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MODEL BUILDING THE SUBSTANCE USE DISORDER WORKFORCE OF THE FUTURE ACT

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LAPPA
LEGISLATIVE ANALYSIS AND PUBLIC POLICY ASSOCIATION

O'NEILL INSTITUTE
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GEORGETOWN LAW

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Sara Pollock Hoverter, JD
Director
Center for Community Health Innovation
O'Neill Institute for National and Global Health Law
Georgetown University Law Center

Regina LaBelle, JD
Director
Center on Addiction & Public Policy
O'Neill Institute for National and Global Health Law
Georgetown University Law Center

Jennifer Li, JD
Director
Center for Community Health Innovation
O'Neill Institute for National and Global Health Law
Georgetown University Law Center

Jennifer A. Martinez, JD, PhD
Law Fellow
Center on Addiction & Public Policy
O'Neill Institute for National and Global Health Law
Georgetown University Law Center

Shelly R. Weizman, JD
Associate Director
Center on Addiction & Public Policy
O'Neill Institute for National and Global Health Law
Georgetown University Law Center

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Daniel Blaney-Koen, JD
American Medical Association

Jean Bennett, PhD
Substance Abuse & Mental Health Services Administration

Allan Clear
New York Office of Drug User Health, AIDS Institute

Kelly Corredor, JD
American Society of Addiction Medicine

Deirdre Dingman, DPh
Temple University College of Public Health

Dan Fishbein
Substance Abuse & Mental Health Services Administration, Office of Behavioral Health Equity

Sadaaki Fukui, PhD
Indiana University School of Social Work

Brandon George
Ascension Recovery Services

Marianne Gibson
National Governors Association

Jena Grosser
Advocates for Health Justice

Vicent Guilamo-Ramos, PhD, RN
Johns Hopkins School of Nursing, Institute for Policy Solutions

Larke Huang, PhD
Substance Abuse & Mental Health Services Administration, Office of Behavioral Health Equity

Andre Johnson, PhD
Detroit Recovery Project

Andrew Karhan, EdD
San Diego State University Interwork Institute

Robert Kent, JD
Kent Strategic Advisors, LLC

Jihoon Kim
InUnity Alliance

Renee Luque
Children & Family Futures

Donald McDonald
JBS International

Robert Morrison
National Association of State Alcohol & Drug Abuse Directors

Fred Rottnek, MD
Saint Louis University

Philip Rutherford
National Council for Mental Wellbeing

Nikki Soda
Sodas Consulting

Marc Stern, MD
University of Washington School of Public Health

Melanie Whitter
National Association of State Alcohol & Drug Abuse Directors

Thaddeus Wientzen
MedStar Georgetown University Hospital

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[Please note: This model act is comprehensive and represents what the drafters believe is the most thorough legislation needed for workforce development in the field of substance use disorder. That said, if a state prefers to shorten certain requirements in some of the sections (*e.g.*, in the gap analysis), the drafters suggest referring to the website of the Health Resources and Services Administration within the U.S. Department of Health and Human Services which provides extensive state level data on workforce shortfalls and can be found at https://bhw.hrsa.gov/.]

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SECTION I. TITLE.

This Act may be cited as the "Building the Substance Use Disorder Workforce of the Future Act," "the Act," or "Model Act."

SECTION II. LEGISLATIVE FINDINGS AND PURPOSE.

(a) Legislative findings. —The [legislature][1] finds that:

(1) The current substance use disorder workforce ("SUD workforce") is insufficient to meet the growing needs of individuals with substance use disorder ("SUD") in the United States and in [state].[2]

(2) There are current and projected shortages across the range of professions that form the SUD workforce, including: psychiatrists, psychologists, physicians who are board-certified in addiction medicine, addiction counselors, social workers, nursing professionals, peer support specialists, and others.[3]

(3) [State] is currently experiencing an SUD workforce shortage in the following professions: [list categories of workers where state is experiencing a shortage].

(4) The need for solutions to the SUD workforce shortage across a variety of settings and time horizons is particularly urgent given the current scale of SUD, which impacts nearly one fifth of Americans and remains a leading cause of death in the United States.[4]

(5) In 2023, 48.7 million Americans – or approximately 17 percent of the population – had an SUD, including 28.9 million with an alcohol use disorder.[5]

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[1] This Act contains certain bracketed words and phrases (*e.g.*, "[legislature]"). Brackets indicate instances where state lawmakers may need to insert state-specific terminology or facts.

[2] *See generally* NAT'L CTR. FOR HEALTH WORKFORCE ANALYSIS, HEALTH RES. & SERVS. ADMIN., BEHAVIORAL HEALTH WORKFORCE, 2023 (2023) [hereinafter BEHAVIORAL HEALTH WORKFORCE, 2023].

[3] *Workforce*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/workforce (last updated Sept. 9, 2024).

[4] *See* Farida B. Ahmad & Robert N. Anderson, *The Leading Causes of Death in the US for 2020*, 325 JAMA 1829, 1829 (2021); MERIANNE R. SPENCER et al., NCHS DATA BRIEF NO. 491: DRUG OVERDOSE DEATHS IN THE UNITED STATES, 2002-2022, at 1 (2024), https://www.cdc.gov/nchs/data/databriefs/db491.pdf.

[5] SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., PEP24-07-021, KEY SUBSTANCE USE & MENTAL HEALTH INDICATORS IN THE UNITED STATES: RESULTS FROM THE 2023 NATIONAL SURVEY ON DRUG USE & MENTAL HEALTH 26 (2024) [hereinafter 2023 NSDUH].

(6) Since 2000, more than one million Americans have died from a drug overdose, a number that has almost quadrupled since 2002.[6] Between 2020 and 2021, there were more than 178,000 deaths attributed to alcohol use alone.[7]

(7) Fewer than one quarter of those with SUD – or 13.1 million nationally – receive treatment.[8] Individuals with SUD who did not receive treatment reported stigma, cost, lack of readiness to receive treatment, and confusion about how or where to receive treatment as reasons for not receiving treatment, underscoring the importance of a robust SUD workforce across the continuum of care.[9]

(8) In [state], [percentage of people with SUD that receive treatment in state] percent of people with SUD receive treatment.

(9) The rates of people with SUD, those who access treatment, and morbidity and mortality rates vary among populations based on race and ethnicity, geographic location, medical needs, and other factors.[10]

(10) Populations at high risk of SUD and fatal overdose include, but are not limited to: American Indian and Alaska Native (AI/AN) people,[11] Black people,[12] LGBTQI+ individuals,[13] pregnant persons,[14] people with physical disabilities,[15]

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[6] SPENCER et al., *supra* note 4.
[7] *Facts About U.S. Deaths from Excessive Alcohol Use*, CTRS. FOR DISEASE CONTROL & PREVENTION ALCOHOL USE (AUG. 6, 2024), https://www.cdc.gov/alcohol/facts-stats/index.html.
[8] 2023 NSDUH, *supra* note 5, at 43.
[9] *Id.* at 48.
[10] *See* OFF. OF ASSISTANT SEC'Y FOR PLAN. & EVALUATION, U.S. DEP'T HEALTH & HUM. SERVS., SUBSTANCE USE AND SUBSTANCE USE DISORDERS BY RACE AND ETHNICITY, 2015–2019, at 1–2 (2023); Andrea Acevedo et al., *Disparities in the Treatment of Substance Use Disorders: Does Where You Live Matter?*, 45 J. BEHAV. HEALTH SERVS. & RSCH. 533, 542–44 (2018); Hortensia Amarao et al., Invited Review, *Social Vulnerabilities for Substance Use: Stressors, Socially Toxic Environments, and Discrimination and Racism*, 188 NEUROPHARMACOLOGY, May 1, 2021, at 1, 1–3, https://www.sciencedirect.com/science/article/pii/S0028390821000721.
[11] *Overdose Death Rates Increased Significantly for Black, American Indian/Alaska Native People in 2020*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION: CDC NEWSROOM, https://www.cdc.gov/media/releases/2022/s0719-overdose-rates-vs.html#print (last updated July 19, 2022).
[12] *Id.*
[13] Margaret M. Paschen-Wolff et al., *Experiences of and Recommendations for the LGBTQ+-Affirming Substance Use Services: An Exploratory Qualitative Descriptive Study with LGBTQ+ People Who Use Opioids and Other Drugs*, 19 SUBSTANCE ABUSE TREATMENT, PREVENTION, & POL'Y, Jan. 3, 2024, at 1, 2.
[14] Khrysta Baig & Stacie B. Dusetzina, Research Letter, *US Trends in Drug Overdose Mortality Among Pregnant and Postpartum Persons, 2017–2020*, 328 JAMA 2159, 2159 (2022).
[15] *See* Katherine L. Hoffman et al., *Independent and Joint Contributions of Physical Disability and Chronic Pain to Incident Opioid Use Disorder and Opioid Overdose Among Medicaid Patients*, 54 PSYCH. MED. 1419, 1425 (2023).

people who are housing insecure or experiencing homelessness,[16] and people in carceral settings or in the process of reentry.[17]

(11) The SUD workforce is often not representative of the racial, ethnic, and linguistic needs of American and [state] communities.[18]

(12) Untreated SUD poses a significant economic cost to workplace productivity, the health care system, social services, and criminal justice resources.[19]

(13) Accordingly, [the legislature] hereby adopts and invests in an evidence-based, coordinated, and accelerated SUD workforce strategy ("strategy") across the continuum of care. The strategy is a pathway to support and advance immediate, intermediate, and long-term measures to build an SUD workforce commensurate with the needs of the [state] by [10-year target date].

