



AWARE

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Montana Department of Labor & Industry
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RE: Licensing Reform Taskforce/ BH Workforce Challenges

Dear Erin:

Thank you for the opportunity to respond to participate in the above-noted taskforce, as well as offer insight into workforce challenges relating to behavioral health.

AWARE is a statewide, community-based behavioral health and developmental disability provider employing roughly 1,300 Montanans across the full continuum of roles—direct support professionals, case managers, teachers, contractors, nurses, licensed behavioral health clinicians, and psychiatrists. The scale of our workforce reflects the scale of the need: in Montana, about 234,000 adults—roughly one in five—experience a mental illness each year, and more than 50,000 adults and 12,000 adolescents have serious thoughts of suicide annually.

Our state's suicide rate, about 32 deaths per 100,000 people, is nearly two and a half times the national average, with 329 Montanans lost to suicide in 2022. At the same time, Montana ranks near the bottom nationally for access to mental health care, and approximately 770,000 residents live in communities with an inadequate supply of mental health professionals. As one of the larger behavioral health employers operating in urban, rural, and frontier communities, AWARE sits at the intersection of these realities: a high and growing demand for services, and a workforce system that is struggling to keep pace.

1. What are the most serious workforce shortages your organization is currently facing?

For AWARE, the most serious shortages are in:

- Direct care/frontline roles
 - Direct Support Professionals (DSPs)
 - Residential and group home staff
 - Community-based support workers for children, adults with developmental disabilities, and people with serious mental illness
- Clinical and licensed roles
 - Licensed Clinical Social Workers (LCSWs)
 - Licensed Professional Counselors (LPCs)
 - Psychiatrists and Psychiatric Nurse Practitioners
 - Licensed Addiction Counselors
 - School- and community-based therapists and behavior specialists
- Nursing roles
 - RNs and LPNs in our residential and community programs

The result is that AWARE regularly have open beds or unfilled service slots—not because the need is not there, but because the Organization does not have enough qualified staff to deliver services safely and effectively.

2. Which occupations are hardest to recruit for, and which are hardest to retain?

Hardest to recruit

- Psychiatrists and Psychiatric NPs, especially child/adolescent and substance-use specialists, and especially in rural communities.
- Licensed therapists (LCSW/LPC), including those willing to work in school-based, in-home, or rural settings.
- Experienced RNs/LPNs with behavioral health or developmental disability experience.

- Specialized behavior analysts / behavior support professionals for individuals with high-acuity or dual diagnoses.
- Direct care staff in rural and frontier communities, where the labor pool is very small and housing is limited.

Hardest to retain

- Direct Support Professionals and other frontline staff
 - Wages are often not competitive with other local jobs that are less demanding and less emotionally taxing.
 - High burnout, secondary trauma, and irregular schedules (nights, weekends, holidays) drive turnover.
- Early-career licensed professionals
 - They often leave for higher-paying telehealth roles or private practice once they're fully licensed.
 - Loan burden and family considerations make it hard to keep them in lower-paying community-based settings.

Retention is especially difficult in programs serving individuals with complex behavioral health and high-acuity needs, where the work is very challenging and safety risks are higher.

3. What recruiting strategies are you using today, and what results are you seeing?

Current strategies

- "Grow-your-own" pipelines
 - Promoting internal career ladders from direct care roles into supervision, case management, and eventually licensed positions, when possible.
 - Partnering informally with local colleges for internships and practicums in social work, counseling, and related fields.
 - Supporting some staff with tuition assistance or flexible schedules to pursue degrees and licensure.
- Expanded outreach
 - Posting on statewide and national job boards and professional association sites.
 - Using social media and our website to highlight AWARE's mission, culture, and impact.
 - Participating in job fairs and community events, especially in areas where we have major programs.
- Targeted rural and specialty recruitment
 - Offering sign-on bonuses or relocation assistance where we can.
 - Flexible work arrangements (hybrid or telehealth for certain clinical roles) to expand our candidate pool.
- Retention-focused recruitment messaging
 - Emphasizing mission-driven work, strong teamwork, and the opportunity to stay in Montana while working at the top of one's training.

Results

- For entry-level direct care roles, we can usually attract candidates, but many do not stay long due to pay, stress, and schedule issues.
- For licensed and highly specialized roles, recruitment remains very challenging, especially outside larger communities; searches frequently take many months and sometimes fail.
- Our "grow-your-own" approaches help, but they are slow and under-resourced relative to the scale of need. We are often training people into roles that our current reimbursement rates make hard to sustain.

4. Where are the biggest barriers: pay, training capacity, supervision, licensing timelines, geography, reimbursement, or something else?

The barriers are interconnected, but for AWARE the most significant are:

1. Reimbursement and pay
 1. Medicaid and other public reimbursement rates for community-based behavioral health and developmental disability services do not fully cover the actual cost of care.
 2. That translates directly into wage ceilings for DSPs, case managers, and even clinicians that are not competitive with other employment options—especially when you factor in the difficulty of the work.
2. Training and supervision capacity
 1. AWARE often cannot bill for time spent training and providing supervision, especially for new or pre-licensed staff.

