direct service to do other work). **Additional feedback.**
- Work to build a less oppositional and more supportive relationship with the State. The State is often in an oppositional position to providers (auditing, monitoring) which creates a sense of fear rather than support. The State should work to provide guidance, catch potential problems early, and help to solve them rather than look to punish them. Consider more frequent audits for small/recently established providers, with a focus on guidance and support. **Additional feedback.**

The following additional recommendations were not included in the initial action plans and have been identified above as "additional feedback" which should be considered for further implementation work by the Governor with the report.

- Fund H1-B visas for behavioral health workers in Oregon.
- Streamline the variance process for licensing/credentialing for workers with out-of-state/out-of-country credentials/experience.
- Restore funding for a coordinator for the Cultural Alliance
- Create and/or support behavioral health councils/advisory groups for culturally specific workers.
- Expand the services that THWs/CHWs can bill for and simplify their billing processes.
- Create templates for approved traditional treatments that are effective but not regularly documented.
- Work to build a less oppositional and more supportive relationship between providers and the State and focus on problem-solving instead of punishment.
- Provide funding for smaller organizations to adopt workable Electronic Health Records systems.
- Clearly communicate the value and role of peers in the behavioral health workforce.
- Integrate peers into policy development and curriculum-building for the peer workforce.
- Encourage clinicians to engage in peer coursework to give them a deeper understanding of the roles peers can play on their teams.
- Provide support for bilingual/multilingual workers in their documentation.
- Provide emergency funding for culturally specific providers whose communities are experiencing severe systemic trauma.
- Provide legal rights training/other trainings for emergent situations.
- Publicly recognize the importance of behavioral health workers, and specifically culturally responsive workers.
- Create more opportunities for behavioral health workers to engage in policymaking, provide education and training, and engage in curriculum development
- Continue to support CSOs financially through CLSS coding.

Appendix E. Frontline Worker Engagement

The First Lady and Governor's Office hosted a round table with frontline behavioral health workers in the Portland Metro area to share about the council's work and receive feedback on draft action plans designed to support the workforce.

During this conversation, frontline workers shared a number of recommendations that have been incorporated into existing Talent Council action plans. These include:

- Prioritize worker safety and involve organizational leadership in the process of making sure that workers are safe. **Included in action plans.**
- Adopt safety best practices that include consideration of:
  - Cameras in residential facilities.
  - Two people per shift in residential.
  - Two people for home and community based visits.
  - Locking staff offices in residential programs.
  - Routine safety checks of equipment including medical devices and panic buttons.
  - Safety protocol training for staff including de-escalation training upon hire with periodic refresh training.
  - **Included in action plans.**
- Pay staff a livable wage. **Included in action plans.**
- Create more professional advancement opportunities to retain staff in the field. **Included in action plans.**

Recommendations regarding safety are included in the recruitment and retention subcommittee's "Support workforce" action plan (**RR.2**), while those regarding pay align with the recruitment and retention subcommittee's action plans on compensation and incentives (**RR.4**).

The following additional recommendations were not included in the initial action plans and have been identified above as "additional feedback" which should be considered for further implementation work by the Governor with the report.

- Improve public safety responses to ensure safety of mobile crisis teams.
- Maintain services for people who are experiencing homelessness to allow them to be successful in treatment.
- Center the voices and experience of frontline staff in their organizations.
- Consider designating mobile crisis workers as "First Responders" along with the benefits and respect that comes with that title.
- Count collateral conversations with client family and community as face-to-face hours for licensure of crisis workers.

Appendix F. Legislative Work Group Alignment

To further inform the Behavioral Health Talent Council's work, the First Lady and the Governor's Office conducted ongoing coordination with active legislative workgroups with focuses related to the behavioral health workforce. This engagement included direct participation from HB 2235 and ADPC members on the council or it's subcommittees, legislative workgroup presentations to council subcommittees, council presentations to legislative workgroups, and outreach from the Governor's Office to legislative workgroup leadership to share overlapping efforts, identify shared goals, review draft reports, and invite feedback. These efforts yielded considerable alignment with the feedback shared and the action plans developed by the council.

Once legislative workgroups finalized their reports in December, the Governor's Office thoroughly analyzed 54 recommendations from the workgroup reports alongside the recommendations from the HECC Talent Assessment and the council's action plans. 23 legislative workgroup recommendations are directly in alignment and represented within council action plans, 19 legislative recommendations are related to workforce and are not represented in a council action plan, and 12 legislative workgroup recommendations are not directly related to workforce and not represented within council action plans.

The following tables identify which legislative workgroup recommendations are directly in alignment with the council's action plans and which have been identified as additional feedback for the Governor's consideration.

Table 1. Legislative workgroup recommendations that are directly in alignment and represented within council action plans.

Workgroup	Recommendation	Description	BHTC Action Plan
ADPC	Develop partnerships OYA / DOC	Develop partnerships between Oregon Youth Authority (OYA) and Department of Corrections (DOC) facilities for workforce placement of youth and young adults in custody	Entry-Level Behavioral Health Positions
HB 2235	Peers with lived experience	Expand strategies to recruit those individuals with lived prior experience and peers	Supporting Lived Experience
HB 4151	BH Workforce Clearinghouse	Central space for information on career tracks in BH, professional networking, training and professional development, management and supervision consultation, and workforce data collection and reporting	Supporting Lived Experience
HB 2235	Licensure delays and inconsistent processes	Eliminate licensing delays with transparent standardization, resources and supports (staffing, technology)	Streamlining
ADPC	Standardize graduate curriculum to include substance use treatment	Work with HECC, large graduate schools and licensing boards to develop a standard graduate level curriculum for mental health clinical training that includes treatment of substance use, especially for youth and families.	Develop clear pathways

Workgroup	Recommendation	Description	BHTC Action Plan
ADPC	Expand career and tech training - high school	Expand Career and Technical Education for high school aged youth interested in recovery mentorship and alcohol and drug counseling.	Develop clear pathways
HB 2235	Supervisor Support	Develop supervisor supports: CLSS, acute care, continuing ed, flexible training, subsidize 30hr clinical supervision training, clinical supervision grant expansion, and loan forgiveness/ repayment opportunities.	Supporting the Workforce
HB 2235	Provider caseload size and wellness	Reduce provider burnout through caseload limits and enhanced support: consultation networks, wellness stipends and programs.	Supporting the Workforce
ADPC	Peer Recovery Support Services (PRSS) guidance	ADPC to prioritize the development of PRSS guidance and site-specific issue briefs in alignment with findings of the Behavioral Health Talent Council.	Supporting the Workforce
HB 2235	Documentation requirements	Increase parity and alignment with the medical field for documentation standards, reducing paperwork and administrative burdens across all provider service settings. Embrace Artificial Intelligence (AI) technologies	Admin Burden
HB 2235	Provider credentialing	Centralize the credentialing process at the state level or through coordinated efforts among CCOs, contracted vendor with blended funding from OHA and health plans - revisit Oregon Common Credentialing Program	Admin Burden
HB 2235	Contract and regulatory standards	Streamline contract and regulatory standards - more specific (cap in outpatient settings), more flexible (rural areas), capitations in collaboration with providers and organizations working within these settings and implement a variance for rural/frontier settings and specific populations.	Admin Burden
HB 2235	Constraints of COA	Revise COA process to eliminate redundancies, allow for accreditation with equivalent regulatory bodies to fulfill OHA audits, and bolster support/resources for the audit process, particularly fidelity audits and specialty programs.	Admin Burden
HB 4092	Statues and OAR burden	Statutes and OARS governing the behavioral health system and contractual agreements implement a system that is in alignment with each other.	Admin Burden

Workgroup	Recommendation	Description	BHTC Action Plan
HB 4092	Review / update OAR 309	1.) Rules for fidelity based programs will be reviewed every 3-5 years and not as standalone fidelity based programs. Address rural areas implementation of fidelity based programs. 2.) Clarify and streamline assessments across SUD and MH. 3.) Certification of unlicensed providers - registry and standardized expectations	Admin Burden
HB 4092	Update OARs 309-018, -019 and -022	TAB recommendations where not considered	Admin Burden
HB 4092	OHA - new reporting system Admin Burden concern	ROADS implementation delayed, REALD data collection, providers are concerned about the potential administrative workload increases tied to this new system.	Admin Burden
HB 4092	Enhance COA databank accessibility	COA (Certificate of Approval) databank, required in ORS, creates a publicly accessible dashboard for verification, improvements are not completed, and databank is not completely functional to meet the needs of CCOs and providers.	Admin Burden
HB 2235	Financial barriers due to high education costs	Continue funding programs supporting loan repayment and tuition assistance to offset the cost of education for the Behavioral Health workforce. Consider reducing the requirements for loan forgiveness programs from 32-28 direct service hours.	Culturally Responsive Workforce/ Incentives
HB 2235	Latine/x/a/o professional supports	Develop and invest in early education career pathways, early mentorship, expand Spanish language tracks, loan forgiveness/repayment, expand eligibility enhanced payment qualification, financial incentives, recognize Latin American 5-year psychology degrees as equivalent for QMHPs, Spanish-language exam options, clinical supervision and documentation in Spanish, peer mentorship/supervision, and legislatively mandate cross-sector council to promote equitable advancement of Latinx BH providers.	Culturally Responsive Workforce/ Incentives
ADPC	Incentivize MH and SU certificates/licenses	Create an incentive program through licensing and certification boards, schools, and peer training centers (individual scholarships and/or grants to organizations).	Culturally Responsive Workforce/ Incentives

Workgroup	Recommendation	Description	BHTC Action Plan
ADPC	Co-occurring certification or endorsement	Create a co-occurring certification or endorsement, combining elements of Qualified Mental Health Associate (QMHA), QMHP, and CADC tracks.	Culturally Responsive Workforce/ Incentives
HB 2235	Low provider salaries	Raise reimbursement rates and salary standards for CMHP, safety net services, and specialty programs providing higher levels of care and team-based approaches. Raise admin cap above 10%.	Compensation

Table 2. Legislative workgroup recommendations that are not currently represented in the council's action plans

Workgroup	Recommendation	Description
HB 2235	Barriers to licensure	Expand licensure pathways for out-of-state, military, and non-traditional applicants
HB 2235	Subsidize licensure and certification fees	Subsidize initial licensing and/or credentialing fees for Behavioral Health providers through their respective regulatory boards. Fund CCO's to provide CEUs.
HB 2235	Clinical supervision	For those previously licensed in another state, require only one year of prior supervisory experience to be eligible to provide clinical supervision in Oregon.
HB 2235	Licensure requirements for associates	Re-examine mandatory wait times required for Associates to obtain licensure, and/or consider adopting a competency-based framework when determining Associates' readiness for licensure.
HB 2235	Clarify roles of certified professionals	Convene a workgroup of licensed providers, subject matter experts, and other key partners to clearly define and expand the roles of QMHAs, Wellness Specialists, Peer Supports/Specialists, and other certified professionals.
HB 2235	Reimbursement disparities across certifications	Add reimbursement differential/modifier for the QMHA-II, may affect other behavioral health credentials.
HB 2235	Burdensome administrative rules	Convene a task force to review and streamline the Certificate of Approval (COA) process
HB 2235	Medicaid billing options	Expand Medicaid billing beyond COA to rural integrated care settings, FQHCs, and certain Tribal BH programs, examine revenue generating opportunities, and provide TA on COA process (Collaborative Care model).
HB 2235	Value-based payments	Convene a dedicated task force or workgroup, to further evaluate and provide recommendations on the design, implementation, and cost coverage of Value-Based Payment (VBP) models in Behavioral Health settings.

Workgroup	Recommendation	Description
HB 2235	Long-term stable funding	Approve multi-year funding extensions for all current OHA-based incentive programs (e.g., loan repayment, stipends, tuition assistance, etc.).
HB 2235	Acute care provider training	Specialized tracks and training placements in acute client services, integrate clinical and practice skills for this setting into Career Technical Education and throughout licensure, provide crisis management, suicide assessment, and substance use detection/ intervention at low/no cost.
HB 4092	Medicaid and Behavioral Health Division - rule making alignment	One rule making web page for all of OHA.
HB 4092	Rulemaking transparency	Create a space for the agency, providers, patient advocates, CCOs, and others to identify concerns and listen for solutions in a shared space an (at least) annual basis.
HB 4092	Analyze/Refine current compliance training practices	OHA in partnership with ODHS to align rulemaking process.
HB 4092	TAB guiding principles	Workgroup believes OHA needs to more consistently follow the adopted TAB guiding principles
HB 4092	Rule interpretation guides for OHA	Clarity with proposed rule and adopted rule after changes - through the rulemaking process.
HB 4092	OHA's approach to rule attribution	The Workgroup is unclear on the status of this work.
HB 4092	Establish scheduled opportunities to update ORS 430.637 and 430.638	Create a space to address updated rules and have conversations around potential changes.
HB 4092	OHA to improve their OBCC bed registry system	Workgroup sees value in a statewide bed registry system but has serious frustrations with OHA's current bed registry as it has proved neither cost-efficient nor useful.
HB 4092	Update and strengthen statutes	ORS 414 and 430 pertaining to behavioral health - Clarify and streamline committees and advisory bodies, Consolidate and align consumer rights, update/define terminology, apply terms for funding dependent services
HB 4092	OHA to address the issue of patients boarding in hospitals	Placement shortages, OHA is responsible for creating a healthy, sustainable and accessible network of care.
HB 4092	OHA needs to clarify roles and responsibilities for care coordination	Care coordination functions are redundant and lack clarity about which entity is responsible for coordinating patient care and in which circumstance. System should promote real time care coordination and eliminate redundant data reporting.

Workgroup	Recommendation	Description
HB 4092	CHMPs & hospitals should utilize a shared template for an MOU	A shared template for MOUs outlining how CMHPs and hospitals work together could help facilitate a more efficient and consistent system across the state.
HB 4092	Regular cost studies	Ensure cost studies required by HB 4092 are conducted every 5 years.
HB 4092	OHA to address severe lack of transport providers	OHA to secure transportation capacity and funding
HB 4151	New Youth BH Credential	Mental Health Regulatory Agency (MHRA) create a credential for a licensed bachelor's level youth behavioral health provider
HB 4151	Expand BH Career and Technical Education (CTE)	Allocate additional resources for development and implementation of behavioral health career and technical education (CTE) programs and other pre-apprenticeship and early workforce readiness initiatives. Implementation of this recommendation should be aligned with existing OHA grants, scholarships for CTE program participants, and other public and foundation revenue streams.
HB 4151	Pay Parity	Share the results of the Myers and Stauffer rate study launched with youth providers in October 2024. Develop a rate formula to be used going forward that utilizes current wage and expense data. Institute a regular review of rates based on the rate formula developed.
HB 4151	Expand Settings for Registered BSW scope of practice	Expand settings where individuals with a Registered Bachelor's in Social Work (RBSW) can practice, and expand billing of Oregon Health Plan for services
ADPC	Create a mental health service professional grant program	Replicate aspects of the US Department of Education's Mental Health Service Professional Demonstration Grant Program
ADPC	Reimbursement of non-licensed behavioral health staff	Assess barriers to public and commercial insurance reimbursement of non-licensed behavioral health staff including Qualified Mental Health Professionals (QMHP), CADCs, and Peer Supports (Youth Peer Support Specialists and Certified Recovery Mentors).

Appendix G. Additional Talent Assessment Recommendations

The following table identifies recommendations from the HECC's Talent Assessment report that were not addressed through a single action because they were either infused throughout all action plans or should be considered in the future.