(b) Purpose.—It is the intent of [the legislature] through this Act to:

(1) Create the Independent Commission on SUD Workforce (Independent Commission or Commission) to complete a preliminary report as outlined in Sections IV and V;

(2) Direct the Independent Commission to develop the data-driven strategy in [state] as outlined in Section VI;

(3) Create the Office of SUD Workforce Transformation (OSWT) to implement the strategy as outlined in Section VII;

(4) Create the Center for SUD Workforce Excellence to provide technical assistance to service providers and job seekers in the SUD field as outlined in Section VII;

(5) Require independent review, assessment, and revision of the strategy as outlined in Section VIII; and

(6) Require funding for the activities under this Act as outlined in Section IX.

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[16] *See* Mark Saldua et al., *Addressing Social Determinants of Health Among Individuals Experiencing Homelessness*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN.: SAMHSA BLOG (Nov. 15, 2023), https://www.samhsa.gov/blog/addressing-social-determinants-health-among-individuals-experiencing-homelessness.

[17] *See* SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., PEP23-06-06-001, BEST PRACTICES FOR SUCCESSFUL REENTRY FROM CRIMINAL JUSTICE SETTINGS FOR PEOPLE LIVING WITH MENTAL HEALTH CONDITIONS AND/OR SUBSTANCE USE DISORDERS 35 (2023).

[18] *See*, *e.g.*, Ayana Jordan & Oluwole Jegede, *The Case for Diversity, Equity, and Inclusion in the Field of Addictions*, 29 AM. J. ON ADDICTIONS 413, 414 (2020).

[19] Erminia Fardone et al., *Economic Benefits of Substance Use Disorder Treatment: A Systematic Literature Review of Economic Evaluation Studies from 2003 to 2021*, J. SUBSTANCE ABUSE TREATMENT, Sept. 2023, at 1, 3–9.

Commentary

This Act provides for the creation of a state-level, Independent Commission to develop a data-driven SUD workforce strategy that provides a pathway for growing and strengthening the SUD workforce in the state over a 10-year target period.

The drafters of this Model Act selected a 10-year target for achieving its objectives, but some members of the working group expressed that the target date was too far in the future and did not reflect the urgency of the challenges of the issue. Other members believed that it would take a long period of time due to the scope and breadth of the need, the timeframe involved in developing a pipeline of new workers, and the limitations of government and funding. Each state may wish to select its own timeline after it conducts an assessment of state capacity and need. In its current form, the legislative text allows the Commission to adjust the timeline depending on capacity, staffing, and other factors. The Commission may also identify and make immediate improvements to extant SUD workforce policies and measures that do not require legislation or other long-term actions.

The SUD workforce comprises an array of disciplines and occupations, requiring varying levels of education, training, credentialing, certification, licensure, and/or scope of practice.[20] Members of the SUD workforce are generally required to have specific and varied competencies, training, and credentials, and to provide services in a variety of settings (*e.g.*, residential and outpatient treatment programs, partial hospitalization programs, opioid treatment programs, office-based specialty addiction treatment practices, primary care settings, emergency rooms, schools, harm reduction organizations, recovery support settings, and criminal justice systems).[21] SUD workforce roles, however, are broad, and SUD paraprofessionals – such as case managers, outreach specialists for the unhoused, or patient aides – may also require certification, depending on the state.[22]

Despite the variety of roles, the current workforce does not sufficiently address the needs of those with SUD,[23] and such SUD workforce shortages are far-reaching in the United States.[24] The U.S. Department of Health and Human Services (HHS) has predicted shortages for key members of the SUD workforce by 2025, including: psychiatrists, psychologists, and social workers.[25] Additionally, the Health Resources and Services Administration (HRSA), an agency of HHS, projects a substantial shortage of two critical treatment providers in the SUD field – adult psychiatrists and addiction counselors – by the year 2036.[26] Between 2021 and 2036, demand for adult psychiatrists is projected to increase by 55 percent, while the supply is

[20] *Workforce*, *supra* note 3.
[21] *Id.*
[22] *Behavioral Health Career Descriptions*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/behavioral-health-careers/career-descriptions (last updated Oct. 17, 2024).
[23] *See generally* BEHAVIORAL HEALTH WORKFORCE, 2023, *supra* note 2.
[24] *Id.*
[25] HEALTH RES. & SERVS. ADMIN., U.S. DEP'T HEALTH & HUM. SERVS., NATIONAL PROJECTIONS OF SUPPLY AND DEMAND FOR SELECTED BEHAVIORAL HEALTH PRACTITIONERS: 2013–2025, at 3 (2016).
[26] *Workforce Projections*, HEALTH RES. & SERVS. ADMIN., https://data.hrsa.gov/topics/health-workforce/workforce-projections (last visited Oct. 24, 2024).

expected to decrease by 18 percent.[27] Similarly, the demand for addiction counselors is projected to increase by 62 percent, while the supply of addiction counselors is expected to decrease by 13 percent.[28] Collectively, these shortages result in a workforce that can only provide adequate care for about 50 percent of those with SUD.[29]

SECTION III. DEFINITIONS.

[States may already have definitions in place for some or all of the following terms. In such case, states may use the existing definitions in place of those listed below.]

For purposes of this Act, the words and phrases listed below have the meanings given to them in this section.

(a) Continuum of care.——"Continuum of care" means an integrated system of care, spanning all levels of intensity, designed so that a patient's changing needs will be met as they move through the treatment and recovery processes.[30] The continuum of care includes prevention, harm reduction, treatment, and recovery[31] delivered across a range of settings and systems including, but not limited to, SUD treatment settings, general hospitals, mental health programs, emergency medical services, jails, prisons, juvenile/adult justice, treatment courts, child welfare, recovery community organizations, harm reduction organizations, education settings, licensed or certified housing, shelters, and employment settings;[32]

(b) Gap analysis.—"Gap analysis" means the identification of differences between a current state (*e.g.*, landscape review of the existing SUD workforce) and projected needs at a

[27] *Id.*
[28] *Id.*
[29] *Id.*
[30] AM. SOC'Y OF ADDICTION MED., THE ASAM CRITERIA: TREATMENT CRITERIA FOR ADDICTIVE, SUBSTANCE-RELATED, AND CO-OCCURRING CONDITIONS: ADULTS 610 (Corey Waller et al. eds., 4th ed. 2023) [hereinafter ASAM CRITERIA].
[31] *See* ROBERT F. FORMAN & PAUL D. NAGY, SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., U.S. DEP'T OF HEALTH & HUM. SERVS., NO. (SMA) 06-4182, SUBSTANCE ABUSE: CLINICAL ISSUES IN INTENSIVE OUTPATIENT TREATMENT: A TREATMENT IMPROVEMENT PROTOCOL (TIP) 47, at 7–16 (2006).
[32] *See generally* OFF. OF SURGEON GEN., U.S. DEP'T OF HEALTH & HUM. SERVS., FACING ADDICTION IN AMERICAN: THE SURGEON GENERAL'S REPORT ON ALCOHOL, DRUGS, AND HEALTH (2016); *see also* Jessica L. Taylor et al., *Substance Use Disorder Bridge Clinics: Models, Evidence, and Future Directions,* 18 ADDICTION SCI. & CLINICAL PRAC., no. 23, Apr. 2023, at 1, 2–7; *About Treatment Courts*, ALLRISE, https://allrise.org/about/treatment-courts/ (last visited Oct. 24, 2024).

future point in time (*e.g.*, projected SUD workforce needs in [10-year target date]), and identifying the measures needed to bridge the gap;[33]

(c) Harm reduction.—"Harm reduction" means incorporating community-driven public health strategies — including prevention, risk reduction, and health promotion — to empower people who use drugs (and their families) with the choice to live healthy, self-directed, and purpose-filled lives. Harm reduction emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission; improving physical, mental, and social wellbeing; and offering low barrier options for accessing health care services, including substance use and mental health disorder treatment;[34]

(d) Health insurance.—"Health insurance" means a legal entitlement to payment or reimbursement for healthcare costs, generally under a contract with a health insurance company, a group health plan offered in connection with employment, or a government program like Medicare, Medicaid, the Veteran's Health Administration, or the Children's Health Insurance Program (CHIP);[35]

(e) Human services.—"Human services" means a range of programs and services designed to enhance the health and well-being of individuals and communities, with a focus on providing resources for housing, food, counseling, treatment, aging and senior services, workforce development, and other services;

(f) Interstate compact.—"Interstate compact" means a legally binding agreement between two or more states. Similar to a contract, a compact establishes a formal, legal relationship among states to address common problems or promote a common agenda;[36]

(g) Landscape review.—"Landscape review" means an examination of the current state practices, challenges, and needs related to the SUD workforce in [state]. The outcome of the landscape review, combined with the needs assessment and gap analysis, is designed

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[33] *Analyze Data & Conduct Gap Analysis*, *Measures Mgmt. Sys.*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://mmshub.cms.gov/measure-lifecycle/measure-conceptualization/information-gathering/analyze-data-gap-analysis (last updated May 2024).

[34] *Harm Reduction*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/find-help/harm-reduction (last updated Apr. 24, 2023).

[35] *Health coverage*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/health-coverage/ (last visited Oct. 24, 2024); *Health Insurance Basics*, CTRS. FOR MEDICARE & MEDICAID SERVS. 1 (Sept. 2023), https://www.cms.gov/files/document/nsa-health-insurance-basics.pdf.

[36] *Frequently Asked Questions*, NAT'L CTR. FOR INTERSTATE COMPACTS, https://compacts.csg.org/faq/ (last visited Oct. 24, 2024).

to help inform policy development and decision-making and support strategic planning for improving treatment outcomes;[37]

(h) Lived experience.—"Lived experience" means having first-hand experience living with substance use and/or mental health disorder and the associated challenges;[38]

(i) Living experience.—"Living experience" means having present and ongoing experiences as individuals who are currently using substances;[39]

(j) Needs assessment.—"Needs assessment" means a process for identifying and analyzing gaps between current and desired conditions;[40]

(k) Peer support.—"Peer support" means non-clinical care and assistance that encompasses a range of activities and interactions between people who share similar experiences of navigating SUD. These activities include but are not limited to:

(1) Supporting individuals in seeking recovery;

(2) Sharing resources and building skills; and

(3) Building community and relationships;[41]

(l) Prevention.—"Prevention" means primary, secondary, and tertiary efforts to avoid the development and progression of SUDs and/or drug-related harms.