2. That makes it expensive to bring in new graduates or career changers—even though “grow-your-own” is the most realistic way to staff rural and high-need programs.
3. Clinical supervision requirements are appropriate for quality, but they are hard to meet consistently in remote areas without funding to support supervisor time.
3. Licensing timelines and flexibility
 1. Delays in licensure processing and limited pathways for out-of-state professionals slow hiring considerably.
 2. Some requirements make it hard to fully leverage telehealth or part-time professionals who might otherwise help rural programs.
4. Geography and housing
 1. Many of our programs are in rural or frontier communities. There is a very small labor pool, limited higher education presence, and often a shortage of affordable housing.
 2. Even when AWARE can recruit someone, they may not be able to find housing they can afford on community-based pay.
5. Workload and complexity
 1. Staff are serving individuals with increasingly complex needs—co-occurring mental health, substance use, medical, and developmental issues.
 2. Documentation, regulatory, and administrative requirements have grown, but reimbursement for non-face-to-face work often has not, increasing burnout.

5. For long-term care and similar settings, are the workforce issues different from those faced by hospitals or clinics?

Yes. Some issues overlap, but long-term care and community-based behavioral/developmental services face unique challenges:

- Less pay and prestige for equally demanding work
 - Our residential and community programs operate 24/7, and staff manage intense behavioral, emotional, and sometimes physical challenges.
 - Yet wages and benefits are often significantly lower than in hospitals or larger health systems.
- Broader, more holistic responsibilities
 - Staff are not just providing clinical care; they’re also supporting daily living, education, employment, and community integration. The skill set is broad and not always recognized in pay structures or career ladders.
- Limited cross-training and pipelines from acute care
 - Nurses or therapists in hospitals may not see a clear or supported pathway into community behavioral health or developmental disability settings, even though their skills could translate with additional training.
- Less infrastructure and support
 - Smaller community providers typically lack HR, training, and recruitment infrastructure comparable to health systems, making it harder to compete for staff and to scale recruitment or residency-like programs.
- Different regulatory and reimbursement environment
 - Many of our services are heavily dependent on Medicaid and state funding, with reimbursement structures that are quite different from hospital payment models, and often not aligned with actual staffing costs.

6. Are there occupations where you would hire and train more people if the financial or regulatory structure made it more workable?

Yes. With more sustainable reimbursement and supportive regulatory structures, AWARE would significantly expand hiring and training in:

- Direct Support Professionals and residential staff
 - AWARE could open additional beds, expand community placements, and reduce waitlists if we could pay wages that compete with other local employers and fund robust onboarding and ongoing training.
- Behavioral health technicians, case managers, and peer support specialists
 - These roles are critical to prevention, engagement, and keeping people stable in the community.
 - With funded on-the-job training and billable supervision time, we could hire more entry-level workers and build them into experienced staff.
- Pre-licensed mental health professionals

- AWARE would like to hire more graduates immediately after school and provide structured supervision and training.
- That would require reimbursement models that recognize supervision time and allow some billing for services provided under supervision.
- Nursing staff specialized in behavioral health and developmental disabilities
 - With better rates and training support, we could create more stable nursing coverage in residential and community settings and reduce reliance on costly temporary staffing.
- Community-based crisis and intensive services teams
 - Where funding and regulation support mobile teams, crisis stabilization, and high-acuity community services, we can often prevent more expensive hospitalizations and out-of-state placements—but we need sustainable staffing models to do it.

7. If the task force were to focus on only a few employer-facing barriers, what should rise to the top?

From AWARE’s perspective, the top priorities should be:

1. Align reimbursement rates with the real cost of staffing community-based and long-term services
 - Ensure Medicaid and other public payers fully cover competitive wages, benefits, training, and supervision for DSPs, clinicians, and nurses.
 - Build in periodic, data-driven rate reviews tied to workforce and inflation trends.
2. Fund training, supervision, and “grow-your-own” workforce pathways
 - Create sustainable mechanisms to pay for:
 1. On-the-job training and clinical supervision time
 2. Apprenticeship and residency-style models for DSPs and behavioral health professionals
 3. Partnerships between providers, community colleges, and universities
 - Support career ladders so entry-level staff can advance within the behavioral health and developmental disability system.
3. Streamline and modernize licensure and practice rules
 - Reduce avoidable delays in licensure processing.
 - Improve reciprocity and temporary licensure for out-of-state professionals.
 - Allow appropriately supervised use of telehealth and hybrid models to extend the reach of scarce specialists into rural areas.
4. Support rural recruitment and retention
 - Consider targeted incentives (loan repayment, housing stipends, rural differential pay) for staff who work in high-need, hard-to-serve communities.
 - Explore public-private partnerships for housing and transportation where those are major barriers.

If there is help to pay competitively, train and supervise new staff, and bring people onboard quickly, especially in rural Montana—organizations like AWARE can do the rest. We have the demand, the infrastructure, and the mission; we need a workforce system and funding model that make it possible to sustain it.

By investing in upstream solutions, the moment challenges arise—building training pipelines before the shortages become catastrophic, aligning reimbursement before providers close their doors, supporting supervision and career pathways before Montana loses another generation of workers—resources and money is not the only thing saved. We save lives, strengthen schools, stabilize families, and preserve the fabric of our communities across every corner of this state.

Thank you for your leadership on this critical work, and for the opportunity to contribute to solutions that will serve all Montanans for generations to come.

Sincerely,

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