Talent Assessment Recommendation	Description	Notes
DEI	Infuse principles of equity and inclusion to diversify and expand the talent pipeline	Lens, factored into all action plans
DEI: barrier busting	Identify and then reduce barriers for BIPOC individuals seeking a career in BH	Lens, factored into all action plans
Diversity: data	Use data to intentionally inform initiatives focused on increasing workforce diversity	Lens, factored into all action plans
Support workers and supervisors: acuity matching	Pair acute clients with appropriately trained providers	Recommendation requires further investigation due to complex funding strategy and the need for caseload mix of acuity to prevent burnout for seasoned providers.
Support workers: reduce staff to client ratio	Reduce staff-to-client ratio	Recommendation is a goal of multiple action plans and doesn't require a standalone plan.
Licensure process: national initiatives	Explore national initiatives such as the National Center for Interstate Compacts, the social work licensure compact, as well as the National Mental Health Workforce collaborative	Recommendation requires further investigation into implementation and standardizing quality of care.
Data: data center	Create a state data center overseen by a data methodologist	This recommendation would require resources to implement and should be explored after highest priority action plans with a fiscal are advanced (e.g., workforce investments)
Data: collection	Enhance IPEDS and BH data processes/protocols to consistently capture primary, relevant, and current data	This recommendation would require resources to implement, and should be explored after highest priority action plans with a fiscal are advanced (e.g., workforce investments)
Data: sharing	Make data readily available for others to access and analyze, for use across stakeholders	This recommendation would require resources to implement, and should be explored after highest priority action plans with a fiscal are advanced (e.g., workforce investments)

Talent Assessment Recommendation	Description	Notes
9C. Data: benchmarks and ongoing eval	Fund a large, primary data collection initiative that leverages an annual longitudinal survey to establish benchmarks and assess where legislative and regulatory initiatives are effectively improving the workforce	This recommendation would require resources to implement, and should be explored after highest priority action plans with a fiscal are advanced (e.g., workforce investments)
3 Increase Access to Educational Programs	Increase access to and financial support for BH-related educational programs to address faculty shortages and regional gaps in access, opportunities, and number of BH professionals.	Requires broad institutional changes to hiring and financing structures beyond the current scope
3A Faculty Salaries	Create pipelines for BH faculty with salaries that support the cost of living.	Requires broad institutional changes to hiring and financing structures beyond the current scope
3E Education & Training Program Funding	Recognize that state funding for educational/training programs needs to come with a 5-to-6-year timeline so that programming can be fully developed and sustainable; accreditation for programs can take up to three years.	Requires systemic changes to higher education financing models beyond the current scope.
3F Cost of Education	Lower the cost of education to increase access, especially for community college and public universitates.	Requires systemic changes to higher education financing models beyond the current scope.
5B Community College Funding	Expand support for community colleges as a step to a bachelor's and beyond: give additional funding to community colleges that have students going on to bachelor's programs.	Requires systemic changes to higher education financing models beyond the current scope.

Appendix H. Full Action Plans

Recruitment and Retention Action Plans 1 – 5

Administrative Burden Action Plan 1

Recruitment and Retention

Purpose

The following action plan covers recommendations established by the Higher Education Coordinating Commission (HECC) that are adopted by the Governor's Behavioral Health Talent Council (BHTC) to establish best practices for supporting the behavioral health workforce. Unnecessary administrative tasks take valuable time away from supporting clients and contribute to provider burnout. This action plan is focused on actions that will enhance provider capacity and client care by streamlining documentation, oversight, and administrative processes through rule revision, technology integration, and standardized templates.

Recommendation Summary

After reviewing the Administrative Burden recommendations from the Behavioral Health Talent Assessment, the Recruitment and Retention Subcommittee recommends:

- The Individual Provider Experience and Prevention of Burnout
    - Create standardized charting and documentation templates to meet minimally necessary federal requirements
    - Provide access to AI health technology tools in behavioral health services
    - Define and protect dedicated administrative time
- Executive and Systemic-Level Reduction of Administrative Burden
    - Revise OHA rules and policies governing behavioral health programs to reduce administrative burdens on providers by promoting parity in documentation with physical healthcare, reduce fidelity requirements and align reporting with federal requirements.
    - Eliminate low-value requirements, move to outcomes-based measures and benchmarks.
    - Establish a centralized grant administration system for OHA to streamline and standardize reporting, auditing, and reduce excessive information and data requests across behavioral health grant programs

Talent Assessment Recommendations

Recommendation	
7C(ii) Admin Burden	Review and simplify administrative burdens placed on BH providers and supervisors to strike a balance between ensuring high-quality patient care without over-burdening providers
7D(ii) Admin Burden	Address the administrative burden on care providers and supervisors; rethink, revise, and simplify reporting, billing, and current redundancies in process and protocols

Goals

- Increase retention of community behavioral health workforce
- Reduce workload on individual providers and their employers
- Increase behavioral health system efficiency
- Maximize workforce time and focus on providing high quality care

Subcommittee Action Recommendations Strategy/ Overview

Strategy: *1.1 Create standardized charting and documentation templates.*

Deliverable: *Research integrated technology, such as AI tools, for charting and documentation OHA will provide guidance that addresses HIPAA, 42 CFR and other privacy concerns in the implementation of AI. Develop Standardized Documentation Templates. OHA will collaborate with providers to design clear and streamlined Electronic Health Record (EHR) templates, including treatment plans, for common visit types that support minimally necessary requirements. Organizations can customize if additional components are desired. DAS to identify best procurement pathway to facilitate AI health technology deployment, including a comparison of state-wide contracting, grant program. Assessment of integrated technology (AI) Standardized templates for charting, documentation, treatment plans, AI scribe implementation.*

Responsible Agency: *OHA*

Fiscal/ No Fiscal: *Minimal fiscal*

Timeline: *12 months*

Strategy: *1.2 Revise OHA rules and policies regarding documentation, reporting, and audit requirements for simplification and parity across disciplines.*

Deliverable: *OHA will revise the 309 Administrative rules to streamline clinical documentation to federal minimum necessary requirements. Use AI to query and assess OHA reporting requirements, rules and policies. Determine which reports are duplicative and add value or are federally required. Eliminate low value reporting requirements Redefine audits and review processes to focus on client-centered outcomes vs. compliance alone. OHA will contract with a third party to provide organizational evaluation, consultation and technical assistance for organizations that are consistently not meeting expectations through audits or other metrics that could lead to termination of COA or contractual agreements. Reduce fidelity program requirements based on emerging evidence and addressing economy of scale requirements for rural providers. Select a centralized credentialing platform that all CCOs are required to use for elimination of duplicative processes. Streamlined rules and policies. Reduced paperwork for frontline staff. Crosswalk of documentation and reporting requirements across disciplines, rules and contracts. Reduction of duplicative processes that require additional administrative staff, effectively increasing resource available for service provision. Fewer required low value or duplicative reports*

Responsible Agency: *OHA*

Fiscal/ No Fiscal: *No fiscal*

Timeline: *6-9 months*

Strategy: *1.3 Define and protect dedicated admin time for workforce.*

Deliverable: *Define and protect paid administrative time in OHA contracts and/or agency staffing models. Provide agency support to conduct regular audits of internal processes to eliminate unnecessary or inefficient administrative steps. Adjust contract terms to include agency audit of administrative procedures and protect admin time.*

Responsible Agency: *OHA*

Fiscal/ No Fiscal: *No fiscal*

Timeline: *6-9 months*

Strategy: *1.4 Centralized grant administration system improvement for OHA.*

Deliverable: *OHA will adopt the mission of reducing administrative burden by creating a centralized grant administration and cross agency reporting unit that assesses and evaluates reporting requirements to eliminate duplicative reporting, ensures high value reporting. OHA will develop and support an administrative burden governing body to oversee the totality of reporting and clinical documentation requirements and provide an analysis of the necessity of the requirements. The governing board will include provider organizations, CCO, CMHP and consumer advocates. OHA will report to the legislature and the Governor every two years on reporting requirements. Inventory of all grantmaking and reporting requirements and ensure reporting is aligned and not duplicative. Recommendation of grant administration system improvements Ongoing accountability to minimize the addition of more requirements*

Responsible Agency: *OHA*

Fiscal/ No Fiscal: *No fiscal*

Timeline: *12 months*

Anticipated Implementation Barriers

- Concerns for privacy with the use of AI that integrates with Electronic Health Records
- Cost of AI programs
- Bureaucratic “red tape” linked to making changes to audit standards. State Plan Amendment change to reduce documentation requirements.
- Care Coordination Organization (CCO) “buy in”, alignment, and slow implementation and additional steps for credentialing unlicensed staff.
- Federally established Medicaid standards require bi-partisan effort with other states to identify a shared ask for reduced regulatory requirements that are overly burdensome

Equity Opportunities

Administrative burden on staff creates significant equity impacts by disproportionately harming marginalized groups and the frontline employees who serve them. Excessive rules, complex procedures and unnecessary paperwork frustrate staff, decrease morale and reduce their ability to provide quality service. For staff, the burden translates to burnout and stress; for consumers, they can experience frustrated and dissatisfied service providers where the process and documentation of care is more important than the care itself. An equity lens may reveal how administrative burden affects different groups unequally. This assessment will be an important part of organizational administrative process auditing.

Workforce Supports Action Plan 2

Recruitment and Retention

Purpose

The following action plan covers recommendations established by the Higher Education Coordinating Commission (HECC) that are adopted by the Governor's Behavioral Health Talent Council (BHTC) to establish best practices for supporting the behavioral health workforce. This action plan aims to create programming that embeds supportive services, mentorship, and wraparound supports within behavioral health organizations to improve recruitment and retention.

Recommendation Summary

After reviewing the attached recommendations for the Behavioral Health Talent Assessment, the Recruitment and Retention Subcommittee recommends that we address workforce safety concerns, focus on recruiting and retaining supervisors who support individuals doing clinical practice, and offer professional development opportunities to retain staff.:

Talent Assessment Recommendations

Recommendation	
7C Supporting Workforce	Establish best practices for supporting workers and supervisors
8D Supporting Workforce	Create programming within organizations that have supportive services, mentorship, and wraparound support built in for staff
8 Cultural Representation in the Field	Infuse principles of equity and inclusion to diversify and expand the talent pipeline
7D Collaboration	Foster collaboration across agencies and stakeholders

Goals

- Increase retention by embedding supportive services (e.g., emotional support and anonymous therapy) for staff in high-trauma roles.
- Improve supervision quality through culturally appropriate, up-to-date training and support for clinical supervisors.
- Establish best practices for organizational environments that enable staff to thrive under stress.
- Promote peer-to-peer support across agencies to share trauma-informed strategies.
- Ensure safety and well-being of staff by strengthening safety standards and providing clear training, protocols, and guidelines.
- Support supervisors with incentives, training, and manageable caseloads.
- Advance equity by prioritizing culturally and linguistically specific supports, improving supervision pathways, and mandating anti-racism and anti-oppression trainings.

Subcommittee Action Recommendations Strategy Overview

Strategy: *2.1 Invest in Supervisor Development*

Deliverable: *OHA will contract with an entity or entities to provide statewide training programs that teach essential management and supervisor skills, offers mentorship and coaching for emerging leaders, and culturally responsive leadership training and development. Contracted entities will develop programming that is available to COA, culturally specific and other organizations part of the publicly funded behavioral health system. OHA and the Governor's office will develop and advocate for legislation to create non-refundable tax credits for clinical supervisors in culturally specific organizations and organizations that provide team-based care and serve high acuity clients as incentives to retain supervisors. This would require legislative approval. OHA to launch free CEUs for clinical supervisors working in publicly funded behavioral health settings, including clinical supervisory working for culturally specific providers. Training and culturally responsive leadership development contracted entity. Non-refundable tax credits for clinical supervisors and PMHNP preceptors. Free CEUs for clinical supervisors. Low-cost financial incentives for clinical supervisors and PMHNP preceptors in publicly funded community behavioral health system*

Responsible Agency: *OHA*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *9-12 months from funding + legislative action*

Strategy: *2.2 Workplace Safety*

Deliverable: *Alert organizations to the benefit of SAIF and workman compensation companies SAIF and workman compensation companies that conduct organizational workforce safety evaluations to address areas of concern proactively. Develop workforce safety best practice guidelines. Provide grant funding for safety technology (e.g. cameras; alert/panic button systems that connect to provider computer network for systemwide alerts and calls for assistance).*

Develop workforce safety best practice guidelines. Provide grant funding for safety technology (e.g. cameras; alert/panic button systems that connect to provider computer network for systemwide alerts and calls for assistance). Organizational workforce safety evaluations workforce safety best practice guidelines available statewide tied to organizational safety plans.

Responsible Agency: *OHA, OSHA*

Fiscal/ No Fiscal: *No fiscal*

Timeline: *6-9 months + legislative action*

Strategy: *2.3 Cultural Representation in the Field*

Deliverable: *Make SAMHSA cultural humility and clinical practice guidelines available via OHA's website. OHA will establish mentorship pathways for culturally specific staff and supervisors through a statewide network of culturally specific providers. SAMHSA cultural humility and clinical practice guidelines on OHA's website. Statewide network of culturally specific mentorship pathways*

Responsible Agency: *OHA*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-9 months from funding*

Strategy: *2.4 Supporting Workforce*

Deliverable: *Contract with statewide organizations, such as Riverside Trauma and the Oregon Wellness Program, that can respond via postvention to traumatic and sentinel events that happen within organizations. Postvention services can support both employees and management who may be traumatized by an event and help mitigate staff turnover. Promote legislation to support making improper restraint and seclusion a licensing matter rather than a child abuse investigation. The potential for founded abuse determinations, which have long term career implications, is disincentivizing future employees from working in children's residential programs. Provide guidelines on recommended caseload size for key roles. Contract for statewide organizational support. Caseload size guidelines. legislation to shift improper restraint and seclusion solely to licensing and credentialing units*

Responsible Agency: *OHA*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-9 months from funding*

Anticipated Implementation Barriers

- Lack of sustainable funding for support programs
- Supervisors carry high caseloads, leaving limited time to provide quality mentorship and supervision
- Minoritized providers, especially Black, Indigenous, People of Color, multilingual and LGBTQ+ staff lack culturally matched supervision and workplace support
- Rural agencies face unique service delivery issues and staffing shortages
- Inconsistent training standards create liability and unequal protection across organizations

Equity Opportunities

Ensure workplace training emphasizes cultural humility. Prioritize culturally specific supports and supervisors. Develop lists of anti-racism/anti-oppression training providers that can be shared, and subsidized CEUs should be offered to reduce cost barriers. Supports should expand access to care by strengthening workforce capacity in rural/frontier regions and culturally specific organizations.

Culturally Responsive Workforce Incentives and Cost of Education Action Plan 3

Recruitment and Retention

Purpose

The following action plan covers recommendations established by the Higher Education Coordinating Commission (HECC) that are adopted by the Governor's Behavioral Health Talent Council (BHTC) to support the behavioral health workforce. This action plan is focused on actions that will grow a more culturally responsive workforce and recruit and retain behavioral health talent by investing in financial incentives for education, clinical supervision and peer support development.

Recommendation Summary

After reviewing the culturally responsive and incentives recommendations from the Behavioral Health Talent Assessment, the Recruitment & Retention Subcommittee recommends the following actions:

- Establish region-specific "grow-your-own" behavioral health career roadmaps to encourage entry, training, and retention of local staff in Tribal, rural, and remote communities. These roadmaps will reflect regional cultural values, and community needs while prioritizing high-need service areas.
- Create financial incentives for roles in crisis response, rural areas, and culturally specific services.
- Invest in clinical supervision to recruit and retain high-quality frontline and supervisory staff.
- Invest in paid internships at an early enter point on the behavioral health education pathway.
- Invest in financial aid for education programs at the community college, bachelor's degree, and graduate level, tied to employment and service commitment in community mental health.
- Invest in the certified workforce (e.g., Peers, QMHAs, CADCs) and behavioral health clinical support roles (Behavioral Health Technicians, Medical Assistants, LPNs, RNs, BSNs) to grow the "entry-level" workforce, expand diversity of our workforce, and support their opportunities for career advancement as a retention strategy.
- Establish statewide operationalizing peer support program to provide technical assistance for organizations and mentoring for peer support workforce.