(1) Primary prevention involves promoting positive youth development and helping individuals avoid the risk factors for and development of addictive behaviors through both universal and individualized efforts;

(2) Secondary prevention consists of uncovering potentially harmful substance use prior to the onset of problems or substance use disorder symptoms through activities such as screening and referral for SUD treatment; and

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[37] *Performing a Landscape Analysis: Understanding Health Product Research and Development: A Quick Guide*, WORLD HEALTH ORGANIZATION [WHO] 2 (2023), https://iris.who.int/bitstream/handle/10665/372696/9789240073319-eng.pdf?sequence=1.

[38] Colin T. Hart, *Lived Experience is Expertise: MHSA Program Highlight*, SAN MATEO CNTY. HEALTH, https://www.smchealth.org/article/lived-experience-expertise (last visited Oct. 24, 2024).

[39] Sara Atif, *Lived and Living Experience*, CANADIAN CTR. ON SUBSTANCE USE & ADDICTION, https://www.ccsa.ca/lived-and-living-experience (last visited Oct. 24, 2024).

[40] *Step 1: Needs Assessment*, *Training and Education*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/training-education/partner-outreach-resources/american-indian-alaska-native/ltss-ta-center/planning/step-1-needs-assessment (last updated Sept. 10, 2024, 6:08 PM).

[41] *Peer Support Workers for Those in Recovery*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/brss-tacs/recovery-support-tools/peers (last visited Oct. 24, 2024).

(3) Tertiary prevention entails treating the medical consequences of substance use and facilitating entry into SUD treatment to avoid a return to substance use so that individuals may maintain their recovery;[42]

(m) Reciprocity.—"Reciprocity" means the process by which an individual holding a license or certification from one state may be granted licensure or certification in another state;[43]

(n) Recovery.—"Recovery" means a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Recovery includes four components:

(1) Health (*i.e.*, managing one's substance use and making informed, healthy choices that support physical and emotional wellbeing);

(2) Home (*i.e*., having a stable and safe place to live);

(3) Purpose (*i.e.,* having the ability to meaningfully participate in daily activities and in society); and

(4) Community (*i.e.,* building relationships and social networks);[44]

(o) Recovery support services.–"Recovery support services" means a collection of services that provide emotional and practical support for continuing recovery, as well as daily structure and rewarding alternatives to substance use;[45]

(p) Social determinants of health.—"Social determinants of health" means the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks;

(q) Substance use disorder (SUD).—"Substance use disorder (SUD)" means the recurrent use of alcohol and/or drugs that causes clinically significant impairment, including health

[42] Amanda D. Latimore et al., Discussion Paper, *Primary, Secondary, and Tertiary Prevention of Substance Use Disorders through Socioecological Strategies*, NAT'L ACAD. OF MED. PERSP. (Sept. 6, 2023), https://nam.edu/primary-secondary-and-tertiary-prevention-of-substance-use-disorders-through-socioecological-strategies/.

[43] *State Health Workforce Toolkit: Licensing and Regulation*, NAT'L GOVERNORS ASSOC., https://www.nga.org/state-health-workforce-toolkit/licensing-and-regulation/ (last visited Oct. 24, 2024).

[44] SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., PEP12-RECDEF, SAMHSA'S WORKING DEFINITION OF RECOVERY: 10 GUIDING PRINCIPLES OF RECOVERY 3 (2012).

[45] ASAM CRITERIA, *supra* note 30, at 612.

or medical problems, and inability to meet major responsibilities at work, school, or home;[46]

(r) Substance use disorder (SUD) workforce.—"Substance use disorder (SUD) workforce" or "workforce" means workforce roles trained to deliver specialty SUD prevention, treatment, and recovery services and address co-occurring medical and mental health disorders throughout and alongside the continuum of care and across a variety of treatment settings. SUD workforce roles include but are not limited to: addiction specialist physicians, advanced practice providers, case managers, community addiction specialists, counselor aides, family peer specialists, group living or group home workers, harm reduction workers, health educators, licensed clinical healthcare professionals, mental health counselors, nurses; outreach specialists, patient navigators, peer support specialists, pharmacists, primary care providers, psychiatrists, psychologists, social workers, and therapists;[47]

(s) Telehealth.—"Telehealth" (also referred to as "virtual care" and "telemedicine") means the delivery of healthcare services, including tech-assisted peer support services, through interactive audio, video, or other electronic media used for the purpose of diagnosis, treatment, consultation, or peer recovery services;[48] and

(t) Treatment.—"Treatment" means a practice or service to medically or clinically intervene upon, care for, manage, slow the progression of, or support recovery from an SUD or co-occurring mental health disorder.[49] Treatment is individualized to address each person's medical needs and includes, but is not limited to, diagnosing SUDs and co-occurring mental or physical health disorders, as well as pharmacological and non-pharmacological therapeutic interventions for SUDs and co-occurring mental health disorders. While

[46] *Mental Health and Substance Use Disorders*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/find-help/disorders (last visited Oct. 24, 2024).
[47] *Workforce*, *supra* note 3. The drafters curated this non-exhaustive list of SUD workforce roles in consultation with members of the working group.
[48] MODEL EXPANDING ACCESS TO PEER RECOVERY SERVICES ACT § IV(i) (LEGIS. ANALYSIS & PUB. POL'Y ASSOC. Proposed Official Draft 2020); *see also Telehealth,* U.S. DEP'T OF HEALTH & HUM. SERVS., https://www.hhs.gov/hipaa/for-professionals/faq/telehealth/index.html (last visited Oct. 24, 2024).
[49] MODEL OPIOID LITIG. PROCEEDS ACT § III(n) (LEGIS. ANALYSIS & PUB. POL'Y ASSOC. Proposed Official Draft 2021).

mutual help and other recovery support services complement professional treatment, they are distinct from professional treatment.

Commentary

The definitions provided in this Act come from a variety of sources. For example, the definition of "substance use disorder" is adapted from the definition of the Substance Abuse and Mental Health Services Administration (SAMHSA) in HHS. In addition, there is a more complex definition of SUD provided in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR).[50] For brevity's sake, and because this Model Act does not focus on the clinical aspects of SUD, SAMHSA's definition is used throughout this Act. The definition of "SUD workforce" is adapted from SAMHSA's description of the behavioral health workforce as well as suggestions and refinements from the working group.

The drafters selected and developed these definitions based on what would best suit the intent of this Act. Accordingly, states are strongly encouraged to follow the definitions and language used in this Act.

For the purpose of this Act, "state(s)" means U.S. states, the District of Columbia, and the U.S. territories.[51] While this Act is intended as a model for all jurisdictions in the United States, the drafters acknowledge that U.S. territories face unique challenges with SUD. Although U.S. territories receive Medicaid funds, the administration of this federal program differs from that of the U.S. states and the District of Columbia,[52] as Medicaid in U.S. territories is subject to both a capped federal allotment[53] and fixed federal matching rate (FMAP).[54]

SECTION IV. CREATION OF THE INDEPENDENT COMMISSION ON SUBSTANCE USE DISORDER WORKFORCE.

(a) Independent Commission.—An Independent Commission on SUD Workforce ("the Commission") is hereby created.

(b) Membership.—

(1) Appointment.—

[50] DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 5TH EDITION, TEXT REVISION (DSM-5-TR) (Am. Psychiatric Assoc. ed., 5th ed. 2022).
[51] 2 C.F.R. § 182.665 (2024).
[52] Lina Stolyar et al., *Community Health Centers in the U.S. Territories and the Freely Associated States*, KFF MEDICAID (Dec. 17, 2021), https://www.kff.org/medicaid/issue-brief/community-health-centers-in-the-u-s-territories-and-the-freely-associated-states/.
[53] MEDICAID & CHIP PAYMENT & ACCESS COMM'N, MEDICAID AND CHIP IN THE TERRITORIES FACT SHEET 2 (2021), https://www.macpac.gov/wp-content/uploads/2019/07/Medicaid-and-CHIP-in-the-Territories.pdf.
[54] ALISON MITCHELL, CONG. RSCH. SERV., IFI 1012, MEDICAID FINANCING FOR THE TERRITORIES 1 (2023).

(A) The Commission shall be composed of [x] members, including both appointed and ex-officio members, all of whom shall be appointed no later than three months after the effective date of this Act.

(B) There shall be [x] public members appointed as follows:

(i) One (1) appointed by the Governor;

(ii) One (1) appointed by the [Senate majority leader or equivalent];

(iii) One (1) appointed by the [Senate minority leader or equivalent];

(iv) One (1) appointed by the [House Speaker or equivalent];

(v) One (1) appointed by the [House minority leader or equivalent];

(vi) One (1) appointed by the [state] Attorney General;

(vii) One (1) appointed by the Chief Judge/Justice of [state]; and

(viii) One (1) representative[s] of Tribal Nations in [state] appointed by the state Committee/Commission on Indian Affairs.

(C) The appointed members shall be individuals who meet at least one or more of the following criteria:

(i) Have experience in providing and/or receiving SUD prevention, treatment, recovery, and/or harm reduction services, including active members of the SUD workforce;

(ii) Have expertise, experience, or education in public health policy or research, SUD, human services, medicine, mental health services, law enforcement, organized labor, and/or workforce development;

(iii) An SUD researcher with knowledge about workforce issues and trends;

(iv) Have lived or living experience with SUD or SUD recovery and/or are family members of individuals who have, or of decedents who had, an SUD; and

(v) Represent communities that have been disproportionately impacted by substance use and experience disparities in access to care and health outcomes.