Talent Assessment Recommendations

Recommendations	
3G Financial Support	Support financial aid, scholarships, tuition reimbursement, and loan forgiveness programs
3H Alternative Options	Explore alternative options to cumbersome and confusing loan forgiveness programs
4D Incentives	Offer region-specific BH career roadmaps to encourage a grow-your-own approach for Tribal, rural, and remote communities
7 Education & Professional Development	Expand funding and resources for education and professional development
7A Financial Incentives	Expand tuition reimbursement programs; subsidize training opportunities and certification costs
7E(ii) Incentives	Fund students in predesignated areas/fields that are experiencing shortages and pair this with a two-year working commitment (e.g., CA title IV-E program focused on child welfare)

Recommendations	
8A Culturally Responsive Workforce	Create programming within organizations that have supportive services, mentorship, and wraparound support built in for staff
8C Incentives	Increase opportunities for the workforce to learn evidence-based practices, professional boundaries and safety, professional writing and digital literacy skills, resilience and self-care, cultural humility, and team-based care skills
8F Compensation	Develop clear career pathways that are supported, well compensated, and sustainable to attract, retain a diverse workforce
8E(i) Culturally Responsive Workforce	Increase access to in person and virtual BH resources in rural areas with culturally competent providers
7C(i) Supporting Workforce	Subsidize Clinical Supervision

Goals

- Increase culturally specific and culturally responsive behavioral health workforce
- Recruit, retain and promote qualified direct-care and supervisory staff through financial incentives and career advancement opportunities
- Incentivize participation in targeted fields experiencing shortages
- Provide paid opportunities to address cost of education at different points along the behavioral health career pathway

Subcommittee Action Recommendations

Strategy: *3.1 Grow-your-own regional career roadmaps.*

Deliverable: *OHA to collaborate with local agencies, licensing and credentialing boards, and Tribal partners, to develop region-specific behavioral health career roadmaps aligned with community cultural values and local service needs. OHA to host roadmaps, training opportunities, and licensure resources online. OHA to create a plan for website hosting, regular updating, and communications. Publicly available regional behavioral health career roadmaps, and guidance for recruitment and training.*

Responsible Agency: *OHA*

Fiscal/ No Fiscal: *No Fiscal*

Timeline: *6-9 months*

Strategy: *3.2 Incentivize specialized workforce roles.*

Deliverable: *OHA to prioritize workforce grants to create financial incentives for roles in crisis response, rural areas, and culturally/linguistically specific services in publicly funded behavioral health settings with service commitments.*

Increased access to crisis response, culturally/linguistically specific and culturally responsive, and rural care. Incentive program guidelines.

Responsible Agency: *OHA*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-9 months*

Strategy: *3.3 Preceptor Incentives for Psychiatric Mental Health Nurse Practitioners (PMHNP's) operating in rural and culturally specific organizations.*

Deliverable: *Fund incentives for Preceptors to accept and supervise students and fund preceptor's organizations to backfill PMHNP's time in smaller organizations that cannot take a PMHNP offline. Increased number of PMHNP's serving in an in-person capacity in rural communities and culturally specific organizations.*

Responsible Agency: *OHA*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-12 months*

Strategy: *3.4 Expand access to supervision and licensure support.*

Deliverable: *OHA to fund supervision stipends, group supervision models, and subsidize clinical supervision through grant opportunities. OHA to provide grants for stipends to incentivize graduate level mental health intern supervision. Subsidies for the costs to train clinical supervisors and the costs associated with providing clinical supervision. Increased number of qualified clinical supervisors providing necessary supervision for licensure, certification, and program completion (e.g., grad interns)*

Responsible Agency: *OHA*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6 months for project start; At least 24 months for first outputs (cohort of supervisees gaining licenses)*

Strategy: *3.5 Incentivize career advancement through funding for education*

Deliverable: *OHA to fund behavioral health scholarships, loan forgiveness, and grants for certifications tied to a service commitment in the publicly financed behavioral health sector. OHA to provide scholarship and retention grants directly to behavioral health employers to increase agency retention. GO and OHA to draft legislation to ensure that any student who receives state behavioral workforce incentive funding for undergraduate, graduate, nursing or medical school will commit to working in the publicly funded behavioral health system for a minimum of two years. Increased number of graduates starting careers, advancing along a career pathway, and remaining within the publicly financed behavioral health sector.*

Responsible Agency: *OHA, HECC*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *12-18 months, (relies on academic calendar)*

Strategy: *3.6 Incentivize Continuing Education (CE)*

Deliverable: *OHA to fund Continuing Education (CE) grants for licensed staff who need financial assistance to pursue continuing education. Increased retention of licensed staff.*

Responsible Agency: *OHA*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-12 months*

Strategy: *3.7 Paid student internships*

Deliverable: *OHA to fund paid internships for students in behavioral health workforce education programs. OHA to draft guidance and rules for conditions by which organizations can receive reimbursement for services provided by MH interns. Expanded number and types of paid internships that result in students entering and advancing in careers in the publicly financed behavioral health sector*

Responsible Agency: *OHA*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *12-24 months*

Strategy: *3.8 Operationalizing Peer Support Program*

Deliverable: *OHA to establish a statewide program to provide free technical assistance to organizations on operationalizing peer support. OHA to contract for statewide training and mentoring support for people in peer roles. OHA to contract for peer supervision and administration training development. OHA to provide guidance, resources and contact information for technical assistance requests. Increased Peer Support retention rates decreased vacancy rates. Pilot program reports including participation rates and qualitative outcomes.*

Responsible Agency: *OHA*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-12 months*

Strategy: *3.9 Culturally Specific Leadership Development*

Deliverable: *OHA will contract with culturally specific organizations for the purpose of providing mentorship and leadership wellness support to culturally specific organizations, particularly those that are experiencing stress due to federal policy decisions. Supporting culturally specific leaders to better support front line staff and strengthen organizational structures.*

Responsible Agency: *OHA*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-12 months*

Anticipated Implementation Barriers

- Fiscal
- Substantial funding would be required for expansion of incentives, subsidies, and grant programs.
    - Long-term sustainability of programs may require legislative support and recurring budget allocations.
- Workforce Capacity
    - Limited availability of licensed supervisors, especially in rural areas and culturally specific settings.
- Coordination
    - Requires collaboration across state agencies, educational institutions, licensing and certification boards, accrediting bodies, behavioral health employers, and community-based organizations.

Equity Opportunities

- Ensure participation prioritizes minoritized, multilingual, and geographically underserved staff.
- Support Tribal, rural, and remote community engagement through locally tailored workforce strategies.
- Invest in culturally specific/responsive clinical supervision to help address inequities in recruitment and retention.
- Invest in career advancement opportunities for Peers, QMHAs, and CADCs to promote retention and diversify the workforce, as the certified workforce is currently more diverse than the licensed behavioral health workforce.

Compensation Action Plan 4

Recruitment and Retention

Purpose

The following action plan covers recommendations established by the Higher Education Coordinating Commission (HECC) that are adopted by the Governor's Behavioral Health Talent Council (BHTC) to support the behavioral health workforce. This action plan is focused on actions that will reduce pay disparities, recruit and retain specialized workforce, and establish a more equitable reimbursement structure.

Recommendation Summary

After reviewing the compensation recommendations from the Behavioral Health Talent Assessment, the Recruitment and Retention subcommittee recommends the following actions:

- The creation of an updated rate methodology for high-acuity, community-based providers.
- The creation of wage differentials for roles in crisis response, rural areas, and culturally specific services.
- The creation of a progressive reimbursement model.
- The creation of crisis stabilization reimbursement across Medicaid and commercial insurance.

Talent Assessment Recommendations

Recommendation	
6 Compensation	Address inequities between community-based and private practice providers.
6B Compensation	Explore and fund financial incentives for specialized workforce roles (e.g., position/job role, region, underserved communities) that align with union regulations and are equitable
6A Compensation	Develop progressive reimbursement rates and billable services, which currently undervalue community-based health care as well as client needs and outcomes and fail to support culturally responsive care
6C Compensation	Redefine and provide the resources to community mental health work as a sustainable career choice rather than a stepping stone to private practice.

Goals

- Reduce pay disparities between community-based and private practice behavioral health providers.
- Incentivize and retain specialized workforce roles in high-need areas and populations.
- Establish a sustainable, equitable reimbursement structure that reflects service complexity and supports culturally responsive care.

Subcommittee Action Recommendations

Strategy: *4.1Define and implement updated rate methodology for high-acuity, community-based providers.*

Deliverable: *OHA to develop criteria and methodology for identifying high-acuity service providers and apply enhanced reimbursement rates. Policy framework and rate schedule for high-acuity provider compensation.*

Responsible Agency: *OHA (Medicaid, Behavioral Health Division).*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *12-24 months*

Strategy: *4.2 Incentivize specialized workforce roles.*

Deliverable: *OHA to modernize and update Medicaid behavioral health billing processes to incentivize providers offering crisis services or culturally specific services, and in rural areas. Incentive program guidelines and funding proposal.*

Responsible Agency: *OHA in partnership with HECC and CCOs*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-9 months*

Strategy: *4.3 Develop progressive reimbursement model.*

Deliverable: *OHA to develop a legislative concept for biennial rate adjustments tied to inflation or cost indices. Legislative concept and fiscal impact analysis.*

Responsible Agency: *OHA, Medicaid*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *12-18 months*

Strategy: *4.4 Supporting existing infrastructure.*

Deliverable: *OHA to develop a funding framework that does not promote significant investment in new services without providing rate adjustments based on inflation or cost indices for existing behavioral health infrastructure, Legislative concept.*

Responsible Agency: *OHA, Medicaid*

Fiscal/ No Fiscal: *No fiscal*

Timeline: *12-18 months*

Strategy: *4.5 Establish crisis stabilization billing codes.*

Deliverable: *OHA to implement new billing codes for short-term crisis stabilization services (4–24 hours) for Medicaid and commercial payors. CMS-approved billing codes and provider guidance*

Responsible Agency: *CMS-approved billing codes and provider guidance*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *9-12 months*

Anticipated Implementation Barriers

Cost

- Rate increases and incentive programs require legislative appropriations and CMS approval.
- Infrastructure for new billing codes and program oversight will require additional staff and system updates.

Operational Complexity

- Defining “high-acuity” and “specialized roles” in a way that is equitable and administratively feasible.
- Ensuring alignment across funding streams (e.g., Medicaid, Measure 110, CMHPs).

Communications

- Clear messaging to providers about eligibility, rate changes, and incentive opportunities.
- Coordination with CCOs and provider networks to ensure uptake and compliance.

Equity Opportunities

- Expand access to culturally and linguistically specific services by supporting workforce development and compensation.
- Ensure that rate-setting and incentive structures do not inadvertently exclude smaller or under-resourced providers.

Incentives Underserved Communities Action Plan 5

Recruitment and Retention

Recommendation Summary

After reviewing the attached recommendations from the Behavioral Health Talent Assessment, the Retention and Recruitment subcommittee recommends:

- Expanding access to supervision and licensure support.
- Creating incentives for career advancement.
- Integrating career pathway information into a workforce website.

Talent Assessment Recommendations

Recommendation	
7B	Subsidize housing, relocation, and childcare costs, particularly in rural areas and within underserved communities.

Goals

- Improve recruitment and retention of behavioral health providers in rural and underserved communities.
- Reduce financial barriers for providers with families, particularly related to housing and childcare.
- Support equitable access to behavioral health services across geographic and demographic lines.

Subcommittee Action Recommendations

Strategy: *5.1 Support childcare access for behavioral health workforce.*

Action: *Propose a statewide childcare subsidy or tax credit for providers with dependents in rural areas*

Deliverable: *Legislative concept and implementation plan*

Responsible Agency: *OHA*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *12-18 months*

Strategy: *5.2 Fund relocation and housing stipends.*

Action: *Develop a grant or stipend program for relocation and housing support for new hires in rural and remote areas*

Deliverable: *Program guidelines and Policy Option Package (POP)*

Responsible Agency: *OHA*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *12-18 months*

Strategy: *5.3 Align incentives with workforce shortage data.*

Action: *Use existing workforce shortage and unmet need, data to prioritize funding*

Deliverable: *Ensure that future grantmaking, eligibility criteria, and priority scoring methods focus on providers and organizations with the greatest childcare and housing needs.*

Responsible Agency: *OHA*

Fiscal/ No Fiscal: *No fiscal (if integrated)*

Timeline: *9-12 months*

Anticipated Implementation Barriers

Cost

- Requires legislative appropriations.
- Childcare and housing subsidies may require ongoing funding to remain effective.
- Even with relocation and housing incentives, providers may still be unable to secure housing due to limited local availability in rural, remote and high-need communities.

Operational Complexity

- Defining eligibility based on service area vs. provider location.
- Ensuring incentives reach safety-net providers and not just private practices.
- Housing and childcare incentives can be administratively challenging to distribute, as availability, cost and case-by-case variability across housing units and childcare providers create significant operational burden and complexities.

Coordination

- Requires collaboration across state agencies, providers to ensure equitable distribution.
- Align with statewide affordable housing and childcare initiatives to ensure workforce incentives are paired with efforts to increase actual housing supply or childcare affordability in underserved areas.

Equity Opportunities

- Expand access to behavioral health services in rural and frontier areas.
- Reduce disparities in provider availability for culturally and linguistically diverse populations.
- Ensure that financial supports are accessible to safety-net and community-based providers, not just private practices.
- Consider higher incentives or tax relief for rural and remote regions, Tribal communities, or areas with significant unmet behavioral health needs.

Licensing and Credentialing Action Plans 1 – 4

Communicating and Requirements Action Plan 1

Licensing and Credentialing

Recommendation Summary

After reviewing the recommendations attached from the Behavioral Health Talent Assessment, the Licensing and Credentialing subcommittee recommends:

- The creation of a Behavioral Health Career Crosswalk by OHA.
- The creation of a centralized Behavioral Health Workforce Resource website to provide an easily accessible, one-stop source of information for behavioral health workers and behavioral health employers for information about entering, advancing in, and supporting the workforce.
- The establishment of real-time chat-based customer service for Oregon's behavioral health licensing boards to help remove obstacles to workers gaining and maintaining their licenses.

Talent Assessment Recommendations

Recommendation	
2E BH Technicians	Promote BH technician roles as a pathway for younger demographics into the BH workforce as this is a position that pays well, serves as an entry point, and does not require lived experience. (See also Action Plan X)
3B(ii) Alternate Pathways	Communicate how Associate of Applied Science (A.A.S.) degrees from BH workforce and allied professional Career and Technical Education (CTE) programs in community colleges are viable pathways.
4C(i) Licensure Process: Best Practices	Research best practices from other states and apply them to Oregon's situation while honoring and preserving a local and responsive quality of care… Massachusetts has created a state-level resource for SUD career development.
4C(ii) Licensure Process: Map requirements	Work to create a crosswalk of BH credential and licensure requirements and standard coursework in relevant fields.
7(D) Collaboration	Foster collaboration across agencies and stakeholders.

Subcommittee Action Recommendations

- OHA, in conjunction with the licensing boards and HECC, will create a crosswalk of the most common behavioral health workforce positions, their educational requirements, and their licensing and credentialing requirements. This crosswalk will need to be kept up to date as licensing requirements can change over time.
- OHA will develop a centralized, accessible website as a one-stop resource for both members of the workforce and employers. The website will include:
    - The BH workforce crosswalk developed above,

- Links to pages with information about each behavioral health workforce role, including:
    - The scope of practice and expected duties of those who work in the role,
    - The educational requirements for the role, with information about Oregon-based programs that meet those requirements and resources for people looking to enroll in those programs including links to their websites,
    - The licensing and credentialing requirements for the role, with information about the agencies responsible for those licenses and credentials and links to their websites,
- Links to available jobs and internships within the field,
- Recruitment and retention resources for employers,
- Relevant data about the workforce for workers and employers,
- Information about trainings and events for workers and employers,
- Information about workforce support initiatives and how to take advantage of them,
- Resources for culturally specific providers, including links to the websites of culturally specific organizations who that are supporting culturally specific providers.

- Licensing boards/GO will seek funding for real-time chat-based customer support roles in licensing agencies (similar to the ones MHACBO already has) who can help guide applicants through any difficulties they have with their applications and can affirmatively reach out to applicants with incomplete or incorrect applications to help them resolve any issues and be licensed faster.
    - If MHRA and BLSW are able to procure their new licensing system, that may eliminate the need for this recommendation or at least reduce its expense, since the system is anticipated to significantly improve efficiency within those agencies.
    - Due to their smaller size, it may be worth exploring whether MHRA and BLSW could share staff in these roles for increased efficiency.

Goals

- Build the behavioral health workforce through clear communication with potential workers.
- Support other workforce training, retention, and advancement efforts by having a centralized site for people to look for resources and opportunities.
- Remove frustration and reduce licensing delays with bolstered customer support.

Strategy/Deliverable Overview

Strategy: *1.1 Create a crosswalk of the most common behavioral health workforce positions, their educational requirements, and their licensing and credentialing requirements.*

Deliverable: *Implementation plan for crosswalk creation.*

Responsible Agency: *OHA*

Fiscal/ No Fiscal: *No Fiscal*

Timeline: *3-6 months*

Strategy: *1.2 Build a public-facing, comprehensive website of useful information for behavioral health practitioners.*

Deliverable: *Implementation plan to create and maintain website.*

Responsible Agency: *OHA (in cooperation with HECC and licensing bodies)*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-9 months*

Strategy: *1.3 Fund real-time, chat-based customer support roles in licensing agencies.*

Deliverable: *Real-time assistance for licensing applicants, including potentially proactive outreach to applicants with incomplete applications*

Responsible Agency: *Licensing bodies*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-9 months from funding*

Anticipated Implementation Barriers

Cost

- Standing up the webpage and keeping it current and relevant will require ongoing staff support at OHA.
- Additional customer support at licensing agencies will require additional FTE, as well as potentially one-time expenditure, to stand up a system for real-time chat-based support.