(D) Commission membership shall represent the geographic regions of the state and shall reflect the racial, ethnic, and other demographic diversity of the state. All appointed members must be residents of this state.

(E) Compensation.—Appointed members shall be compensated at the rate of [$x] per year in recognition of the time commitment and effort involved.

(2) Ex-officio membership.—The Commission shall include the heads of each agency, department, or association listed below or their designees, with every effort to include individuals with lived experience:

(A) [Single State Agency], who will act as chair of the Commission;

(B) [State Department of Health];

(C) [State Medicaid Agency];

(D) [State Department of Labor];

(E) [State Department of Mental Health];

(F) [State Department of Human Services];

(G) [State Department of Corrections];

(H) [State Department of Veterans Affairs];

(I) [State Department of Education];

(J) [State Insurance Commission];

(K) [State Department of Higher Education];

(L) [State Department of Economic Development];

(M) [State association of public health agencies];

(N) [State association of local criminal justice agencies]; and

(O) [State association of county officials].

(3) Term.—Members shall serve for the full term of the Commission.

(4) Vacancy.—Any vacancies shall be filled by the original method of appointment or by the new senior representative of the appropriate agency for ex-officio members.

(5) Removal.—A member appointed Commissioner may be removed by the appointing authority for failure to attend at least 50 percent of the regularly scheduled (quarterly) meetings in any one-year period, or for unethical, dishonest,

or bad faith conduct. Members shall be subject to applicable state ethics and conflict of interest rules.

(c) Powers and duties.—

(1) The Commission shall have the following powers:

(A) To request and receive timely and complete information from state agencies, boards, commissions, courts, and legislators;

(B) To hire and manage all necessary staff, including the executive director;

(C) To hire, contract with, or consult subject matter experts in public health, epidemiology, workforce development, and other relevant fields as necessary using Commission funds;

(D) To compensate appointed members from Commission funds as set forth in this section; and

(E) To create subcommittees as appropriate to work on specific tasks or issues.

(2) The Commission shall perform the following duties:

(A) Conduct the landscape review, needs assessment, and gap analysis as outlined in Section V;

(B) Define, identify, and devise the strategy to support and strengthen the SUD workforce across the continuum of care as outlined in Section VI;

(C) Coordinate with state workforce efforts, state agencies, SUD councils, opioid abatement/settlement commissions, [state] behavioral health commissions, and local governments at all stages of assessment and strategic planning;

(D) Create a mechanism for ongoing, meaningful, and sustained community input, which shall include people with lived and living experience;

(E) Create and maintain a public dashboard that must include, at minimum, Commission minutes, attendance rolls, and votes, as well as other materials developed by the Commission;

(F) Publish and transmit the preliminary report and strategy to the Governor, [the legislature], the Attorney General, the Chief Judge/Justice, and the

Committee/Commission on Indian Affairs of the state as outlined in Sections V and VI; and

(G) Share research, analysis, and data collected by the Commission with the OSWT, as created in Section VII, along with all official materials, such as meeting agendas and minutes.

(3) Meetings.—

(A) The Commission shall hold at least four public meetings per year, at least one per quarter, with the first meeting being held no later than [three (3)] months after the effective date of this Act.

(B) A meeting may be called by the chair or by a majority of the members.

(C) Members may attend meetings in person, remotely by audiovisual means, or, upon approval by the chair, by audio-only means.

(D) Meetings shall be held in a manner reasonably designed to facilitate in-person and live-stream attendance by residents throughout the state; notice shall be given to the public in compliance with state open meetings laws.

(E) The Commission shall function in a manner consistent with [statutory reference to state's open meetings law], [statutory reference to state open records law], and with the federal Americans with Disabilities Act,[55] as amended.

(F) The Commission shall post the names of all members, the minutes of all meetings, and a record of all votes to the public dashboard created in subsection (c)(2)(E).

(G) Meetings shall provide an opportunity for public input.

(d) Staffing.—

(1) The Commission shall employ a full-time executive director for the duration of its work to support and plan the Commission's day-to-day activities, coordinate Commission meetings, and ensure that the stages of work are accomplished in accordance with this Act.

[55] *See generally* Americans with Disabilities Act (ADA) of 1990, 42 U.S.C. §§ 12101 et seq. (1990).

(2) In addition to the executive director, the Commission is authorized to employ sufficient staff to carry out its duties.

(3) The [SSA] shall be responsible for hiring and payment of the salaries for the executive director and staff.

(e) Termination.—

(1) The Commission shall terminate after the OSWT has been in operation for twelve (12) months.

(2) The Commission shall transfer all records, data, and information to the OSWT in advance of its termination.

Commentary

This Section establishes the Commission. Due to SUD's reach across all branches of government, the Commission must be an independent entity, unencumbered by the restraints of placement within a single agency or department, and must be empowered to coordinate and develop recommendations across all systems. This Act contemplates that all three branches of state government, as well as local and tribal governments, will work together to take action to ensure the adequacy and quality of the SUD workforce for the future. This structure ensures that no single branch of government has sole control over the composition of the Commission.[56] Additionally, Commission members are empowered to consult and contract with subject matter experts (*e.g.*, addiction medicine professionals, vocational rehabilitation and disability specialists, social workers, federally qualified health centers, and a host of others) as they carry out their duties.

One key priority identified by the drafters and the working group was the need for a diverse, expert, and experienced Commission membership that reflects the demographics of the state. Some members of the working group suggested considering a mandate of a set percentage of appointed members who represent the populations, demographics, and expertise listed in Section IV(b)(1(C). The drafters chose not to include mandatory percentages, but states may choose to do so.

The number of Tribal representatives appointed to the Commission should be appropriate for that state.[57] Alternatively, states may institute a Tribal consultation process, defined as "a formal, two-way, government-to-government dialogue between official representatives of Tribes and

[56] *See*, *e.g.*, *Illinois Advisory Council on Alcoholism and Other Drug Dependency,* GOVERNOR'S OFF. OF EXEC. APPOINTMENTS, https://govappointments.illinois.gov/boardsandcommissions/details/?id=9915cb5e-2007-ee11-8f6d-001dd8068008 (last visited Oct. 24, 2024).

[57] *See State Committees and Commissions on Indian Affairs*, NAT'L CONF. OF STATE LEGISLATURES, https://www.ncsl.org/quad-caucus/state-committees-and-commissions-on-indian-affairs (last updated June 9, 2021).

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Federal agencies to discuss Federal proposals before the Federal agency makes decisions on those proposals."[58]

The exact proportion of appointed ex-officio members, as well as the total number of members, is left to each state, as is the total number of members of the Commission. While not included in this Act, states may wish to establish a mechanism for members of the public to apply for appointment. The Model Opioid Litigation Proceeds Act[59] drafted by the Legislative Analysis and Public Policy Association creates an opioid settlement fund which has such a mechanism[60] which states may wish to reference or replicate for this Commission.

Because the SUD workforce is interwoven in the mission of the single state agency (SSA), the drafters recommend that the head of the SSA chair the Commission.

To obtain high level buy-in across government agencies, the Commission includes senior representatives from numerous entities that can help expand the SUD workforce, including labor, economic development, human services, educational institutions (*e.g.*, State universities, Historically Black Colleges and Universities, and community colleges), veterans affairs, Medicaid and private insurers, and corrections. States with many active local governments may want to include more local representatives from public health and other agencies.

The working group identified prioritization of public access to and engagement in the activities of the Commission, in compliance with open meeting laws that provide transparency to the public regarding regulatory meetings and decisions.

SECTION V. PRELIMINARY REPORT: LANDSCAPE REVIEW, NEEDS ASSESSMENT, AND GAP ANALYSIS.

(a) In general.—The Independent Commission shall create a preliminary report ("preliminary report") that includes a landscape review, needs assessment, and gap analysis to inform the development of the strategy.

(b) Preliminary report.—Within fifteen (15) months of the passage of this legislation and twelve (12) months of the creation of the Commission, the Commission shall conduct and transmit:

(1) A state-level landscape review that identifies the existing programs, policies, data, and other information about the existing SUD workforce in [state] as outlined in this Section;

[58] *What is a Tribal Consultation?*, U.S. DEP'T OF INDIAN AFFS., https://www.bia.gov/service/tribal-consultations/what-tribal-consultation (last visited Oct. 24, 2024).
[59] *See generally* MODEL OPIOID LITIG. PROCEEDS ACT, *supra* note 49.
[60] *Id.* §§ IV(a), V(c).

(2) A state-level needs assessment that identifies projected needs in the SUD workforce between [current year] and [10-year target date]; and

(3) A state-level gap analysis to identify any gaps, barriers, and areas for improvement between the current state of the SUD workforce, as identified in the landscape review, and the projected workforce requirements for [10-year target date], as identified in the needs assessment.

(c) Methodology.—

(1) The Commission shall conduct research and analysis for the preliminary report in consideration of, at a minimum, the following priority areas:

(A) Increasing the SUD workforce to meet the needs of a diverse population with SUD and their families across the continuum of care and settings where services and supports are provided;

(B) Improving recruitment and retention to promote the long-term sustainability of the SUD workforce;

(C) Maximizing the use of resources and administrative efficiency;

(D) Incentivizing integrative approaches to achieve holistic outcomes; and

(E) Identifying and leveraging funding and financing mechanisms.

(2) The preliminary report shall be developed in consultation with relevant stakeholders, including, but not limited to, partner agencies, relevant licensing boards, local governments, Tribal governments and communities, existing members of the SUD workforce, treatment centers, people with lived and living experience, non-governmental organizations, and members of the public.

(3) Consultations shall take the form of surveys, personal interviews, focus groups, and/or public commentary, including, as appropriate, the ability to participate anonymously.

(4) Consultations shall be offered in person, virtually, and in writing, as appropriate, and in locations and in a format accessible to the target populations.