Communications

- In order for the website to have value, we will need to find ways to make sure people know that it exists and what resources can be found on it.

Equity Opportunities

Some culturally specific and regional organizations have already developed online resources for these purposes. We can link to their resources and uplift the work that they have already been doing.

Entry-Level Behavioral Health Positions Action Plan 2

Licensing and Credentialing

Recommendation Summary

After reviewing the recommendations attached from the Behavioral Health Talent Assessment, the Licensing and Credentialing subcommittee recommends:

- MHACBO will collaborate with OHA to create an entry-level behavioral health credential, reflecting that the recipient has received the trainings required by OHA rules to be able to practice within the position.
- OHA will review billing structures for behavioral health services and determine if changes can be made to make it more feasible for non-residential providers to hire entry-level support staff.

Talent Assessment Recommendations

Recommendation	
2E BH Technicians	Promote BH technician roles as a pathway for younger demographics into the BH workforce as this is a position that pays well, serves as an entry point, and does not require lived experience. (See also Action Plan X)
3D Mobile Positions	Analyze which credentials offer limited career mobility and which provide broader opportunities to better inform investments intended to bolster the BH workforce.
4C(ii) Licensure Process: Map requirements	Work to create a crosswalk of BH credential and licensure requirements and standard coursework in relevant fields.
7E(i) Pathways	Add tiered pathways into BH jobs that support education and employment together as one, not separately.

Subcommittee Action Recommendations

Per HECC Talent Assessment Recommendation 3D (Analyze which credentials offer limited career mobility and which provide broader opportunities to better inform investments intended to bolster the BH workforce), the subcommittee identified entry-level positions and peer positions as those with the most limited career mobility due to inherent structural issues with the way those positions are hired, trained, and credentialed. Action plan (insert number here) will address issues with mobility for peers; below are the recommendations to improve career mobility for entry-level behavioral health workers:

- MHACBO will work with OHA, with input from providers, to create a new voluntary behavioral health credential for behavioral health workers who do not have college degrees or previous behavioral health work experience but have completed the necessary training to meet the requirements for them to perform their positions under statute and administrative rules.
    - The creation of an entry-level behavioral health credential will help build professional identity early in people's careers and encourage them to remain in the field. It will also help people coming out of CTE programs to be able to enter the field.
- Currently the terms "behavioral health associate," "mental health associate," "behavioral health technician," and "residential support staff" are used for positions requiring the same level of experience in different settings, which can cause confusion. While it is not feasible to change the designations of these positions by every provider and in every setting, having a uniform credential for these positions

will help clarify the skills needed for the position and create increased portability for workers in these important roles.

- These positions can be crucial for supporting teams in residential settings and could potentially be useful in out-patient settings as well. They also serve as the entry point for many people who go on to work long-term in the behavioral health field (MHACBO estimates that 50% of their licensees begin in these or similar positions). However, the training required for these workers to fulfill their roles is currently not portable, which means if they switch between employers, they are required to be completely re-trained.

    - MHACBO already built QMHA requirements off of the DSW (Direct Service Worker) competencies, which could serve as the basis for this new certification.
    - It will be important to ensure that this new credential is a benefit to behavioral health providers and their workers, not an additional burden. If implemented correctly, this should make it easier for entry-level behavioral health workers to meet training requirements and move around in the field without having to re-train; if implemented incorrectly, it potentially creates another hurdle/layer of complexity for entry-level workers without any commensurate benefit. Providers should be involved in the planning process for this credential from the beginning, and MHACBO should feel empowered not to move forward on the new credential if it is determined that it will not benefit the workforce.
    - It may be worth exploring whether an enhancement rate would be appropriate to incentivize people receiving this credential.

- OHA and the Medicaid division will review billing structures for behavioral health services and determine if it is feasible to move to billing structures that allow more flexibility for hiring non-billing support staff for providers who are currently unable to do so.

    - Talent council members have regularly identified good staffing as one of the keys to retaining staff. Having sufficient support staff and being able to provide care in team-based models reduces burnout and allows every member of the team to operate at the top of their license and skills.
    - In settings that bill on a per-bed basis (i.e. most residential settings), it is possible to budget for non-licensed support staff (which is where a large number of people in the behavioral health workforce begin their careers). However, in settings that rely on hourly billing by licensed staff, it can be difficult or impossible to budget for non-licensed support staff, and some staff are required to go through lengthy licensing processes just so that they can bill for some of the work they do (i.e. performing intakes).

Goals

- Increase access to entry-level, non-licensed direct service worker positions, which are one of the primary entry points into the behavioral health field.
- Make it easier for entry-level workers to move between positions while gaining experience and not burdening the workers and their employers with duplicative training requirements.
- Create professional identity
- Facilitate the hiring of more support staff to reduce burnout and encourage team-based treatment by examining billing structures for behavioral health providers and determining whether structures that better support team-based services can be implemented.

Strategy/Deliverable Overview

Strategy: *2.1 Create a new entry-level BH worker license/certification to allow greater portability for people new to the field.*

Deliverable: *Implementation plan for the creation of the new license/recommendation on whether to move forward*

Responsible Agency: *MHACBO/ OHA*

Fiscal/ No Fiscal: *Fiscal (BHD Licensing Unit)*

Timeline: *6 months*

Strategy: *2.2 Review existing billing structures for BH services and determine if there are options to change those structures to allow providers more flexibility to hire entry-level and support staff.*

Deliverable: *Recommended changes to billing structures, including recommended statutory/rule changes if needed.*

Responsible Agency: *OHA*

Fiscal/ No Fiscal: *No fiscal*

Timeline: *12 months*

Anticipated Implementation Barriers

Avoiding Unnecessary Complexity

- While creating a new credential can be helpful, it also adds an additional level of complexity to the existing system, and it is important to ensure that this new credential does not serve as an additional obstacle for entry-level workers. It will have to be very carefully tailored to serve its intended purpose.

Limitations of Medicaid

- The state will only be able to make changes to billing under the limitations of existing federal Medicaid law.

Equity Opportunities

Increasing access to and structure of entry-level positions will create more pathways into the workforce across demographics and geographic regions.

More opportunities in the field for people to establish their career prior to pursuing graduate-level education and/or licensure will support grow-your-own pipelines in regions where those resources are more challenging to access.

Supporting Licensees and Reducing Barriers Action Plan 3

Licensing and Credentialing

Recommendation Summary

After reviewing the recommendations attached from the Behavioral Health Talent Assessment, the Licensing and Credentialing subcommittee recommends:

- Invest in an updated licensing database for MHRA and BLSW, as the current one is outdated and significantly impeding the efficiency of both agencies.
- Increase staffing at the Mental Health Regulatory Agency (MHRA) and Board of Licensed Social Workers (BLSW) to allow for quicker processing of licenses and more robust customer service for people seeking to be licensed. Consider creating positions that serve both boards if that will reduce cost/increase efficiency.
- Direct MHRA and BLSW to implement alternative pathways to licensure for people who have been unable to pass the exam but are able to demonstrate proficiency through other channels.
- Continue existing investments in test preparation and explore other avenues of helping potential licensees prepare for tests (particularly for licensees with culturally and/or linguistically diverse backgrounds). This could include providing resources/support for providers to purchase study materials and arrange study groups for employees.
- Explore increasing access to supervision/eliminating downward pressure on supervisors providing meaningful support and preparation created by tension between that obligation and providing billable services.

Talent Assessment Recommendations

Recommendation	
4C Streamline Licensure and Credentialing	Streamline and standardize licensure process and requirements.
7E(i) Pathways	Add tiered pathway into BH jobs that support education and employment together as one, not separately.

Subcommittee Action Recommendations

- MHRA and BLSW are currently both working with outdated licensing systems that cause delays in licensing and are at risk of losing support from their vendor in the near future. The Governor's Recommended Budget for the 2025-2027 biennium requested funding for an updated system, but the agencies were asked to work with DAS to further refine the request.
    - Replacing the outdated licensing system currently in use by MHRA and BLSW will allow those agencies to continue to improve licensing speed and customer service responsiveness.
    - MHRA has indicated that this would be the most impactful recommendation for them, as the new licensing system will be a staff multiplier that will create opportunities to speed up licensing and improve customer service without hiring more staff.

- Two of the most important roles that the licensing boards can play in bolstering the workforce are processing applications for licensure in as timely a manner as possible and providing robust customer support to people applying for licensure to help them navigate obstacles in the application process. This is particularly important in making licensure more accessible to a diverse workforce, who may have unique needs that require additional support throughout the process.

    - MHRA and BLSW have limited staffing for processing licenses, responding to licensee inquiries, and investigating complaints against licensees. A significant increase in the number of complaints being received across all licensing boards has continued to strain those resources.
    - By bolstering staffing at the licensing agencies, we can improve processing time for applications of licensure, allow the agencies to more proactively assist applicants in overcoming obstacles to licensure, and give the agencies the capacity and flexibility to continue working on innovation and improvement without having to divert resources from their day-to-day work.
    - Given the similarity and overlap in some of their work, it may be possible for MHRA and BLSW to share resources to reduce the fiscal impact of this recommendation.

- MHRA and BLSW will work with their boards to explore and implement alternative pathways to licensure for applicants who are unable to complete their testing requirements but are otherwise qualified to practice.

    - There are significant racial disparities in the first-time passage rates of exams for behavioral health workers, as well as in the rates for applicants for whom English is not their primary language. The Talent Assessment shows that there is a significant need in Oregon for culturally and linguistically competent behavioral health workers, and it is crucial to make sure that people with those skills who are qualified to do the work can get their licensure without being stymied by a lack of test-taking skills.
    - While the test can be a useful tool for ensuring that licensees have the skills necessary to do their work, it is not the only tool. Several states have recently implemented alternative pathways to licensure. One of the most promising models is Utah's, which allows an applicant who fails the licensing test to be licensed if they complete an additional 500 direct client care hours, 25 of which are direct clinical supervision hours and five of which are direct observation hours, and submit two letters of recommendation from their clinical supervisor and a licensed mental health therapist who has directly observed their work.

- MHACBO currently provides testing assistance to applicants through a grant that is about to expire. With an OHA grant of $50,000 a year, MHACBO has offered test prep to 1,811 QMHA and QMHP, and those who have participated have reported that the program has been very helpful. With relatively minimal resources, we can continue the testing assistance that MHACBO currently provides, expand access to testing assistance to licensees with other agencies, and explore other possibilities for assisting people with testing.

    - Testing can also be a significant obstacle for multilingual applicants or applicants transferring from out of country, and providing assistance specific to those populations could open up the workforce to professionals with much-needed skills and backgrounds.
    - Some providers already provide study materials to workers and help them to arrange study sessions or have paid time off to study for licensure. OHA and the licensing boards should continue to look into ways to encourage/incentivize providers to support their employees' professional development in this way.

- Supervisors play a role in making sure that behavioral health professionals are receiving the training and feedback that they need to be able to successfully advance through the field. However, our current system disincentivizes meaningful support from supervisors, since time they spend working with supervisees is time that they aren't spending doing billable direct service. The Recruitment and Retention subcommittee is already producing recommendations around improving supervision in the behavioral health workforce; the Licensing and Credentialing subcommittee supports those recommendations and emphasizes the importance of access to quality supervision in building a sustainable system.

    - Clarifying the roles of clinical vs. administrative supervisors, and providing sufficient resources for both, will help clinical supervision be more available and meaningful.

Goals

- Accelerate expansion of the workforce by allowing people to be licensed faster and have immediate access to staff who can help them navigate barriers they encounter.
- Increase pass rates for licensure exams without sacrificing workforce readiness by supporting applicants in gaining the skills and knowledge they need to achieve their licensing requirements.
- Increase the diversity of the workforce by helping workers coming from backgrounds of lived experience, or from linguistically and culturally specific backgrounds, prepare for and pass tests not traditionally designed for them.

Strategy/Deliverable Overview

Strategy: *3.1 Update the Licensing Database for Licensing Agencies*

Deliverable: *Invest in an updated licensing database for MHRA and BLSW, as the current database is outdated and significantly impeding the efficiency of both agencies.*

Responsible Agency: *MHRA/ BLSW*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6 months*

Strategy: *3.2 Bolster staffing at MHRA and BLSW to improve licensing time and customer support access.*

Deliverable: *Additional agency staff leading to reduced licensing wait times and increased access to real-time customer support for licensees.*

Responsible Agency: *MHRA/ BLSW*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6 months*

Strategy: *3.3 Create Alternative Pathways to Licensure.*

Deliverable: *Direct the MHRA and BLSW to implement alternative pathways to licensure for individuals who have been unable to pass the exam but are able to demonstrate full proficiency through other methods.*

Responsible Agency: *MHRA/ BLSW*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *9 months*

Strategy: *3.4 Continue to provide testing support through MHACBO, and explore expanding testing support and providing culturally and linguistically specific support to applicants who need it.*

Deliverable: *Availability of testing support leading to higher pass rates for licensing exams and a more diverse workforce*

Responsible Agency: *MHACBO and other licensing agencies.*

Fiscal/ No Fiscal: *Small fiscal*

Timeline: *Immediate-6 months*

Strategy: *3.5 Explore methods to help employers support their employees in preparing for licensure.*

Deliverable: *Additional licensure preparation resources and opportunities leading to higher rate of successful licensure*

Responsible Agency: *OHA, working with providers and licensing agencies.*

Fiscal/ No Fiscal: *No fiscal*

Timeline: *6 months*

Anticipated Implementation Barriers

Fiscal Barriers

- Licensing agencies are funded out of licensing fees; therefore, in order to fund additional personnel or a new licensing system, either fees would have to be raised or the legislature would have to allocate money to defray the need to raise fees. Raising fees itself creates barriers to licensing, particularly for people without access to the resources to pay them. It will be important to balance the need to properly resource our licensing agencies with the need to keep financial barriers to entry into the profession low.

Equity Opportunities

Licensing can be a particular barrier for people coming from non-academic backgrounds, people who do not speak English as their first language, or people transferring from places with different requirements and processes. By providing additional resources for those groups, including tailored test preparation and real-time culturally specific customer service, we can increase access to the profession for some of the people whose experience and expertise is most needed.

Supporting Lived Experience in the Workplace Action Plan 4

Licensing and Credentialing

Recommendation Summary

After reviewing the attached recommendations from the Behavioral Health Talent Assessment, the Licensing and Credentialing subcommittee recommends the following actions to support behavioral health workers with lived experience throughout the behavioral health field, including peer workers:

- MHACBO will combine current peer credentials with duplicative training requirements into a single credential with associated micro-credentials for peers who wish to be credentialed in more specialized fields of service.
- OHA will collaborate MHACBO to identify overlaps between the OHA Traditional Health Worker (THW) credentials and the MHACBO Certified Recovery Mentor (CRM) credentials, and determine if additional actions should be taken to streamline and consolidate peer-focused credentials.
- The Alcohol and Drug Policy Commission will convene a committee to examine background check requirements for behavioral health providers with the goal of streamlining the background check process, identifying unnecessary exclusions, and designing a clear background check process for providers treating Integrated Co-Occurring Disorders (ICOD).
- OHA, ADPC, and the Licensing Agencies will collaborate to create materials to assist people in navigating the background check process and assembling the necessary materials to be successful.

Talent Assessment Recommendations

Recommendation	
3I Micro-Credentials	Provide funding for micro-credentials.
3D Mobile Positions	Analyze which credentials offer limited career mobility and which provide broader opportunities to better inform investments intended to bolster the BH workforce.
4C Streamline Licensure and Credentialing	Streamline and standardize licensure process and requirements.
7D Collaboration	Foster collaboration across agencies and stakeholders.

Subcommittee Action Recommendations

Per HECC Talent Assessment Recommendation 3D (Analyze which credentials offer limited career mobility and which provide broader opportunities to better inform investments intended to bolster the BH workforce), the subcommittee identified entry-level positions and peer positions as those with the most limited career mobility due to inherent structural issues with the way those positions are hired, trained, and credentialed. Action plan (insert number here) addresses issues with mobility for entry-level behavioral health workers; below are the recommendations to improve career mobility for peers and people with lived experience:

- MHACBO will develop a single peer credential with endorsements/micro-credentials that attach to someone's credential and allow them to expand the scope of their practice without having to complete duplicative trainings/requirements.

    - The members of the licensing and credentialing subcommittee were largely uninterested in micro-credentials as a pathway to expand career mobility and raised concerns about them being a tool to convince workers to add more "alphabet soup" to their resumes without providing them with additional useful skills or a pathway to higher pay/additional responsibilities. However, this is the one area where the subcommittee agreed that micro-credentials are a useful tool to allow peers to get an underlying credential and then specialize, since peers are utilized across a large and diverse spectrum of the behavioral health system.
    - This will also potentially require Oregon Administrative Rule adjustments to ensure that these endorsements support the workforce as meaningfully as possible.

- OHA and MHACBO will collaborate to examine overlap between credentials for Certified Recovery Mentors overseen by MHACBO and those for Traditional Health Workers overseen by OHA, and determine changes that can be made so that the system credentials peers for their full range of abilities and experience while eliminating duplicative trainings and requirements for those who seek multiple credentials.

    - Currently Certified Recovery Mentors (peers who work in the addiction field) are certified by MHACBO, while Traditional Health Workers (a designation that includes peers who work in the mental health field such as Peer Support Specialists and Peer Wellness Specialists) are certified by OHA. While some peers will only work on one side or the other of this divide, many have lived experience in both fields and will end up working with both populations. However, the training and requirements for the two different credentials can be duplicative.
    - Furthermore, Certified Recovery Mentors and Peer Support Specialists have the same Medicaid billing codes and so are often used interchangeably by programs, so getting both credentials does not necessarily open up additional opportunities for workers, even though they are required to have both to work in both MH and SUD.

- The Alcohol and Drug Policy Commission will convene a committee to examine current background check processes and requirements for behavioral health workers, with the goal of streamlining processes, eliminating unnecessary exclusions, and designing a clear and accessible background check process for providers treating Integrated Co-Occurring Disorders.

    - Background checks are a significant barrier to new hires being able to start work. When a person is hired, their background check can take up to a month, after which their CCO paneling can take up to an additional month. This means that a provider has to pay the employee for two months or more before they can actually work with clients, and if the employee fails the background check or the CCO paneling the employer may have to start over (see Action Plan insert number here for recommendations around CCO paneling).
    - Current exclusionary criteria do not necessarily do a good job of screening out people who should not be doing this work and allowing in those who should. Providers have indicated that it is sometimes strange or surprising who is screened out, which again makes it difficult for them to have a predictable hiring process. Some of this is due to exclusions being built around criminal code, which was not designed for such nuanced determinations. For instance, Identity Theft is currently a crime of exclusion. Under Oregon law, Identity Theft could include taking financial advantage of a vulnerable person, but it could also include using a stolen ID to get into a bar when a person was underage. By making the crime a blanket exclusion we are potentially excluding many people with valuable lived experience and no real indication that they are not suited to practice in the field.

- The current background check system is also very flattened, assuming all workers are working with populations of the same vulnerability when in truth that work varies and the legal definition of a vulnerable population has only grown more expansive (i.e. someone who only provides outpatient services to people with depression would legally be considered to work with a "vulnerable population). This committee may want to consider creating more levels of risk/vulnerability with different exclusions for those levels. This is already happening on an informal basis but could be better managed and less susceptible to unconscious bias if it were formalized.
- Our current background check system is not built for providers treating Integrated Co-Occurring Disorders, which is increasingly common. Staff who work with SUD clients go through the standard national and statewide background check process. Staff who work with MH clients go through the more rigorous ORCHARDS background check process through the Background Check Unit (BCU) at DHS. Currently there is no specific background check process for staff treating Integrated Co-Occurring Disorders.
- Because of this, providers are forced to adopt costly and time-consuming workaround to separate their MH staff from their SUD staff, and people with SUD backgrounds are often excluded from treating people with co-occurring conditions, which is where their skills may be most needed.
- This committee should include representatives from the BCU experts in CMS law, and perspectives from the peer and provider communities. It should include multiple members with lived experience in the criminal justice system so no one person is singled out as providing that perspective.

- OHA will work with ADPC and the relevant licensing agencies to build a toolkit/guide for people with lived experience who have to navigate the background check process.

    - Subcommittee members who have previously been through this process indicated that it can be frustrating because there is no guidance as to how to be successful (creating a portfolio of support, documenting evidence, filing attestations). Creating such a toolkit could prevent good people from being screened out just by the difficulty, frustration, and trauma of the process.
    - Additionally, if a person is rejected by the BCU, they have to put together a package of materials in order to file an appeal, in a process that can take months. If applicants had some direction as to how to put together those materials before they even submit for their background check, it could save the applicant and their employer significant time and resources.

Goals

- Streamline peer credentialing, eliminate duplicative requirements, and make sure that peer credentials actually match up to job/career advancement opportunities.
- Increase accessibility to the behavioral health field for people with lived experience by improving the background check system and providing resources to navigate it.

Strategy/Deliverable Overview

Strategy: *4.1 Consolidate peer credentials with duplicative trainings and add certifications/micro-credentials for more specialized areas of practice.*

Deliverable: *New peer credentialing model based on MHACBO recommendations*

Responsible Agency: *MHACBO*

Fiscal/ No Fiscal: *No fiscal*

Timeline: *12 months*

Strategy: *4.2 Examine opportunities to merge credentialing for SUD/MH peers, improve accessibility to credentialing and training for people working in both fields, and eliminate extraneous requirements.*

Deliverable: *Joint recommendations from OHA and MHACBO to streamline peer credentialing.*

Responsible Agency: *OHA/MHACBO*

Fiscal/ No Fiscal: *No fiscal*

Timeline: *12 months*

Strategy: *4.3 Convene a committee to improve background check process for behavioral health workers.*

Deliverable: *Recommendations for background check process improvements, including new processes for ICOD providers.*

Responsible Agency: *ADPC*

Fiscal/ No Fiscal: *No Fiscal*

Timeline: *12 months*

Strategy: *4.4 Create a toolkit and guide for people with lived experience navigating the background check process.*

Deliverable: *Toolkit and guide publicly available and widely accessible.*

Responsible Agency: *ADPC/OHA/ BCU/Licensing Agencies.*

Fiscal/ No Fiscal: *Potentially small fiscal*

Timeline: *12 months*

Implementation Barriers

Systemic Inertia

- The central role of peer workers and workers with lived experience to the behavioral health workforce has grown quickly in recent years, and our system was not necessarily built to accommodate it. Making the necessary changes may require system actors to re-examine assumptions and be open to creative solutions, including changes to long-standing systems.

Stigma

- While gains have been made in the behavioral health system and in society as a whole, there remains significant stigma to overcome for people with lived experience with mental illness, substance use, and criminal justice involvement. Despite the incredible value these experiences bring to the profession, there may still be pushback from some quarters on efforts to lower barriers for people with these experiences to participate in the systems that most affect them. People with lived experience should not be forced to be their own only advocates; the Behavioral Health Talent Council should stand strongly with them in advancing recommendations that support them.

Equity Considerations

This is an area in which there are significant opportunities to advance equity in the behavioral health workforce. Due to institutional racism and homophobia, BIPOC, Latine, Native, and LGBTQ+ community members are more likely to have experienced mental illness or substance use and more likely to have had contact by the criminal justice system. This can create additional barriers for them to become providers, when in reality they have exactly the experiences and skills to provide the services our communities are most in need of. Lowering barriers for people with lived experience to enter the behavioral health workforce could significantly increase the diversity of that workforce as well, and in doing so increase its effectiveness.

Education Training and Pathways Action Plans 1 – 8

Developing Clear Pathways Action Plan 1

Education Training and Pathways

Recommendation Summary

After reviewing the attached recommendations from the Behavioral Health Talent Assessment, the Education and Training subcommittee recommends:

- The alignment and evaluation of behavioral health academic pathways across high school, community college, and university levels to improve transfer rates, degree completion, and equitable workforce entry.
- The design and piloting of inclusive high school behavioral health curriculum units and mentoring programs that expose students to the field's career options, transferable skills, and pathways to employment.
- The strengthening of transfer and articulation agreements in psychology and social work programs to ensure seamless transition and full credit transfer between Oregon's community colleges and public universities.
- The development of accessible, multilingual Behavioral Health Career Pathway resources and digital tools included in a Behavioral Health Resource Hub that clearly outline steps for education, training, and advancement across the behavioral health workforce.

Talent Assessment Recommendation

Recommendation	
1 Academic pathway efficacy	Evaluate the efficacy of academic pathways leading to employment in the BH sector. Conduct further investigations into successful practices and outcomes based on educational data tables (Table 9, 10, and 11) to determine and help inform initiatives to bolster enrollment, career guidance, and entry into the BH sector.
2C Highschool curriculum development	Define and pilot high school-level curriculum unit(s) or electives that reflect authentic rewards and challenges in providing BH care services (e.g., virtual reality/experiential modules), including individual and group mentoring to explore and develop transferable skills. Support state initiatives to minimize the urban/rural divides in education about and access into the BH field.
3B(i) Transferrable credits	Bolster Associate of Arts Oregon Transfer (A.A.O.T) and Associate of Science Oregon Transfer (A.S.O.T) degree pathways concentrated in psychology/social work so that students have complete transferrable credits in Oregon public universities.
4B Career pathway mapping	Create information for career pathways that outlines clear steps to obtain various BH careers (e.g., human services, social work, counseling) informed by BH professionals' experiences; offer comprehensive, publicly accessible career and credentialing information with no fee, membership, or registration required.
5 Define and expand educational pathways	Define and expand support for educational pathways from high school and across all postsecondary options.

Subcommittee Action Recommendations

Strengthen and Align Behavioral Health Education Pathways

- Convene HECC, OHA, and ODE with community colleges and universities to review current behavioral health degree pathways, enrollment data, and transfer outcomes to identify gaps and promising practices.
- Launch a coordinated process to align and streamline high school, community college, and university pathways with clear progression from coursework to employment.
- Develop cross-agency agreements to improve data sharing and monitor enrollment, transfer, and completion outcomes by race, region, and lived experience.

Develop and Pilot Inclusive High School Behavioral Health Curriculum

- Collaborate with ODE, OHA, and partner districts to design a high school behavioral health elective or unit, incorporating virtual/experiential modules and mentorship opportunities with behavioral health professionals.
- Pilot the new curriculum in at least two districts (one rural, one urban) with attention to representation, transferable skills, and awareness of community service roles.
- Collect feedback from students, educators, and mentors to guide broader curriculum adoption and refinement.

Improve Transfer Pathways and Credit Mobility

- Work with the Oregon Transfer Council to review and update AAOT/ASOT/MTM program maps in psychology and social work to ensure seamless transfer to public universities.
- Improve consistency and clarity in transfer advising through shared training and updated statewide advising materials.
- Pilot at least two strengthened transfer pathways between community colleges and universities to support diverse and rural students.
- Expand Accessible Career Pathway Information
- Create a user-friendly, no-cost Behavioral Health Career Pathway Guide as part of a Behavioral Health Resource Hub that outlines academic routes, credentials, and job progression.
- Ensure resources are multilingual, culturally responsive, and accessible to students, advisors, educators, and jobseekers statewide.
- Partner with community-based and culturally specific organizations to disseminate materials and collect usage data for continuous improvement.

Goals

- Broaden and streamline behavioral health education and career pathways to improve clarity, alignment, and equitable entry for high school students, college students, and career changers.
- Expand participation and successful completion rates for BIPOC, rural, and underserved students in behavioral health programs through improved curriculum, transfer mobility, and support structures.
- Increase statewide awareness and use of accessible, culturally relevant career pathway guides and advising resources for behavioral health fields.
- Strengthen collaboration among agencies, education partners, and stakeholders to monitor progress, evaluate equity impacts, and maintain continuous system improvement.

Strategy/Deliverable Overview

Strategy: *1.1 Strengthen and align behavioral health education pathways.*

Deliverable: *Cross agency review of current BH academic pathways; gap analysis report with recommendations for improving coordination and equity in enrollment and completion*

Responsible Agency: *HECC (with OHA and ODE)*

Fiscal/ No Fiscal: *No Fiscal*

Timeline: *3-6 months*

Strategy: *1.2 Develop and pilot inclusive high school behavioral health curriculum.*

Deliverable: *Draft and pilot a behavioral health elective or module in at least two districts (urban and rural) including mentorship components*

Responsible Agency: *ODE (in collaboration with OHA and pilot districts)*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-9 months*

Strategy: *1.3 Improve transfer pathways and credit mobility*

Deliverable: *Updated, standardized transfer maps for AAOT/ASOT psychology and social work, approved and shared with community colleges and universities.*

Responsible Agency: *HECC (with Oregon Transfer Council and public universities)*

Fiscal/ No Fiscal: *No fiscal*

Timeline: *3-9 months*

Strategy: *1.4 Expand accessible career pathway information.*

Deliverable: *Public, no cost Behavioral Health Career Pathway Guide included in a comprehensive Behavioral Health Resource Hub showcasing clear steps, transferable credits, and career options.*

Responsible Agency: *HECC (with OHA and community college partners)*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-9 months*

Anticipated Implementation Barriers

Funding and Resource Constraints

- Limited funding to support curriculum pilots, mentorship activities, and translation of materials for multilingual access.
- Insufficient staff capacity within HECC, OHA, and education partners to design, coordinate, and evaluate multiple concurrent initiatives.
- Inconsistent curricular standards and transfer policies across higher education institutions.

Data and Technology Limitations

- Lack of integrated systems to track student transitions from high school to college to employment in behavioral health.

- Incomplete or inconsistent data disaggregation (race, geography, income) preventing precise equity analysis or outcome tracking.
- Technical challenges in creating user friendly online tools and career pathway dashboards accessible to students and advisors statewide.

Equity and Accessibility Gaps

- Persistent disparities in behavioral health program enrollment, persistence, and completion among BIPOC, rural, and first-generation students.
- Uneven broadband and technology access in rural and frontier communities limiting digital engagement with career resources.
- Limited representation of diverse and lived experience voices in the design and field testing of new pathway tools and curricula.

Equity Opportunities

This plan presents clear opportunities to advance equity by embedding inclusive participation and culturally responsive practices across Oregon's behavioral health education system. It expands equitable access for BIPOC, rural, multilingual, and first-generation students through co-designed curricula, improved credit mobility, and accessible career resources. These actions strengthen transparency and representation in behavioral health pathways, ensuring a workforce that better reflects Oregon's diverse communities and improves statewide access to culturally relevant care.

Transparency About Licensure Requirements Action Plan 2

Education Training and Pathways

Recommendation Summary

After reviewing the attached recommendations from the Behavioral Health Talent Assessment, the Education and Training subcommittee recommends:

- The development of multilingual, culturally responsive toolkits and a Behavioral Health Career Crosswalk by OHA to clearly outline licensure requirements and pathways for workforce entry and advancement.
- The creation of a centralized, accessible Behavioral Health Resource Hub website to serve as a one-stop source for licensure, supervision, and career information for workers and employers.
- The launch of targeted mentorship and navigation pilots, organized through cross-agency collaboration, to guide BIPOC, rural, and multilingual candidates in completing licensure steps.
- The establishment of new, transparent data systems and regular partner engagement to drive continuous improvement, monitor equity impacts, and ensure that licensure resources remain current and relevant.

Talent Assessment Recommendation

Recommendation	
4E Transparency about licensure requirements	Be transparent about the time commitment and costs to get licensure or further degrees (e.g., supervision hours, costs associated with supervision) so students and newcomers to the field understand the full breadth of requirements

Subcommittee Action Recommendations

Develop and Launch Licensure Toolkit Prototype

- Assign OHA Behavioral Health Division as lead.
- Establish a drafting team with representation from licensing boards, HECC, and culturally specific organizations.
- Draft toolkit content in plain language with equity review.
- Translate materials into top non-English languages spoken by prospective trainees and BH employees in Oregon.

Pilot an Interim Licensure Information Portal

- Assign OHA IT/staff to create a basic website/landing page.
- Post the draft toolkit and FAQ materials.
- Identify points of contact for monthly content updates and user feedback.

Establish a Licensure Transparency Workgroup

- Convene OHA (BH Division), HECC, licensing boards, selected community college advisors, and two culturally specific community-based organizations.

- Set regular (e.g., monthly) meetings to review toolkit/portal progress and coordinate outreach.
    - Assign responsibility for pilot school/college selection and implementation.