(d) Landscape review.—The landscape review shall collect information about each of the priority areas, including, at minimum, the following:

(1) The extent to which the current SUD workforce is meeting the needs of a diverse population with SUD and their families across the continuum of care and in settings where services and supports are provided under the following topic areas:

(A) The Commission shall investigate the following elements of SUD workforce composition.—

(i) Identify the size and composition of the current SUD workforce, including:

a) Number and type of SUD workforce members across the continuum of care;

b) Demographics of the current SUD workforce, including age, race, gender, sexual orientation, sexual identity, disability, language, and lived and living experience; and

c) Services and resources for supporting the existing SUD workforce;

(ii) Identify the capacity and scopes of practice for each profession that comprises the SUD workforce, including:

a) Curricula, training, and education requirements and practices, including core curricula for each role in the SUD workforce; and continuing education content, requirements, availability, accessibility, enrollment, and participation; and

b) Scopes of practice, including treatment and services that members of the SUD workforce are educated and trained to perform; that they are permitted to, or restricted from, performing under state law; and those they are actually performing;

(iii) The skills and competencies of the existing SUD workforce, including the alignment of the SUD workforce's education, experience, and training to the needs of individuals with SUD across the continuum of care;

(iv) Existing initiatives, incentives, training, and requirements that support or require programs and providers to hire and maintain a workforce that addresses the needs of specific populations; and

(v) Disparities in the availability of and access to training and education across demographics.

(B) The Commission shall investigate the following elements regarding individuals with SUD.—

(i) The demographics of the current population of people with SUD in [state], the percentage of each demographic within that population receiving SUD treatment and/or services, and the quality of the treatment and/or services; and

(ii) Identify the demographics of the SUD population that is currently underserved in SUD treatment.

(2) The current recruitment and retention policies, programs, and initiatives in place in [state] to promote the long-term sustainability of the SUD workforce including, at a minimum, the following:

(A) Existing processes and pathways for entering the SUD workforce, including certification, credentialing, licensure, and registration in [state];

(B) Salaries, benefits, and incentives for the SUD workforce, including:

(i) Trends in wages and salaries over the previous five years for each position compared with other related fields and across the public and private sectors;

(ii) The range of benefits offered, including health care, transportation, childcare, retirement, and family leave;

(iii) The availability of tuition reimbursement programs and other financial resources for education and training; and

(iv) Union density of the SUD workforce;

(C) Recruitment and retention practices in specific SUD workforce settings, including, but not limited to, inpatient and residential settings, partial hospitalization programs, outpatient clinics, state-operated facilities,

shelters, hospitals, carceral settings, courts, child welfare systems, jails and prisons, primary care, mobile units, organizations providing recovery support services, and harm reduction programs;

(D) Barriers and incentives for licensure, certification, and credentialing for SUD workers, including:

(i) Steps for completing the credentialing and certification process;

(ii) State credentialing and certification exam requirements;

(iii) Hours of supervision for licensed, certified, and credentialed professions;

(iv) Incentives for high-quality, effective supervision; and

(v) Available financial support, including tuition incentives, stipend programs, scholarships, upfront tuition payments, loan repayment, financial support for supervision, and waiver of licensure fees;

(E) Use of reciprocity and interstate compacts in professional licensing and certification; and

(F) Turnover rates and retirement trends for each position in the SUD workforce.

(3) How stakeholders are making use of resources and administrative efficiency including, but not limited to, the following:

(A) Use of technology and telehealth services, including:

(i) Regulatory requirements and reimbursement for and access to telehealth services;

(ii) Existing telehealth services, including in rural communities and on Tribal lands and among different demographics;

(iii) The use of artificial intelligence and other emerging technologies for streamlining and updating electronic medical records, expanding telehealth options, and other uses; and

(iv) Existing training programs for current and emerging technology and telehealth capabilities.

(B) Assessment of provider workload and time, including:

(i) The range of activities that the SUD workforce is expected to perform, including supervision, service delivery, and administrative activities;

(ii) Training and reimbursement for identified activities; and

(iii) Expectations, capacity, and competencies of workers to serve patients with complex needs.

(4) The extent to which the government integrates and aligns its approach to the SUD workforce development with related efforts in similar fields, including, but not limited to, the following:

(A) Coordination and partnership between SUD workforce development and other workforce areas, including health care, mental health, and human services; and

(B) Compatibility with the state's other economic development and labor goals.

(5) Existing funding and financing mechanisms, including federal, state, local, and private-sector sources including, but not limited to, the following:

(A) For individual providers, clinics, and delivery of services in non-clinical settings:

(i) Reimbursement rates;

(ii) Requirements for funding and reimbursement; and

(iii) Challenges related to funding and reimbursement;

(B) Coverage of services;

(C) Utilization management practices;

(D) Network adequacy;

(E) Cost-sharing practices in community-based and carceral settings;

(F) Other practices related to health insurance coverage of SUD services;

(G) Parity between public and private reimbursement rates, including for plans sold through state health insurance exchanges; and

(H) Use of public-private partnerships.

(6) Any other element identified by the Commission.

(e) Needs assessment.—The needs assessment shall use workforce projection models to estimate the supply and demand of the SUD workforce in [state] by [10-year target date]. The needs assessment shall address each of the categories analyzed under the landscape review.

(f) Gap analysis.—The gap analysis shall identify any gaps, barriers, and areas of improvement between the current SUD workforce, as identified under each of the categories by the landscape review, and the projected workforce requirements for [10-year target date], as identified by the needs assessment.

(g) Reporting.—The Commission shall provide the preliminary report to the Governor, legislature, Chief Judge, and State Tribal Committee/Commission within 12 months of the Commission's first meeting. The report shall be published, at a minimum, on [state agency/department/division] website.

Commentary

The purpose of this section is to guide the Commission's development of a comprehensive overview of the existing state of the SUD workforce infrastructure to understand the state's current needs and challenges, which will help inform the setting of targets during the development of the strategy in Section VI.

This Act directs the Commission to complete all stages of the preliminary report and transmit it to all appropriate policymakers 12 months after the first meeting of the Commission (15 months after the effective date of the Act). This timeline reflects a balance between the time needed to complete a thorough investigation and analysis and the feedback from the working group that the timeline should underscore the urgency of the problem and the need to move quickly toward implementation. States can adapt these deadlines according to their own needs and capacity.

The landscape review, needs assessment, and gap analysis are related but distinct processes that contribute to the development of the strategy. The landscape review is a factual exploration of the existing conditions for each of the identified priority areas. The considerations detailed under each of the five categories for review are minimums, and states may expand and elaborate upon each of these categories as appropriate. Importantly, across each stage of the preliminary report, there is an emphasis on understanding the demographics and composition of both those with SUD and the members of the SUD workforce. This focus reflects research indicating that racial or ethnic concordance in health care (*e.g.*, between patient and provider) is associated with improved treatment outcomes.[61]

[61] *See* Ann Neville Miller et al., *The Relationship of Race/Ethnicity Concordance to Physician–Patient Communication: A Mixed–Methods Systematic Review*, 38 HEALTH COMMC'N 1543, 1543–44 (2024); O. Trent Hall et al., *Group–Based Medical Mistrust and Care Expectations Among Black Patients Seeking Addiction Treatment*, DRUG & ALCOHOL DEPENDENCE REP., Mar. 2022, at 1, 3; John E. Snyder et al., Original Investigation, *Black*

Relatedly, the role of the needs assessment builds on the factual context established under the landscape review to project SUD workforce needs by the 10-year target date. The needs assessment calls for the use of health workforce projection models, which are quantitative tools that estimate the supply of and demand for healthcare workers currently and at a future target date, stratified by workforce roles, geographic area, population trends and other demographics, differing levels of access to care, and other factors as relevant.[62] While a healthcare workforce projection is fundamentally an analysis of the labor market, the nature of healthcare systems complicates the issue (*e.g.,* the lengthy training period for health professionals, the regulatory framework governing the health workforce,[63] and the social determinants of health that impact disease prevalence).[64] Nevertheless, health workforce projection models should take into consideration important features of an effective health workforce, including ensuring a sufficient number of workforce members who are trained and have the resources to deliver treatment and services at the appropriate time and place, with the appropriate financial resources to address the health of the community.[65]

States may refer to existing resources and models for calibrating their 10-year target date projects in the needs assessment. A recent systematic review identified eight models for workforce projection and forecasting, covering supply, demand, and budgetary issues.[66] HRSA utilizes the Health Workforce Simulation Model to forecast the healthcare workforce, including the behavioral health workforce,[67] and further delineates its analysis by state.[68] The Bureau of Labor Statistics in the U.S. Department of Labor similarly forecasts workforce trends[69] and recently reported that the healthcare and social assistance sector is projected to have the largest growth over the next six years, largely driven by chronic conditions and an aging population.[70] Moreover, the Fitzhugh Mullan Institute for Health Workforce Equity at the George Washington University[71] maintains a behavioral health workforce database with a focus on addressing health

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Representation in the Primary Care Physician Workforce and Its Association with Population Life Expectancy and Mortality Rates in the US, 6 JAMA NETWORK OPEN, no. 4, 2023, at 1, 9.

[62] *See Technical Documentation for HRSA's Health Workforce Simulation Mode*, HEALTH RES. & SERVS. ADMIN., https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand/technical-documentation (last visited Oct. 24, 2024).

[63] *See* John Tayu Lee et al., *Methods for Health Workforce Projection Model: Systematic Review and Recommended Good Practice Reporting Guideline*, *in* 22 HUM. RES. FOR HEALTH 1, 2 (2024).

[64] *See Social Determinants of Health*, WORLD HEALTH ORG. [WHO], https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1 (last visited Oct. 24, 2024).