Launch Mentorship and Navigation Pilots

- Identify two to three community organizations to co-design pilot peer mentorship/navigation.
- Develop simple mentor/navigator intake guidelines and recruitment criteria.
- Initiate small-scale pilot with tracking of participant demographics and initial feedback.

Goals

- Increase transparency and statewide access to clear, multilingual information about
    - behavioral health licensure requirements, timelines, and costs.
- Expand equitable participation in licensure pathways by reducing informational, financial, and navigation barriers for BIPOC, rural, multilingual, LGBTQ+, and lived experience candidates.
- Strengthen coordination among OHA, HECC, licensing boards, and education partners to align communication, track licensure progress, and ensure accountability for equitable outcomes.

Strategy/Deliverable Overview

Strategy: *2.1 Develop and launch multilingual licensure toolkit.*

Deliverable: *Multilingual, culturally responsive toolkit outlining time commitments, costs, and supervision requirements for BH licensure; distributed online and in print.*

Responsible Agency: *OHA (in collaboration with Licensing Boards and HECC).*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *3-6 months*

Strategy: *2.2 Establish interim licensure information portal.*

Deliverable: *Basic centralized online portal hosting licensure information, toolkits, FAQs, and guidance updates; accessible, mobile-friendly site.*

Responsible Agency: *OHA (Behavioral Health Division) with IT and Licensing Boards.*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-9 months*

Strategy: *2.3 Build cross-agency workgroup and education partnerships.*

Deliverable: *Cross-agency licensure transparency workgroup launched; integration of licensure guidance into advising systems at select community colleges,*

Responsible Agency: *OHA (with HECC and CBO partners).*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-9 months*

Strategy: *2.4 Pilot mentorship and navigation supports.*

Deliverable: *Mentorship/navigation pilot program targeting BIPOC, rural, and multilingual candidates; evaluation framework for tracking participation and outcomes.*

Responsible Agency: *OHA (with HECC and CBO partners).*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-9 months*

Anticipated Implementation Barriers

Funding and Resource Constraints

- Limited initial funding to support development, translation, and long-term maintenance of multilingual toolkits and the licensure portal.
- Competing budget priorities and grant dependencies may delay fiscal approvals or sustainability planning.

Data and Technology Limitations

- Difficulty aligning information systems across boards and agencies for real-time tracking and updates.
- Insufficient digital accessibility in rural and low-bandwidth regions, limiting equitable use of online resources.

Equity and Accessibility Gaps

- Ongoing trust barriers and underrepresentation of BIPOC, rural, and lived-experience voices in system design and early implementation.
- Limited availability of culturally responsive or language-specific technical reviewers and project contributors.

Equity Opportunities

This action plan presents clear opportunities to advance the Council's equity goals by embedding equity into every stage of implementation. The plan can expand participation of BIPOC, rural, multilingual, and lived experience candidates by codesigning licensure guidance, mentorship, and navigation supports with affected communities. These actions intentionally reduce structural and informational barriers, strengthen trust in state systems, and promote equitable access to behavioral health career advancement.

Improving Communications and Transparency Action Plan 3

Education Training and Pathways

Recommendation Summary

After reviewing the attached recommendations from the Behavioral Health Talent Assessment, the Education and Training subcommittee recommends:

- The development and launch of a statewide multilingual, culturally responsive marketing campaign that clearly defines Behavioral Health, identifies required skills, and promotes the full range of career options in the field.
- The creation and dissemination of a statewide Behavioral Health Career Guidance Toolkit and best-practice resources to support advisors, educators, and workforce partners in helping individuals explore behavioral health careers.
- The establishment of a unified, plain-language definition of Behavioral Health through a partner-driven process to ensure accessible, consistent communication across agencies and educational systems.
- The creation of a statewide Behavioral Health Resource Hub providing public, no-cost access to career, education, and communications tools developed collaboratively with community and lived-experience partners.

Talent Assessment Recommendation

Recommendation	
2A Marketing campaign	Design and disseminate a marketing campaign for a broad audience of partners from high school students to legislators that answers a set of basic questions: (1) what is BH, (2) what skills are needed or preferred, and (3) what is the scope of roles from entry-level direct service to management to analysts?
2B Career Guidance	Establish and disseminate best practices in BH career guidance to better assess, inform, and encourage job fit (e.g., personality/skill inventories to inform career exploration, encourage a discursive process, information interviews)
4 Clearly communicate what behavioral health is to support people navigating BH pathways	Create clear language to define BH and manage publicly accessible resources to help guide and support those entering and working within the BH field.
4A Communication: Clear language	Convene a working group of partners to create clear language around BH (e.g., as well defined as physical health) to foster more cohesive and consistent vocabulary and structure

Subcommittee Action Recommendations

Marketing and Outreach Campaign

- Develop and launch a statewide multilingual and culturally responsive marketing campaign that defines "What is Behavioral Health," highlights required skills, and features a clear overview of career options from entry-level to leadership roles.
- Partner with education institutions, workforce boards, and community organizations to target outreach to high school students, career changers, and rural and underserved populations.
- Implement mobile-friendly and accessible campaign materials across digital, print, and community-based channels with plain-language messaging and diverse representation.

Career Guidance and Navigation

- Establish and disseminate best practices for behavioral health career guidance, including skill and personality inventories, structured informational interviews, and peer mentoring models.
- Create a centralized behavioral health career guidance library and toolkit for use by schools, advisors, and workforce programs statewide.
- Pilot career guidance workshops in community colleges and high schools, emphasizing early exploration and job fit for BIPOC, rural, and multilingual students.

Communications and Clarity in Behavioral Health Definition

- Convene a cross-sector working group (HECC, OHA, ODE, licensing boards, and community partners) to create clear, standardized language defining behavioral health and its key disciplines.
- Integrate this shared terminology into all print, web, and training materials to establish consistent, plain-language communication across agencies and education systems.
- Vet all public-facing resources through lived-experience reviewers and focus groups to ensure cultural relevance and accessibility statewide.

Public Access and Engagement Infrastructure

- Create and maintain a public, no-cost online resource hub that consolidates marketing materials, career guidance tools, and plain-language definitions in one multilingual, accessible site.
- Launch iterative community engagement cycles, including focus groups, student feedback, and user testing, to continuously refine tools and messaging.
- Develop and publicize data dashboards to track usage, engagement, and equity outcomes, ensuring transparency and continuous improvement.

Goals

- Increase public understanding of behavioral health by developing consistent, culturally responsive messaging and clear definitions that make the field more visible and approachable statewide.
- Expand equitable access to behavioral health career information, resources, and guidance tools for students, job seekers, and professionals from BIPOC, rural, multilingual, LGBTQ+, and lived experience communities.
- Strengthen cross agency collaboration and community engagement to ensure all communication, marketing, and guidance efforts are codesigned, data informed and continuously improved for relevance and accessibility.

Strategy/Deliverable Overview

Strategy: *3.1 Develop and launch a statewide behavioral health marketing campaign.*

Deliverable: *Multilingual, culturally responsive marketing campaign and outreach materials answering, "What is Behavioral Health?" featuring broad career pathways and diverse workforce representation.*

Responsible Agency: *HECC (with OHA, ODE, and community partners.*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *3-6 months*

Strategy: *3.2 Establish and disseminate best practices in career guidance.*

Deliverable: *Behavioral Health Career Guidance Toolkit including skill assessments, mentoring templates, and informational interview resources for schools and workforce programs.*

Responsible Agency: *HECC with ODE and workforce boards.*

Fiscal/ No Fiscal: *No Fiscal*

Timeline: *6-9 months*

Strategy: *3.3 Create and standardize clear behavioral health language.*

Deliverable: *Statewide adoption of consistent, plain language definitions for Behavioral Health fields and roles vetted through partner working groups*

Responsible Agency: *OHA (with HECC and Licensing Boards)*

Fiscal/ No Fiscal: *No fiscal*

Timeline: *3-6 months*

Strategy: *3.4 Develop and launch an accessible behavioral health resource hub.*

Deliverable: *Cross agency public online portal consolidating marketing materials, guidance tools, and BH definitions in multiple languages with user testing for accessibility.*

Responsible Agency: *HECC (with OHA and community partners).*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-9 months*

Anticipated Implementation Barriers

Funding and Resource Constraints

- Limited budget for multilingual content creation, translation services, and sustained marketing or outreach campaigns.
- Insufficient staff time and capacity within lead agencies to manage cross-platform
- communications, data updates, and evaluation.
- Competition among state workforce and communications initiatives may delay prioritization or resource sharing.

Data and Technology Limitations

- Lack of integrated data systems to monitor user engagement, reach, and equity outcomes across communication channels.
- Challenges building and maintaining accessible digital tools that comply with ADA, language, and cultural responsiveness standards.
- Limited analytics infrastructure to evaluate the long-term impact of marketing and education campaigns.

Equity and Accessibility Gaps

- Messaging and resources risk overlooking rural communities, non-English speakers, and individuals without reliable internet access.
- Insufficient inclusion of BIPOC, LGBTQ+, and lived-experience voices in early codesign, resulting in materials that may not fully resonate with target audiences.
- Reliance on digital-first tools may inadvertently reinforce disparities among lower income populations with limited connectivity or digital literacy.

Equity Opportunities

This plan creates meaningful opportunities to advance equity by ensuring that behavioral health information, materials, and resources reflect the voices, languages, and lived experiences of Oregon's diverse communities. Through multilingual outreach, co-designed communication tools, and consistent, plain-language definitions, the plan increases visibility and access for BIPOC, rural, multilingual, LGBTQ+, and lived-experience populations. These actions help dismantle historical information barriers, build trust across communities, and support a more inclusive and representative behavioral health workforce.

Culturally Responsive Services Action Plan 4

Education Training and Pathways

Recommendation Summary

After reviewing the attached recommendations from the Behavioral Health Talent Assessment, the Education and Training subcommittee recommends:

- The coordinated expansion of culturally responsive and rural workforce development strategies to increase access and retention through partnerships among OHA, HECC, MHACBO, tribal programs, and community based training providers.
- The creation of inclusive training pipelines across degree, nondegree, peer, and apprenticeship pathways that prepare and advance multilingual, bicultural, and lived experience professionals within Oregon's behavioral health system.
- The implementation of sustainable funding and incentive structures, such as loan repayment, housing stipends, and supervision supports, to strengthen recruitment and retention in rural and frontier regions.
- The strengthening of community based and innovative service models by piloting and evaluating models that support safety and wellbeing for students and professionals; and integrating equity focused data tracking to inform future statewide initiatives.

Talent Assessment Recommendation

Recommendation	
8E Culturally responsive services	Focus on rural and culturally relevant services

Subcommittee Action Recommendations

Identify and Address Rural and Cultural Service Gaps

- Convene OHA and HECC, in collaboration with local workforce boards, tribal governments, community-based and immigrant refugee organizations, and training providers serving rural and frontier regions, to map behavioral health service and workforce gaps.
- Develop regional equity dashboards documenting disparities in access and workforce representation to inform targeted investment and program development.
- Apply a targeted universalism framework that sets shared statewide access goals while
- tailoring strategies to meet each community's distinctive cultural and geographic needs.

Expand Culturally Specific Workforce Pathways

- Partner with OHA, HECC, MHACBO, and a range of training providers, including community colleges, universities, apprenticeships, peer training programs, and community-based education partners, to expand culturally and linguistically responsive behavioral health training pipelines.
- Develop pathways for bilingual, bicultural, and lived experience individuals to enter behavioral health careers through certificate, peer support, apprenticeship, and degree options.
- Embed cultural responsiveness, trauma informed practice, and regional service needs within behavioral health curricula and supervision training, regardless of provider type.

Incentivize and Sustain Rural and Multicultural Practice

- Expand loan repayment, housing stipends, tuition assistance, and rural internship support to increase the number of bilingual and multicultural providers serving in frontier and underserved regions.
- Collaborate with regional workforce boards, CCOs, and private foundations to cofund incentives and scholarships for rural and culturally specific workforce development.
- Establish regional mentorship and supervision networks to support isolated practitioners and integrate nontraditional supervision models that recognize experience gained through peer or community practice.

Strengthen Community Based and Innovative Service Models

- Pilot and evaluate innovative rural service models such as mobile behavioral health clinics, tele-behavioral health, and community wellness roles within schools, faith centers, and social service agencies.
- Collaborate across provider systems, including nonprofit, tribal, workforce board, and peer led organizations, to design culturally relevant behavioral health outreach and recovery programs.
- Build safety and wellbeing supports for both students and professionals through virtual learning options, peer support, and flexible training delivery models in regions where travel or public visibility pose risks.
- Collect and publish equity-based data on rural workforce retention, client access, and community outcomes through the statewide Behavioral Health Resource Hub, using findings to refine and scale successful programs.

Goals

- Expand equitable access to behavioral health services across rural, frontier, and culturally distinct communities through targeted workforce initiatives and community-based service models.
- Strengthen recruitment, training, and retention pipelines for bilingual, bicultural, and lived-experience practitioners by integrating culturally responsive curricula and credential pathways across degree and non-degree training providers.
- Increase workforce and service alignment with Oregon's equity goals by applying targeted universalism, addressing shared statewide access goals through community-specific strategies that reduce identified regional disparities.
- Sustain and incentivize rural and multicultural practice by coordinating state, regional, and philanthropic investments that support long-term workforce development, supervision, and safe practice environments.

Strategy/Deliverable Overview

Strategy: *4.1 Identify and address rural and cultural service gaps.*

Deliverable: *Conduct statewide mapping and equity analysis of rural, frontier, and culturally distinct communities to identify behavioral health service and workforce gaps. Publish regional dashboards to inform funding priorities and program development.*

Responsible Agency: *OHA will serve as the lead agency, collaborating with the HECC, tribal and community-based partners, and local workforce boards.*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-9 months*

Strategy: *4.2 Expand culturally specific workforce pathways.*

Deliverable: *Develop and expand culturally responsive pipelines through the coordinated efforts of higher education institutions, MHACBO, community colleges, peer training programs, and community-based providers to deliver aligned curriculum and supervision training that reflects cultural and regional needs.*

Responsible Agency: *HECC (lead) with OHA, MHACBO training providers and community partners*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-9 months*

Strategy: 4.3 Incentivize and sustain rural and multicultural practice.

Deliverable: Launch targeted recruitment campaigns that include specific loan repayment and housing incentives for bilingual, bicultural, and lived-experience providers serving in rural and frontier regions.

Responsible Agency: OHA (lead), collaborating with the HECC, local workforce boards, CCOs, and private foundation partners.

Fiscal/ No Fiscal: Fiscal

Timeline: *9-12 months*

Strategy: *4.4 Strengthen Community-Based and Innovative Service Models*

Deliverable: *Pilot and evaluate mobile, tele-behavioral health, and community wellness service models delivered through schools, faith centers, and trusted local organizations, while integrating data tracking into the Behavioral Health Resource Hub to measure access, equity, and provider retention*

Responsible Agency: *OHA (lead) with HECC, tribal partners, workforce boards and training providers including CBOs and employer-based programs.*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-12 months*

Anticipated Implementation Barriers

Funding and Resource Constraints

- Limited, short-term funding for rural and culturally specific workforce initiatives, with little continuity for community or peer-led programs.
- Insufficient staff capacity within agencies and partner organizations to coordinate rural, cross-agency initiatives and maintain compliance with federal reporting requirements.
- Persistent reimbursement and pay disparities for community-based, culturally responsive, and non-degree practitioners, limiting workforce recruitment and retention.
- Shifting state and federal funding priorities, along with complex grant and contracting processes, complicate long-term planning and equitable resource allocation. Data and Coordination Limitations
- Fragmented data systems across OHA, HECC, MHACBO, and workforce boards limit tracking of rural, frontier, and nontraditional training outcomes.
- Inconsistent data collection from peer, community, and employer-based training providers prevents full visibility into culturally and geographically diverse workforce pipelines.
- Lack of shared metrics and interoperability between state and federal systems hinders analysis of workforce equity, licensing progress, and supervision access.

- Limited cross-sector coordination among state, regional, and philanthropic partners reduces efficiency and alignment for rural program development. Equity and Accessibility Gaps
- Ongoing workforce shortages and infrastructure barriers (travel, broadband, housing) restrict training and service access in rural and frontier regions.
- Immigration, safety, and federal eligibility policies create fear and participation barriers for immigrant, refugee, and lived-experience workers.
- Limited flexibility in supervision and licensing pathways, particularly for community based and tribal providers, delays workforce entry and advancement.
- Underrepresentation of diverse and community-based voices in federal and state workforce planning perpetuates inequities in program design and funding.

Equity Opportunities

This plan presents clear opportunities to advance health equity through rural workforce investment and culturally responsive training pathways. It strengthens equitable access by expanding participation of community-based, tribal, peer, and bilingual providers who reflect the diversity of Oregon's communities. By aligning with federal equity initiatives and funding priorities, the plan positions Oregon to align strategies for inclusion, workforce safety, and rural service expansion. These efforts will help address persistent geographic and cultural gaps in behavioral health access while fostering a more representative, trusted, and resilient statewide workforce.

Enhancing Partnerships and Collaboration Action Plan 5

Education Training And Pathways

Recommendation Summary

After reviewing the attached recommendations from the Behavioral Health Talent Assessment, the Education and Training subcommittee recommends:

- The development and implementation of coordinated pilot programs that provide early exposure to behavioral health careers through job shadowing, peer mentorship, and culturally responsive wellness ambassador models in partnership with schools, community organizations, and tribal education programs.
- The establishment of standardized partnership frameworks between higher education, training providers, and behavioral health employers to expand paid internships, apprenticeships, and practicum opportunities, particularly in rural, frontier, and tribal regions.
- The creation of a statewide Behavioral Health Career Consortium led by OHA, HECC, and ODE to unify recruitment, messaging, and resource development under a single, equity centered brand.
- The advancement of equitable pathways and Credit for Prior Learning (CPL) opportunities that recognize peer, lived experience, and workforce training for academic credit, ensuring mobility and access across Oregon's behavioral health education system.

Talent Assessment Recommendation

Recommendation	
2D Career experiences:	Identify and pilot viable early BH career experiences such as partnering with social service agencies who address food and housing insecurities, job shadowing of nonclinical roles paired with informational interviews with clinicians, and wellness coaches/ambassadors in schools.
7E Collaborations: Partnerships	Continue to create partnerships between employers and higher education

Subcommittee Action Recommendations

Pilot Early Behavioral Health Career Experiences

- Convene OHA, ODE, and HECC with training providers, higher education institutions, school districts, and local workforce partners to design pilot models that offer early exposure to behavioral health careers (e.g., job shadowing, peer mentorship, and wellness ambassador).
- Partner with school districts, tribal education programs, and peer-run or community-based organizations to implement supervised experiences emphasizing youth peer, family support, and culturally specific roles in rural, urban, and tribal regions.
- Collaborate with ODE to align pilots with existing CTE and health science programs, integrating reflection and credit-bearing components for participating students.
- Develop participation guidelines and supervisor training with OHA and ODE to ensure trauma-informed, developmentally appropriate practices.
- Evaluate pilot outcomes through HECC's Office of Research and Data to assess equity impacts, participant experience, and scalability.

Strengthen Partnerships Between Employers and Higher Education

- Convene HECC, OHA, and the Oregon Workforce Partnership with higher education institutions, training providers, and behavioral health employers to develop standardized frameworks and funding models for paid training opportunities.
- Expand access to internships, apprenticeships, and practicums for rural, frontier, and tribal areas through collaborations with employers, training providers, and local workforce boards.
- Strengthen CTE Professional Learning Communities connecting employers with educators and community college faculty to align coursework and on-the-job learning.
- Develop data-sharing agreements through HECC's Office of Research and Data to track participation, completion, and demographic trends.

Establish an Oregon Behavioral Health Career Consortium (This is Behavioral Health")

- Leverage existing regional work to establish a statewide consortium led by OHA, HECC, and ODE to unify messaging, recruitment, and career promotion under one brand.
- Integrate peer and lived-experience representatives in consortium leadership.
- Collaborate with higher education institutions, training providers, workforce boards, and regional partners to co-create multilingual materials and statewide outreach events.
- Coordinate with the Behavioral Health Resource Hub to ensure consistent public access to career and education resources.

Advance Equitable Pathways and Credit for Prior Learning (CPL)

- Coordinate HECC and OHA collaboration with MHACBO, training providers, community colleges, and universities to expand CPL opportunities that recognize peer, lived experience, and workforce training for certificate and degree credit.
- Develop standardized articulation agreements and assessment processes using Oregon's CPL Standards.
- Partner with employers and tribal workforce programs to identify eligible workers and implement culturally responsive CPL pilots.
- Monitor outcomes through HECC's data systems and OHA's workforce reporting to evaluate reach and equity.

Goals

- Broaden and strengthen behavioral health partnerships among education, employers, and community organizations to expand coordinated, high-quality career experiences and training opportunities statewide.
- Expand access to early behavioral health career exposure and paid work-based learning
- experiences for BIPOC, rural, tribal, and underrepresented students and workforce participants.
- Increase alignment between education systems and employers to ensure coursework, internships, and apprenticeships reflect real-world behavioral health practice needs and equity priorities.
- Strengthen collaboration among state agencies, workforce boards, and institutional partners to align data sharing, evaluate partnership outcomes, and sustain coordinated behavioral health workforce strategies across Oregon.

Strategy/Deliverable Overview

Strategy: *5.1 Pilot Early Behavioral Health Career Experiences.*

Deliverable: *Implement 2 regional pilots (rural and urban) offering early BH exposure through job shadowing, mentorship, and student wellness ambassador roles. Include alignment with existing CTE frameworks, trauma-informed supervision, and evaluation for statewide scaling.*

Responsible Agency: *OHA (lead) with ODE, HECC, school districts, community colleges, and tribal/ community-based partners.*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-9 months*

Strategy: *5.2 Strengthen Partnerships Between Employers and Higher Education.*

Deliverable: *Develop and implement standardized partnership frameworks connecting higher education, employers, and training providers to expand paid internships, apprenticeships, and rural/tribal placements.*

Responsible Agency: *HECC (lead) with OHA, Oregon Workforce Partnership, higher ed partners, training providers, and employers.*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *3-9 months*

Strategy: *5.3 Establish an Oregon Behavioral Health Career Consortium.*

Deliverable: *Launch a statewide consortium coordinating messaging, recruitment, and career promotion under unified brands. Produce multilingual marketing materials and conduct 2– 3 career events with employer and peer -workforce representation.*

Responsible Agency: *OHA (lead) with HECC, ODE, community colleges, universities, training providers, workforce boards, and employers.*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-9 months*

Strategy: *5.4 Advance Equitable Pathways and Credit for Prior Learning (CPL).*

Deliverable: *Develop statewide CPL (Credit for Prior Learning) guidance recognizing peer and workforce training for academic credit, pilot CPL articulation agreements across three institutions, and monitor equity participation and outcomes through HECC/OHA data systems.*

Responsible Agency: *HECC (lead) with OHA, MHACBO, community colleges, universities, training providers, tribal workforce programs, and employers.*

Fiscal/ No Fiscal: *No Fiscal (initial implementation).*

Timeline: *3-9 months*

Anticipated Implementation Barriers

Funding and Resource Constraints

- Limited funding for early career pilots, including student stipends, supervision time, and culturally specific program design in rural and tribal communities.
- Insufficient staff capacity and cross-agency alignment within OHA, HECC, and ODE to coordinate pilots, track data, and sustain partnerships.
- Limited ongoing resources to maintain mentorship, supervision, and coordination post pilot.
- Competing state workforce initiatives dividing available behavioral health investment.

Data and Technology Limitations

- Lack of integrated data systems connecting education, employers, and workforce boards to track training and employment outcomes.
- Limited system interoperability between OHA and HECC preventing consistent measurement of partnership results and equity progress.
- Gaps in longitudinal data for early-career and lived-experience roles not captured in standard academic reporting.
- Privacy and technical barriers to cross-agency data sharing.

Equity and Accessibility Gaps

- Pilot opportunities and supervision sites concentrated in metro areas, limiting access for rural, frontier, and tribal participants.
- Financial and logistical barriers, unpaid time, childcare, and transportation, restrict participation for students and working adults.
- Underrepresentation of BIPOC, multilingual, and lived-experience professionals in supervisory and mentorship roles.
- Inconsistent inclusion of peer and community voices in governance and program design.

Equity Opportunities

This plan offers clear opportunities to advance equity through codesigned partnerships that expand access to behavioral health career experiences and collaborative training statewide. It prioritizes inclusion of BIPOC, tribal, rural, and lived experience participants in pilot projects, mentorship roles, and workforce learning structures. By embedding culturally responsive supervision, shared data tracking, and community partnership models, these actions strengthen equitable career pathways and ensure Oregon's behavioral health workforce better reflects and serves its diverse populations.

Community College Collaboration Action Plan 6

Education Training and Pathways

Recommendation Summary

After reviewing the attached recommendations from the Behavioral Health Talent Assessment, the Education and Training subcommittee recommends:

- A coordinated, equity-driven approach to understanding and addressing barriers in behavioral health program enrollment and transfer at Oregon's community colleges, with HECC, OHA, and community colleges working closely with community-based and culturally specific partners.
- The development and piloting of welcoming, flexible on-ramps, such as dual credit, CTE, and Credit for Prior Learning (CPL) pathways, co-designed by ODE, HECC, community colleges, CTE directors, and peer/lived-experience organizations to better serve rural, BIPOC, immigrant, and nontraditional students.
- Targeted incentives and updated articulation agreements to make movement from community college to university transparent and equitable, led by HECC, OHA, and the Oregon Transfer Council with institutional partners.
- The expansion of local partnerships and resource networks, led by community colleges, in concert with tribal entities, workforce boards, employers, and culturally specific/peer organizations, to provide mentorship, field placements, and additional supports in underserved regions.
- Establishing joint data tracking, disaggregation, and reporting, driven by HECC, OHA, and institutional leaders, to ensure ongoing accountability, guide investment, and foster continuous community-centered improvement in Oregon's behavioral health education pipeline.

Talent Assessment Recommendation

Recommendation	
3C Community College Outcomes	Investigate further the trend of declining number of students entering the BH field from community colleges (Table 10).
5B(i) Community College Collaboration	Incentivize collaboration (i.e. articulation agreements) with community colleges to facilitate a viable career pathway

Subcommittee Action Recommendations

Analyze and Understand Enrollment Patterns

- HECC and OHA, in partnership with community colleges and community-based organizations, review statewide enrollment and transfer data post-pandemic to identify changes and gaps in the behavioral health pipeline.
- Community colleges, together with culturally specific organizations and student services, engage students, advisors, and faculty to better understand barriers and motivations for BIPOC, immigrant, rural, and linguistically diverse learners.
- HECC and workforce boards map regional program capacity and student outcomes to find opportunities for strengthening transfer pathways and awareness/support in key communities.

Develop and Pilot Inclusive On-Ramps

- ODE and HECC (lead) collaborate with OHA, community colleges, high schools and CTE directors to co-design and pilot dual credit, CTE, and CPL pathways providing culturally responsive, flexible entry points for behavioral health programs.
- Community colleges, with peer/lived-experience partners and local advisory committees, test models integrating peer, workforce, and community-based entry, including for students progressing from ESL or ABE programs. Strengthen Articulation and Credit Mobility
- HECC (lead), working with OHA, the Oregon Transfer Council, and institutional registrars, drives the development of new or improved articulation agreements and transfer maps that include clear CPL options.
- Community colleges and universities jointly create and update statewide advising tools, transfer maps, and field experience standards to ensure students benefit from transparent, consistent credit recognition and advisement. Expand Local Partnerships and Capacity
- Community colleges (lead), in coordination with HECC, workforce boards, tribal and culturally specific/peer organizations, and local employers, build partnerships for student mentorship, field placement, and outreach, targeting rural and remote areas for support.
- Community college staff and regional partners strengthen ESL and developmental education bridges into behavioral health programs and ensure support for nontraditional entry points.

Ensure Equity-Driven Accountability and Continuous Improvement

- HECC and OHA establish data-sharing agreements, working with community colleges, workforce boards, and employer councils to track and disaggregate enrollment, transfer, CPL use, and completion data by region and equity group.
- All partners share results and lessons learned routinely, using data to drive investment, target improvement efforts, and ensure Oregon's behavioral health workforce pipeline steadily becomes more inclusive, accessible, and responsive to community need.

Goals

- Increase equitable entry and completion in community college behavioral health pathways, with special attention to BIPOC, rural, immigrant, and linguistically diverse students, by mapping barriers and launching new supports.
- Expand and streamline culturally responsive on-ramps, including dual credit, CTE, and CPL pathways, enabling learners with varied backgrounds and experiences to pursue behavioral health careers.
- Strengthen articulation, advising, and credit mobility between community colleges and universities so that all students, including those with work and lived experience, can transfer efficiently and receive full credit for prior achievement.
- Build regional capacity and partnerships, especially in rural and under-resourced areas, to ensure students have access to mentorship, field placements, and tailored educational supports.
- Use shared data and continuous feedback to monitor, evaluate, and improve enrollment, progression, and completion, ensuring Oregon's community college behavioral health pipeline becomes more inclusive, transparent, and connected to workforce needs.

Strategy/Deliverable Overview

Strategy: *6.1 Analyze and understand enrollment patterns.*

Deliverable: *Statewide analysis report on behavioral health enrollment trends and equity gaps in community colleges, with partner input*

Responsible Agency: *HECC (lead), OHA, community colleges, community-based organizations.*

Fiscal/ No Fiscal: *No fiscal*

Timeline: *3-6 months*

Strategy: *6.2 Develop and pilot inclusive on-ramps.*

Deliverable: *Pilot pathways and entry points, including dual credit, CTE, CPL, and peer/lived-experience onramps, with co-designed curriculum and support models.*

Responsible Agency: *ODE & HECC (lead), OHA, community colleges, high schools, CTE directors, peer/ lived-experience partners.*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-9 months*

Strategy: *6.3 Strengthen articulation and credit mobility.*

Deliverable: *New or revised articulation agreements, transfer maps, and statewide advising tools that clarify credit and CPL movement from community colleges to universities.*

Responsible Agency: *HECC (lead), OHA, Oregon Transfer Council, community colleges, universities.*

Fiscal/ No Fiscal: *No fiscal*

Timeline: *3-9 months*

Strategy: *6.4 Expand local partnerships and capacity.*

Deliverable: *Network of local partnerships in targeted regions providing mentorship, placements, ESL/ developmental education supports, and holistic outreach.*

Responsible Agency: *Community colleges (lead), HECC, workforce boards, employers, tribal and culturally specific/ peer organizations.*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-12 months*

Strategy: *6.5 Ensure equity- driven accountability and continuous improvement.*

Deliverable: *Routine cross-agency reporting on enrollment, transfer, CPL use, and completion, disaggregated by region/equity group and tied to improvement cycles.*

Responsible Agency: *HECC (lead), OHA, community colleges, workforce boards, institutional partners.*

Fiscal/ No Fiscal: *No fiscal*

Timeline: *6-12 months*

Anticipated Implementation Barriers

Funding and Resource Constraints

- Limited funding for launching and sustaining new pilots, such as dual credit pathways, CPL review, and culturally specific mentorship or navigation supports.
- Insufficient faculty, advising staff, and peer mentors at community colleges, especially in rural and remote regions, make expansion and outreach difficult.
- Competing institutional priorities, faculty workloads, and staffing shortages may slow collaborative innovation or program scaling. Data and Technology Limitations
- Existing data systems across HECC, OHA, and colleges are not fully integrated, making it difficult to track student entry, transfer, CPL use, and workforce placement in real time.
- Incomplete data disaggregation (e.g., lived experience, language, geography, race/ethnicity) hinders precise understanding and action on equity gaps.
- Barriers to developing and updating accessible, user-friendly online advising and career exploration tools for all student groups. Equity and Accessibility Gaps
- Systemic and community-level barriers, including cost, lack of awareness about pathways, English language proficiency, licensure complexity, and stigma, continue to limit access for BIPOC, immigrant, rural, and nontraditional students.
- Transfer and articulation processes, including CPL recognition, are not consistently implemented or understood, leading to lost credits and discouraging progression.
- Limited engagement and leadership opportunities for students and community-based partners with lived experience may hinder the creation of truly inclusive, culturally relevant pathways.

Equity Opportunities

This action plan creates important opportunities to advance equity by placing community college collaboration at the center of Oregon's behavioral health workforce strategy. Through active engagement with community-based organizations, culturally specific partners, and students with lived experience, the plan is designed to address barriers at every stage, from outreach and advising to credit mobility and completion. By emphasizing flexible on-ramps, Credit for Prior

Learning (CPL), and targeted resource investments for rural, BIPOC, immigrant, and multilingual learners, these coordinated actions will foster more equitable access, stronger representation, and better retention of diverse talent across the behavioral health education pipeline, helping build a workforce that reflects and serves Oregon's communities.