[65] *See* Lee et al., *supra* note 63, at 4; Ian Crettenden et al., *Right Time, Right Place: Improving Access to Health Service Through Effective Retention and Distribution of Health Workers*, HUM. RES. FOR HEALTH, Nov. 25, 2013, at 1, 1–2.

[66] *See* Lee et al., *supra* note 63, at 4–7.

[67] *See Health Workforce Projections Dashboard*, HEALTH RES. & SERVS. ADMIN., https://data.hrsa.gov/Content/Documents/topics/About%20the%20Workforce%20Projections%20Dashboard.pdf (last visited Oct. 24, 2024).

[68] *See Workforce Projections*, *supra* note 26.

[69] *See Employment Projections*, U.S. BUREAU OF LAB. STATS., https://www.bls.gov/emp/ (last visited Oct. 24, 2024).

[70] BUREAU OF LAB. STATS., U.S. DEP'T OF LAB., USDL-24-1776, EMPLOYMENT PROJECTIONS – 2023–2033 5 (2024).

[71] *See About the Institute*, GEO. WASH. FITZHUGH MULLAN INST. FOR HEALTH WORKFORCE EQUITY, https://www.gwhwi.org/about.html (last visited Oct. 24, 2024).

equity.[72] Several states, including North Carolina,[73] Arkansas,[74] and Arizona[75] are already analyzing employment trends to help guide their economic landscapes.

The landscape review and needs assessment are followed by a gap analysis that surveys and reviews the gaps, barriers, and/or unmet needs between the current landscape (landscape review) and the desired goals (needs assessment). For example, the gap analysis could consider shortages in the types of services needed along the continuum of care and who is qualified to provide such services. The gap analysis could also identify the legislative, regulatory, or administrative requirements in the state that might limit the SUD workforce pool (*e.g.,* state regulations that prescribe a minimum percentage of certain professionals within the SUD workforce).[76] In short, while the landscape review surveys current SUD workforce conditions, the needs assessment identifies goals for a future workforce in the 10-year target date, and the gap analysis identifies the existing deficits that create barriers to achieving those goals.

When developing the preliminary report, the Commission may consult a myriad of resources to ensure that the information collected presents an accurate reflection of the existing SUD workforce. For example, the use of surveys can help encourage participation by current and potential service recipients and SUD workforce members. Surveys could be anonymous to address fears of workplace retaliation or other concerns. It is also important to survey individuals across sectors and organizations, including state agencies and nonprofit organizations, and practitioners, people with lived and living experience, and family members. Additionally, the Commission may consult existing state-level resources, as available, as well as federal resources, including tools and dashboards provided by HRSA's National Center for Health Workforce Analysis.[77]

The elements explored under the needs assessment and gap analysis will vary based on the conditions identified under the landscape review. However, given the extended timeline for the development and implementation of the strategy, the needs assessment and gap analysis should focus not only on existing needs and barriers at the time of review but also on projected needs and barriers within the 10-year target date of the strategy.

Depending on the outcome of the needs assessment and the gap analysis (*e.g*., the volume and types of gaps, barriers, and unmet needs in the SUD workforce), states may consider prioritizing and adjusting the goals and projected 10-year needs. For example, states may consider funding,

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[72] *Behavioral Health Workforce*, GEO. WASH. FITZHUGH MULLAN INST. FOR HEALTH WORKFORCE EQUITY, https://www.gwhwi.org/behavioralhealth.html (last visited Oct. 24, 2024).
[73] *See Employment Projections*, N.C. DEP'T OF COM., https://www.commerce.nc.gov/data-tools-reports/labor-market-data-tools/employment-projections (last visited Oct. 24, 2024).
[74] *See Employment Projections*, ARK. DIV. OF WORKFORCE SERVS., https://www.discover.arkansas.gov/Employment/Employment-Projections/index (last visited Oct. 24, 2024).
[75] *See Employment Projections*, ARIZ. OFF. OF ECON. OPPORTUNITY, https://oeo.az.gov/labor-market/employment-projections (last visited Oct. 24, 2024).
[76] *E.g.*, CAL. CODE REGS. tit. 9, § 13010 (2010) (requiring 30 percent of the SUD workforce be licensed or certified counselors).
[77] *See Health Workforce Data, Tools, and Dashboards*, *National Center for Health Workforce Analysis*, HEALTH RES. & SERV. ADMIN., https://data.hrsa.gov/topics/health-workforce/data-research (last visited Oct. 24, 2024).

administrative resources, regulatory landscape, size of impacted populations, interim benchmarks, and other varied factors that might influence the feasibility of the strategy.

SECTION VI. STATE STRATEGY FOR SUD WORKFORCE [10-year target date].

(a) In general.—The Commission shall develop an SUD workforce [10-year target date] strategy based on the outcomes of the preliminary report, as well as information and public input gathered throughout the strategy development process.

(b) Development of the strategy.—

(1) The Commission shall set specific and measurable targets for each workforce category projected to be insufficient for the need in [10-year target date] based on the preliminary report as set forth in Section V. These targets shall be crafted to create a diverse, concordant workforce that meets the needs of [state]'s residents.

(2) The strategy shall identify actions and policies to achieve those targets by [10-year target date] and shall have immediate, intermediate, and long-term actions and policies. These immediate, intermediate, and long-term determinations shall be prioritized by and include items that:

(A) Require legislative action to implement, including, but not limited to, funding appropriations; modification of Medicaid reimbursement rates and/or reimbursable roles; and licensing, credentialing, and certification requirements;

(B) Require coordination across multiple agencies or partners;

(C) Require regulatory rulemaking as mandated by [relevant state statute on rulemaking];

(D) Require reciprocity or participation in an interstate compact;

(E) Require collaboration with higher education institutions for the development and implementation of SUD-informed curricula;

(F) Incorporate harm reduction principles to reduce fatal overdoses and improve outcomes; and

(G) Identify and correct policies and practices that are egregiously harmful to the SUD crisis or the SUD workforce or are antithetical to the purpose of this Act.

(3) The strategy shall be consistent with and rely on the results of the preliminary report set forth in Section V.

(4) The strategy shall be developed in consultation with all relevant stakeholders, including partner agencies, relevant licensing boards, local governments, people with lived and living experience, existing members of the SUD workforce, and members of the public.

(5) The strategy shall draw upon best practices or models from other states as appropriate.

(6) The Commission shall provide regular opportunities for public input throughout the strategy development process, including public comment on the proposed strategy before finalization.

(7) The Commission shall develop and transmit the strategy within twelve (12) months of the completion of the preliminary report.

(c) SUD strategy priorities.—The strategy shall, at a minimum, address the following priority areas:

(1) Meeting the needs of a diverse population with SUD and their families across the SUD continuum of care and settings where services and supports are provided;

(2) Improving recruitment and retention to promote the long-term sustainability of the SUD workforce;

(3) Maximizing use of resources and administrative efficiency;

(4) Incentivizing integrative approaches to achieve holistic outcomes; and

(5) Identifying new funding and financing mechanisms, maximizing existing mechanisms, and documenting any cost savings and/or economic value from providing SUD services.

(d) Meeting the needs of a diverse population with SUD and their families across the continuum of care and in the community.—The strategy shall:

(1) Set forth affirmative steps through recruiting, partnerships, and retention to ensure an SUD workforce that is concordant with and can meet the needs of the identified patient base, taking into consideration race, age, gender, sexual orientation, sexual identity, physical disability, insurance status, health status,

parenting status, housing status, geographic location, income level, language capabilities, occupation, military experience and veteran status, experience in child welfare and/or the criminal justice system, and other lived and living experience;[78] and

(2) Prioritize actions and policies to build an SUD workforce that reflects and meets the needs of people with SUD with respect to demographics, geography, and cultural and linguistic capabilities. The strategy shall also include policies to promote SUD workforce concentration in areas of greatest need to reduce disparities in access to services.

(e) Improve recruitment and the SUD workforce pipeline.—

(1) The strategy shall include actions to improve recruitment of SUD workforce members, targeting the types and numbers of professions and workers needed as outlined in the preliminary report pursuant to Section V.

(2) Recruitment actions and policies shall focus on achieving equitable access to services across the SUD continuum of care and shall take geography, language access, cultural and linguistic capabilities, and any other actions identified by the Commission into consideration as appropriate.

(3) The strategy shall include actions to build a pipeline of new workers sufficient to meet [state]'s needs by [10-year target date] and specific to the type and number of workers identified in the preliminary report. Actions shall include, but not be limited to, the following:

(A) Partnering with local community colleges, [state's university system], and [any historically Black, minority-serving, and Tribal colleges and universities situated in state]:

(B) Developing internships and apprenticeships;

(C) Increasing residency and fellowship positions for the physician workforce;

(D) Developing micro-credentialing options for the workforce;

(E) Creating opportunities for leadership development;

[78] Charushila Rukadikar et al., Review Article, *A Review on Cultural Competency in Medical Education*, 11 J. FAM. MED. & PRIMARY CARE 4319, 4319–23 (2022).

(F) Increasing opportunities for shared learning, shadowing, and mentorship;

(G) Maximizing the capacity of underrepresented communities and developing specific recruitment strategies for those communities;

(H) Updating and modernizing the existing curriculum to address the full array of needs in SUD care; and

(I) Any other actions identified during the course of strategy development.

(4) In building the pipeline of new workers, the strategy shall focus on workers for the full continuum of care and any settings where services are provided and shall include actions and policies to support alternative pipelines into SUD careers, particularly for underserved communities, including partnerships with minority-serving institutions.

(5) The strategy shall include actions and policies to expand and strengthen the workforce to support adolescents with SUD and their families.

(6) The strategy shall include actions to provide incentives and address barriers to licensure, certification, and credentialing, including, but not limited to:

(A) Alternative pathways to licensure, certification, and credentialing;

(B) Actions and policies to reduce the barriers to supervision; and

(C) Financial support, including tuition incentives, stipend programs, scholarships, upfront tuition payments, loan repayment, financial support for supervisors, and waiver of licensure fees.

(f) Improve retention to promote the long-term sustainability of the SUD workforce.—The strategy shall include recommendations and actions to address barriers to workforce retention. The strategy shall:

(1) Include assessment and consideration of the following actions to address identified barriers, including, but not limited to:

(A) Addressing legislative, regulatory, and administrative requirements by state government that serve as barriers to SUD workforce entry and retention;

(B) Providing targeted incentives for addressing gaps in the continuum of services and needs;

(C) Waiver of credentialing and certification fees;

(D) Streamlining and limiting administrative requirements, including paperwork for treatment planning and service delivery;

(E) Updating state laws that limit or prevent implementation of best practices, including hub-and-spoke models of care;

(F) Addressing worker burnout,[79] including modification to industry standards for provider business models and practices, caseloads, and standards related to workplace well-being and support;

(G) Provision of clinical support for frontline SUD workers to reduce vicarious or exacerbating pre-existing trauma;

(H) Targeted support and professional development for supervisors; and

(I) Any other actions identified by the Commission to meet the gaps identified in the preliminary report;

(2) Address compensation and benefits, including:

(A) Salary adjustments;

(B) Benefits, including health insurance coverage, transportation, childcare, retirement, holiday pay, vacation, sick days, and family leave;

(C) Financial incentives (*e.g.*, bonuses, tuition reimbursement); and

(D) Any other actions to keep positions attractive to potential workers identified by the Commission;

(3) Include actions and policies to incentivize and support SUD workforce employers to become recovery-ready workplaces;[80]

(4) Identify flexible, supportive, and trauma-informed policies and actions to support both recruitment and retention of the peer recovery and harm reduction workforces, including, but not limited to:

(A) Wages;

(B) Supervision practices;

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[79] "Burnout" is a term generally used to refer to "job-related stress in any health practice environment," particularly among those caring for vulnerable patients. Lisa S. Rotenstein et al., Original Investigation, *Prevalence of Burnout Among Physicians: A Systematic Review*, 320 JAMA 1131, 1132 (2018).

[80] *See Recovery–Ready Workplace Resource Hub*, U.S. DEP'T OF LAB. EMP. & TRAINING ADMIN., https://www.dol.gov/agencies/eta/RRW-hub (last visited Oct. 24, 2024).

(C) Development of career ladders;

(D) Plans to disperse such workforce members throughout the SUD continuum of care;

(E) Policy changes to maximize reimbursement for peer services and harm reduction services;

(F) Opportunities for mutual support;

(G) Opportunities to address burnout, including clinical care;

(H) Policies to reduce unnecessary barriers related to background checks, criminal records, educational attainment, certification, licensing, and credentialing; and

(I) Any other actions identified by the Commission to meet the gaps identified in the preliminary report; and

(5) Identify and consider actions to ensure adequate initial and continuing training and education for workforce members, as well as appropriate curricula for both, including, but not limited to:

(A) Partnerships with high schools, community colleges, colleges and universities, student-run organizations, professional schools, and clinics;

(B) Innovative teaching models;

(C) Funding for teaching positions;

(D) Updating curricula to include cultural responsiveness, strategies to address higher acuity patients, and strategies specific to suicide and overdose prevention and post-intervention;

(E) Consultation with accrediting bodies to align the breadth and scope of licensing and certification exams with SUD needs; and

(F) Consultation with educational bodies to include evidence-based SUD care in the curricula to prepare for certification exams.

(g) Maximize use of resources and administrative efficiency.—The strategy shall:

(1) Include methods to eliminate or reduce those administrative burdens identified by the preliminary report;

(2) Include actions to ensure that the SUD workforce can take full advantage of new and emerging technology to improve care delivery and reduce administrative burdens. The strategy shall include methods for training the workforce on these new technologies and shall include recommendations for any necessary policy changes, including telehealth legislation or regulations; and

(3) Include recommendations for building the infrastructure for the SUD workforce and their workplaces and financial and technical assistance for treatment providers and non-clinical settings, including capital funding, billing, and support for small and nonprofit businesses to develop new programs.

(h) Incentivize cross-systems approaches.—The strategy shall:

(1) Maximize cross-system approaches to workforce development;

(2) Ensure alignment with [state]'s other economic development, workforce development, and labor goals;

(3) Develop community engagement and education on the SUD continuum of care, including engaging with community voices, targeting underserved populations for increased access to services, and developing community engagement and resilience programs;

(4) Consider the role of reciprocity and interstate compacts in professional licensing and certification to increase the pool of available workforce members and maximize access to quality and tailored care for people with SUD;

(5) Consider the possibility of endorsements for out-of-state credentials and the potential impact of interstate compacts for both in-person and telehealth practices for all members of the SUD workforce; and

(6) Consider waiving fees for transferring credentials.

(i) Identify sources of funding and financing.—The strategy shall:

(1) Identify opportunities to maximize all sources of funding and financing, including federal, state, and private sources, and explore financing and alternative financing models to support the full continuum of the SUD workforce;

(2) For actions and policies recommended by the Commission, the Commission shall make every effort to estimate budget costs over time and shall also take into

account any projected cost savings as a result of implementing the strategy. The Commission shall also investigate funding sources for SUD workforce development including federal, state, and private funding sources; and

(3) Specifically identify opportunities for:

(A) Expanding Medicaid and Medicare coverage for a range of SUD services including those delivered in medically managed levels of care in the continuum of care, harm reduction services, and peer support services;

(B) Enforcing parity laws, especially for plans sold through state health insurance exchanges;

(C) Covering services, utilization management practices, network adequacy, and other requirements and practices related to health insurance coverage of SUD services;

(D) Identifying new funding sources to sustain funding over time;

(E) Creating public-private partnerships, including with universities;

(F) Ensuring that all health insurance entities operating within [state] offer reimbursement for the full range of clinical and non-clinical SUD services, including those delivered in medically managed levels of care in the continuum of care, recovery support services, harm reduction services, family support, prevention, supervisor support, and other health needs. Health insurance entities shall include all types of state-regulated insurance plans; and

(G) Amending state regulations to, at a minimum, be consistent with federal rules governing SUD workforce opioid treatment program operations and telehealth.

Commentary

Purpose

The purpose of this section is to enable the Commission to set specific and measurable 10-year targets for state workforce needs based on the preliminary report and develop specific actions and policies based on the listed categories to achieve those targets and, thus, the goals. Some of the actions and policies may be possible under the existing legal framework; in the event that

recommendations conflict with current laws, regulations, ordinances, and policies, states, counties, and other localities may also be required to reconsider and amend them.
This Act seeks to balance the urgency required of the current SUD workforce shortage with the long-term strategies needed to transform the SUD workforce by the 10-year target date to meet the growing needs of communities to address SUD. The drafters and members of the working group believe that a 12-month period of time to draft the strategy following submission of the preliminary report adequately strikes the balance; however, they acknowledge that states may need to adjust the timeline, depending on their capacity, budget cycle, and staffing.

The Commission is required to organize actions and policies into immediate, intermediate, and long-term categories in order to begin processes that can immediately advance the SUD workforce. The Commission is required to act immediately to make incremental progress towards the ultimate goal of building an SUD workforce commensurate with the growing needs of individuals with SUD by the 10-year target date.

One potential short-term action that can be implemented immediately is the expansion of Medicaid-reimbursable roles for the SUD workforce. For example, since 2020, California has added multiple new roles to its list of Medicaid-billable provider types, including doulas, peer support specialists, and community health workers.[81] States can also act to increase medications for opioid use disorder (MOUD) uptake.[82] A recent analysis showed that allowing MOUD initiation via telehealth can increase uptake of these life-saving medications.[83] Additionally, the scopes of practice for licensed, credentialed, and certified professionals in health care are set by legislation and/or regulation.[84] Therefore, amending those laws and/or regulations to permit providers to prescribe buprenorphine, if they are educated and trained to do so, can also increase treatment capacity for individuals with SUD.

SUD Workforce Shortage

The traditional behavioral health workforce, which includes the SUD workforce, comprises an array of disciplines and occupations with differing levels of education, training, licensure, and scopes of practice.[85] Of these varied roles, HRSA projects a substantial shortage of two critical treatment providers in the SUD space – adult psychiatrists and addiction counselors – by the year 2036.[86]

Key SUD workforce shortage factors identified by the workgroup include:

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[81] Rachel Aberbach Metz, *Medi-Cal Explained: New Medi-Cal Services at a Glance (2020–2023)*, CAL. HEALTH CARE FOUND. 1 (Aug. 2023), https://www.chcf.org/wp-content/uploads/2023/08/MediCalExplainedNewServicesGlance20202023.pdf.
[82] *See*, *e.g.*, *Improving Access to Opioid Use Disorder Treatment in Kentucky*, KY. OFF. OF DRUG CONTROL POL'Y, https://odcp.ky.gov/Resources/Documents/Pew%20Kentucky%20Memo%20FINAL.pdf (last visited Oct. 24, 2024).
[83] *See State Policy Changes Could Increase Access to Opioid Treatment via Telehealth*, PEW CHARITABLE TRS. (Dec. 14, 2021), https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2021/12/state-policy-changes-could-increase-access-to-opioid-treatment-via-telehealth.
[84] *What is Scope of Practice?*, AM. MED. ASSOC. (May 25, 2022), https://www.ama-assn.org/practice-management/scope-practice/what-scope-practice.
[85] *See Workforce*, *supra* note 3.
[86] *Workforce Projections*, *supra* note 26.