Expand Degree Pathways and Completion Action Plan 7

Education Training and Pathways

Recommendation Summary

After reviewing the attached recommendations from the Behavioral Health Talent Assessment, the Education and Training subcommittee recommends:

- The alignment and continual evaluation of behavioral health degree, credential, and CPL pathways across high school, community college, and university to improve credit mobility, transfer rates, completion, and equitable workforce entry.
- The collaborative design and piloting of behavioral health CTE and dual-credit options— including inclusive curricular units, mentorship, and recognition of lived/work experience—to help students explore the full range of career options and advance efficiently at each stage.
- The strengthening of articulation, transfer, and CPL agreements in key behavioral health fields, ensuring pathways are navigable, transparent, and inclusive for rural, BIPOC, first generation, and peer/lived-experience students.
- The creation of accessible, multilingual resources (digital and print) and expansion of community-led advising and navigation tools, ensuring that all Oregonians can clearly see and successfully pursue behavioral health education and career opportunities.

Talent Assessment Recommendation

Recommendation	
3B Degrees offered	Increase BH degrees offered (community college, bachelor's, and graduate degree levels) and slots within programs
5A Pathways: pre-med	Create a curriculum akin to a "premed" path for BH careers that has a recognized value when applying to the next level of education. Work with the boards or education to include BH as a focus within health career pathways. The National Occupational Competency Testing Institute (NOCTI) could be contracted to work with a cohort of leaders to craft curricula and develop micro-credentials in BH
5C Completion rates	Work within bachelor's and graduate degree programs to support BH pathways to raise completion rates

Subcommittee Action Recommendations

Strengthen and Align Behavioral Health Degree Pathways

- Bring together HECC, OHA, ODE, and key higher education and workforce partners to map the current landscape of behavioral health pathways, enrollment data, and opportunities for CPL and recognition of work or lived experience.
- Invite cross-agency review of transfer, stackable credentials, and CPL processes to better understand and address the barriers experienced by underrepresented, rural, and lived experience learners.
- Use these insights to identify promising practices and priority opportunities for coordination, alignment, and expanded access.

Develop and Pilot Inclusive High School-to-Career Pathways

- Collaborate with ODE, HECC, OHA, local CTE directors, and culturally specific organizations to co-design pilot behavioral health CTE sequences and early college curricular options, embedding dual credit, CPL, and robust supports for peer/lived experience students.
- Ensure pilot efforts include mentorship elements, trauma-informed curriculum, and flexible pathways that encourage career exploration and promote smooth transitions at each point in the continuum.

Promote Collaboration, Credit Mobility, and Data Sharing

- Work together across agencies (HECC, OHA, ODE, Oregon Transfer Council, campus registrars) to modernize articulation agreements, streamline CPL processes, and update transfer maps for high-value pathways, placing special emphasis on clear advising, accessibility, and equitable recognition of prior learning.
- Develop cross-agency agreements to enhance tracking of enrollment, CPL uptake, and completion, using this to identify equity gaps and inform continuous improvement.

Grow Equity-Focused Supports and Faculty/Staff Capacity

- Support colleges, universities, and community partners as they expand targeted student recruitment, scholarships, mentorships, and field placements, with an emphasis on BIPOC, rural, peer/ lived experience, and nontraditional students.
- Encourage institutional investment in faculty/staff development, supervision, and capacity-building to ensure sustainable program growth, keeping workload and wellness in view.

Foster Accountability for Completion, Employment, and Equity

- Commit to transparent collection and reporting of data on enrollment, completion, transfer, and CPL usage, with outcomes disaggregated by race/ethnicity, region, and lived experience.
- Use regular progress reviews to guide resource allocation, policy refinement, and shared learning as Oregon builds a more diverse, supported, and community-responsive behavioral health workforce.

Goals

- Expand clear, inclusive behavioral health pathways that help more Oregonians, including BIPOC, rural, and lived-experience learners, enter and complete degrees that lead to meaningful careers.
- Increase credit mobility and student advancement by streamlining Credit for Prior Learning (CPL), work, and lived-experience recognition at every stage.
- Foster coordinated partnerships among HECC, OHA, ODE, education, and workforce leaders to align pathways, supports, and faculty resources.
- Make transitions, from high school through graduate study to employment, more seamless through stackable credentials, dual-credit opportunities, and robust transfer agreements.
- Use strong data and ongoing collaboration to ensure equity, track progress, and support a behavioral health workforce that reflects and serves Oregon's communities.

Strategy/Deliverable Overview

Strategy: *7.1 Strengthen and align behavioral health degree pathways.*

Deliverable: *Cross-agency review of current behavioral health academic pathways; gap analysis identifying areas for coordination and equity improvements, including credit for prior learning (CPL).*

Responsible Agency: *HECC (with OHA and ODE).*

Fiscal/ No Fiscal: *No Fiscal*

Timeline: *3-6 months*

Strategy: *7.2 Develop and pilot inclusive high school-to career pathways.*

Deliverable: *Collaborative design and pilot of behavioral health CTE courses and dual credit modules integrating CPL and mentorship in diverse districts/colleges.*

Responsible Agency: *ODE (with HECC, OHA, CTE directors, pilot districts).*

Fiscal/ No Fiscal: *No Fiscal*

Timeline: *6-9 months*

Strategy: *7.3 Promote collaboration, credit mobility, and data sharing.*

Deliverable: *Enhanced transfer pathways, articulation agreements, and initial cross-agency data sharing protocols with CPL utilization tracked.*

Responsible Agency: *HECC (with OHA, ODE, Oregon Transfer Council, institutions).*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *3-9 months*

Strategy: *7.4 Expand equity- focused recruitment and supports.*

Deliverable: *Framework for targeted recruitment, scholarships, mentoring, and CPL support tailored to BIPOC, rural, and lived experience students.*

Responsible Agency: *Colleges/universities (with HECC, OHA, ODE).*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-9 months*

Strategy: *7.5 Foster accountability for completion and workforce outcomes.*

Deliverable: *Prototype data dashboard for public reporting of enrollment, completion, CPL use, and licensure outcomes disaggregated by key equity factors.*

Responsible Agency: *HECC (with OHA, workforce boards).*

Fiscal/ No Fiscal: *No Fiscal*

Timeline: *6-9 months*

Anticipated Implementation Barriers

Funding and Resource Constraints

- Limited funding to support curriculum pilots, mentorship efforts, and activities related to Credit for Prior Learning (CPL) review and recognition, as well as translation and adaptation of materials for multilingual and multicultural accessibility.
- Insufficient staff capacity within HECC, OHA, and education partners to co-design, coordinate, and evaluate multiple concurrent pathway pilots, especially as new CPL and credit-mobility efforts scale up.
- Challenges with securing long-term funding for faculty, advisors, and peer mentors, and the administrative costs of maintaining cross-institutional and cross-agency coordination.
- Variation in curricular standards, CPL practices, and transfer/credit policies across institutions can make efficient scaling and sustainability difficult without additional resources dedicated to collaboration.

Data and Technology Limitations

- Lack of integrated statewide data systems to track student movement, transfer, CPL utilization, and workforce outcomes across high school, college, and career.
- Incomplete or inconsistent disaggregation of student data (race/ethnicity, geography, income, lived/work experience) that can obscure equity gaps and hinder precise outcome tracking or continuous improvement.
- Technical and policy barriers, such as privacy regulations or misaligned local practices, make it challenging to create user-friendly, multi-institutional online tools and dashboards accessible to students and advisors statewide.

Equity and Accessibility Gaps

- Disparities in behavioral health program enrollment, persistence, and completion among BIPOC, rural, low-income, immigrant/refugee, and first-generation students—often linked to inconsistent implementation of CPL and navigation supports.
- Unequal access to broadband, digital devices, and local technology in rural and frontier areas limits effective engagement with career and pathway resources.
- Limited or inconsistent involvement of diverse voices—including peer, lived-experience, and culturally specific communities—in both the design and ongoing assessment of new pathway tools, CPL structures, and curriculum pilots.
- Stigma or lack of understanding around nontraditional entry (CPL, work/lived expertise) among some institutions and employers can impede widespread acceptance and limit the effectiveness of new opportunities.

Equity Opportunities

This plan creates new pathways to advance equity by embedding inclusive co-design, culturally responsive teaching, and intentional Credit for Prior Learning (CPL) throughout Oregon's behavioral health education system. By offering multiple, flexible entry points and meaningful recognition of work and lived experience, it expands access for BIPOC, rural, multilingual, first generation, and non-traditional students. Through stronger data practices, improved advising, and deeper partnerships with community and peer-led organizations, the plan supports more transparent, representative behavioral health pathways, helping to build a workforce that both reflects and better serves Oregon's diverse communities, while strengthening statewide access to culturally relevant care.

Career Exploration and Professional Development Action Plan 8

Education Training and Pathways

Recommendation Summary

After reviewing the attached recommendations from the Behavioral Health Talent Assessment, the Education and Training subcommittee recommends:

- Building equitable, statewide behavioral health career exploration and professional development opportunities that begin early and remain accessible across the education continuum.
- Streamlining and disseminating clear guidance on pathways, roles, and requirements in coordination with credentialing and licensure organizations, to reduce confusion and barriers, especially for rural, BIPOC, and multi-role professionals.
- Prioritizing funding and technical assistance for rural, culturally specific, and under resourced partners, ensuring all communities have meaningful access to mentorship, internships, and career-connected learning.
- Expanding portable, CEU-eligible professional development, including in evidence-based practice, safety, cultural humility, and digital skills, to strengthen workforce readiness and retention at every level.
- Establishing regular, inclusive feedback mechanisms with students, educators, practitioners, and workforce partners to ensure all actions remain responsive, clear, and centered on equitable outcomes for Oregon's behavioral health workforce.

Talent Assessment Recommendation

Recommendation	
2 Early career exploration, work-based learning experiences, career guidance	Craft a set of statewide initiatives to provide early career exploration, appropriate work-based learning experiences, and career guidance based on individual interest, skills, and career fit.
8C Retention: Professional development	Increase opportunities for the workforce to learn evidence based practices, professional boundaries and safety, professional writing and digital literacy skills, resilience and self-care, cultural humility, and team-based care skills

Subcommittee Action Recommendations

Broaden and Align Career Exploration Pathways

- Strengthen interagency collaboration (HECC, ODE, ESDs, workforce boards, CBOs) to align behavioral health career exploration with the ODE Career Connected Learning framework, expanding early awareness, job shadowing, and CCL-aligned experiences from middle school onward.
- Develop and share a statewide roadmap for student internships and observation in behavioral health, detailing opportunities and requirements at every level, with explicit guidelines for confidentiality, safety, and agency participation. Clarify Roles, Certification, and Credentialing Pathways
- Collaborate directly with credentialing and licensure organizations and educational and workforce partners to create and disseminate clear, user-friendly guidance on certification and licensing pathways across behavioral health roles (e.g., CADC-R, CADC, QMHA, LMSW, LPC, THW and others), including role definitions, regional expectations, and continuing education requirements.

- Integrate credentialing and licensure navigation and advising into career counseling/advising at schools, colleges, and community agencies so all participants, especially in rural and multi-role contexts, can make informed choices.
- Foster technical assistance forums and feedback channels with credentialing and licensure organizations and stakeholders to update educators, students, and employers on evolving requirements and best practices.

Enhance Professional Development and Retention Supports

- Expand access to professional development covering evidence-based practices, boundaries, safety, writing, digital skills, cultural humility, and teamwork, delivered in online and in-person formats with CEU/credentialing eligibility.
- Support the creation of mentorship, peer learning, and reflective practice programs for new and existing professionals, with targeted attention for rural and multi-role settings.
- Provide resources and funding specifically for rural, culturally specific, and smaller agencies to build and sustain career-connected learning, professional development, and student engagement.

Continuous Feedback and Communication

- Establish ongoing feedback loops with practitioners, supervisors, students, and workforce agencies (including credentialing and licensure organizations) to identify new barriers, clarify pathways/certifications, and continually refine relevant offerings for students and professionals.

Goals

- Expand equitable opportunities for Oregon students to explore, enter, and progress through behavioral health career pathways, starting early and spanning high school through advanced degrees.
- Clarify and streamline behavioral health certification and licensure navigation so students, educators, and employers can confidently map roles, requirements, and advancement options across the workforce pipeline.
- Increase workforce readiness and retention by providing accessible professional development in foundational and emerging behavioral health skills, including evidence-based practices, documentation, digital literacy, team-based care, and cultural humility.
- Strengthen rural and culturally specific participation in behavioral health fields by supporting local partners, agencies, and schools with targeted resources for career exploration, training, and student engagement.
- Foster a responsive, statewide system of continuous feedback and collaboration among education, workforce, and credentialing/licensure organizations to ensure all pathways and supports remain relevant, coordinated, and equitable.

Strategy/Deliverable Overview

Strategy: *8.1 Broaden and align career exploration.*

Deliverable: *Statewide CCL-aligned behavioral health career days, job shadowing, and roadmap for internships and observation with confidentiality/safety guidance.*

Responsible Agency: *ODE (lead), HECC, ESDs, workforce boards, CBOs.*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-12 months*

Strategy: *8.2 Clarify roles, certification, and credentialing pathways*

Deliverable: *Comprehensive, accessible guidance and integrated advising on behavioral health certifications/licensure (CADC, QMHA, LPC, peer roles, etc.).*

Responsible Agency: *HECC, ODE, community colleges, workforce agencies, Credentialing and Licensure Organizations (lead for pathways).*

Fiscal/ No Fiscal: *No fiscal*

Timeline: *3-9 months*

Strategy: *8.3 Enhance professional development and retention.*

Deliverable: *Modular, portable professional development in evidence-based practice, documentation, digital skills, self-care, team-based care; launch rural/peer mentorship.*

Responsible Agency: *HECC (lead), OHA, credentialing and licensure organizations, community colleges, universities, CBOs.*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-12 months*

Strategy: *8.4 Support rural and community-based programs*

Deliverable: *Technical assistance, resource grants, and engagement initiatives for rural/culturally specific agencies to expand BH learning opportunities.*

Responsible Agency: *OHA (lead), HECC, workforce boards, CBOs.*

Fiscal/ No Fiscal: *Fiscal*

Timeline: *6-12 months*

Strategy: *8.5 Continuous communication and feedback*

Deliverable: *Advisory groups, student/practitioner surveys, and forums, collaborating with credentialing and licensure organizations, for ongoing pathway, certification, and training improvement.*

Responsible Agency: *HECC (lead), ODE, workforce boards, credentialing and licensure organizations.*

Fiscal/ No Fiscal: *No Fiscal*

Timeline: *6-12 months*

Anticipated Implementation Barriers

Funding and Resource Constraints

- Limited or short-term funding for developing, sustaining, and expanding CCL-aligned career exploration, paid internships, and rural/culturally specific program supports.
- Insufficient resources for professional development (e.g., CEU-eligible training, mentorship) accessible to all providers and students statewide, especially in smaller or under-resourced agencies.
- Staffing shortages and competing priorities at credentialing, licensure, and educational organizations that slow updates to pathways, guidance, and technical assistance.

Data and Technology Limitations

- Disconnected or incomplete systems for tracking participation and outcomes across K-12, higher education, credentialing, and workforce agencies, making it difficult to assess progress and equity gaps.
- Limited capacity for sharing data or updating cross-system career navigation tools in real time, especially for new or evolving behavioral health roles and certifications.
- Barriers to developing and maintaining user-friendly, multilingual online guidance and advising resources.

Equity and Accessibility Gaps

- Structural barriers (cost, geography, representation, language) that limit access to internships, mentorship, and exploration opportunities for rural, BIPOC, or first-generation students.
- Variability in how professional and credentialing pathways are understood or communicated, especially in rural, multi-role, or community-based organizations.
- Ongoing stigma, confidentiality, and safety concerns that may restrict the range and depth of observation and work-based learning experiences for students in behavioral health settings.

Equity Opportunities

This action plan creates clear opportunities to advance equity by embedding culturally responsive, career-connected learning and accessible professional development at each stage of Oregon's behavioral health workforce pipeline. By coordinating with credentialing and licensure organizations, education agencies, and community partners, the plan aims to clarify pathways and remove barriers that disproportionately affect rural, BIPOC, immigrant, and first-generation students. Expanding resources for mentorship, early exposure, and tailored support helps ensure that both students and the current workforce can see themselves in, and fully access, behavioral health careers, ultimately building a workforce that reflects and serves Oregon's diverse communities.

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