(a) *Low salaries for SUD workforce* – Salaries for many members of the SUD workforce are lower than for colleagues in other healthcare professions, in allied human services, or for those with equivalent education.[87] The average annual salary for a social worker in the addiction field is $38,600.[88] This is low in comparison to the average healthcare worker's salary of $47,230 and far less than the average salary of $52,760 for others with a social work degree.[89] Further, the average annual salary for someone with a bachelor's degree is $67,860, and only 12 percent of the total SUD workforce with a bachelor's degree earn more than $50,000.[90]

(b) *Low SUD workforce retention rates* – The average turnover rate for the U.S. workforce is 13.5 percent, excluding volunteers, contractors, and retirees.[91] However, a recent survey reported that the turnover rates of those in the SUD workforce are more than twice as high, at 32 percent.[92] These high turnover rates in the SUD workforce negatively affect the quality, continuity, and consistency of behavioral health services for those in need, while simultaneously contributing to low workplace morale, reduced productivity and effectiveness, increased costs to hire and train new workers,[93] and loss of institutional knowledge.[94]

(c) *Racial disparities within senior leadership roles in health care* – Behavioral health systems are often racially stratified organizational hierarchies, with overrepresentation of white people in leadership or upper management positions and the majority of direct care, lower wage roles occupied Black people.[95]

(d) *Lack of concordance* – The workforce must reflect the needs of individuals across the continuum of care.[96] Racial or ethnic concordance between patient and provider is associated with improved treatment outcomes; however, racial and ethnic groups are

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[87] *See* Luke Nasta & Patricia Strach, *What Drives Staffing Levels for Substance-Use Disorder (SUD) Services in New York?*, ROCKEFELLER INST. OF GOV'T 11 (2021), https://rockinst.org/wp-content/uploads/2021/11/NYS-SUD-Workforce-2021.pdf.

[88] *'Behavioral Health Workforce' Will Have Shortage of Addiction Professionals: HRSA*, ALCOHOLISM & DRUG ABUSE WKLY., May 8, 2023, at 1, 2.

[89] Nasta & Strach, *supra* note 87.

[90] *Id*.

[91] *How Much Turnover is Too Much?: Results of the 2024 US and Canada Turnover Surveys*, MERCER (Sept. 5, 2024), https://www.imercer.com/articleinsights/workforce-turnover-trends.

[92] *See 'Behavioral Health Workforce' Will Have Shortage of Addiction Professionals: HRSA*, *supra* note 88.

[93] Danielle R. Adams et al., *Therapist Financial Strain and Turnover: Interactions with System-Level Implementation of Evidence-Based Practices*, 46 ADMIN. & POL'Y IN MENTAL HEALTH 713, 713 (2019), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7083521/.

[94] Bill Stauffer, *Loss in Institutional Knowledge—A Critical Tipping Point in the SUD Workforce Crisis*, RECOVERY REV. (May 15, 2022), https://recoveryreview.blog/2022/05/15/loss-of-institutional-knowledge-a-critical-tipping-point-in-the-sud-workforce-crisis/.

[95] *See* Eric Kyere & Sadaaki Fukui, *Structural Racism, Workforce Diversity, and Mental Health Disparities: A Critical Review*, 10 J. RACIAL & ETHNIC HEALTH DISPARITIES 1985, 1987 (2023); Janette Dill & Mignon Duffy, *Structural Racism and Black Women's Employment in the US Health Care Sector*, 41 HEALTH AFFS. 265, 269 (2022).

[96] *See generally* BEHAVIORAL HEALTH WORKFORCE, 2023, *supra* note 2.

underrepresented in behavioral health.[97] For example, 63 percent of addiction counselors are white, while only 11 percent are Black.[98] A scant two percent of psychiatrists are Black.[99] Black, Hispanic, and AI/AN individuals are underrepresented in the workforce pool of physicians, physician assistants, nurse practitioners, and psychologists while white individuals are overrepresented in these workforce pools.[100] For example, 18.02 percent of the American workforce identifies as Hispanic, yet only 7.42 percent of physicians, 8.75 percent of physician assistants, 6.03 percent of nurse practitioners, and 7.98 percent of psychologists identify as Hispanic.[101] Hispanic and AI/AN people are also underrepresented in the social worker and marriage counselor worker pools, as well.[102] Similarly, 11.54 percent of the American workforce identifies as Black, yet only 5.64 percent of physicians, 4.7 percent of physician assistants, 7.24 percent of nurse practitioners, and 5.45 percent of psychologists identify as Black.[103]

(e) *Licensing fees and clinical practice hours* – Occupational licensing fees can be a barrier to entering the SUD workforce. For example, the licensing exam proctored by the Association of Social Work Boards costs $230,[104] and certification as a National Certified Peer Specialist is $235 in addition to a $150 exam fee.[105] Some states, such as Arizona,[106] Florida,[107] and Indiana,[108] have waived licensing fees for low-income individuals and members of the military. In addition, licensure, certification, or credentialing also requires hundreds or thousands of clinical practice hours. Forty-four states require 3,000 or more social work clinical hours, with Louisiana requiring the most hours (5,760) hours in the nation.[109]An applicant must also acquire between 75 and 300

[97] *See* Miller et al., *supra* note 61; Hall et al., *supra* note 61; Snyder et al., *supra* note 61.
[98] *Substance Abuse Counselor Demographics and Statistics in the US*, ZIPPIA: THE CAREER EXPERT, https://www.zippia.com/substance-abuse-counselor-jobs/demographics/ (last visited Oct. 24, 2023).
[99] *Black Mental Health Workforce Phase 1 Report*, THE ASSOC. OF BLACK PSYCH. INC.: THE BLACK MENTAL HEALTH SURV. REP. 6 (2022), https://abpsi.org/blackmhworkforce/.
[100] *See Health Workforce Diversity Tracker*, *Health Workforce Diversity Initiative*, GEO. WASH. FITZHUGH MULLAN INST. FOR HEALTH WORKFORCE EQUITY, https://www.gwhwi.org/diversitytracker.html (last visited Oct. 24, 2024); Victor A. Lopez-Carmen et al., Comment, *Equitable Representation of American Indians and Alaska Natives in the Physician Workforce Will Take Over 100 Years Without Systemic Change*, LANCET REG'L HEALTH: AMS., Oct. 2023, at 1, 1; Karen Stamm, Meron Assefa & Luona Lin, Datapoint, *Psychologists Need More Experience Working with Indigenous Populations*, 54 MONITOR ON PSYCH., no. 7, at 21, 2023, https://www.apa.org/monitor/2023/10/gaps-treating-race-ethnicity-populations.
[101] *Health Workforce Diversity Tracker*, *supra* note 100.
[102] *Id.*
[103] *Id.*
[104] *How Much Does the ASWB Exam Cost?*, AATBS (Feb. 8, 2023), https://aatbs.com/blog/post/how-much-does-the-aswb-exam-cost.
[105] *National Certified Peer Recovery Support Specialist (NCPRSS)*, NAADAC: THE ASSOC. FOR ADDICTION PRO., https://www.naadac.org/ncprss (last visited Oct. 24, 2024).
[106] *See* H.R. 2741, 55th Leg., 2d Reg. Sess. (Ariz. 2022).
[107] *See* Fla. H.R. Comm. on Com. PCB 615 (2017), https://www.flsenate.gov/Session/Bill/2017/615/BillText/Filed/PDF.
[108] *See* H.R. 1555, 123rd Gen. Assemb., 1st Reg. Sess. (Ind. 2023).
[109] *Comparison of U.S. Clinical Social Work Supervised Experience License Requirements*, ASSOC. OF SOC. WORK BDS., (Sept. 23, 2019), https://www.aswb.org/wp-content/uploads/2021/01/Comparison-of-clinical-supervision-requirements-9.23.19.pdf.

hours of supervised practice hours but must pay, on average, $100/hour for that supervision.[110]

(f) Administrative burden and burnout – Many members of the SUD workforce report feelings of stress and burnout due to substantial administrative burdens, high caseloads, low pay, and the emotional nature of SUD work.[111] According to a 2023 national survey, approximately 33 percent of behavioral health and SUD professionals spend the majority of their working hours on administrative tasks, taking time away from the treatment of people with SUD.[112] Studies suggest that the creation of career ladders for SUD workers encourages retention of experienced workers; upskilling scholarships or stipend programs with universities or psychiatric residency programs could facilitate advancement.[113]

(g) Scopes of practice, licensing, and certification – Various licenses and certifications are administered and regulated by state-level boards which generally restrict practice to the state that issued the credential. Reciprocity refers to the process by which a licensed or certified professional in one state seeks to be recognized by the state board in another state; reciprocity can work alongside telehealth regulations to allow cross-border services to be delivered.[114] This cross-state reciprocity can be challenging, given not only the variation in state-level requirements for differing licenses but also the fact that some members of the workforce (*e.g.,* peer support specialists) are certified or credentialed in some states but not others.[115]

During the COVID-19 pandemic, some states relaxed rules regarding cross-state border practice to increase access to services. New Jersey, for example, extended temporary emergency reciprocity of licensure to 31,000 out-of-state practitioners during the pandemic, resulting in over one million patients served in 36 different languages.[116] While this emergency measure was much broader than just the SUD workforce, it suggests that an expansion of reciprocity can yield significant volumes of culturally appropriate care. States can also join a variety of interstate compacts for counselors,[117] social workers,[118] and advanced practice registered nurses,[119] or can participate in

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[110] Jane Shersher, *Social Work Supervision Requirements*, SOCIALWORKLICENSURE.ORG, https://www.socialworklicensure.org/articles/social-work-supervision/ (last visited Oct. 24, 2024).
[111] *See* Rotenstein et al., *supra* note 79.
[112] *Industry Workforce Shortages Research*, Presentation, NAT'L COUNCIL FOR MENTAL WELLBEING (Mar. 16, 2024), https://www.thenationalcouncil.org/wp-content/uploads/2023/04/Workforce-Shortage-Survey-Results-1.pdf?gfaction=event_send&category&action&label&entryid=0&nonce=cb72ac9310.
[113] *See* Nasta & Strach, *supra* note 87, at 17.
[114] *State Health Workforce Toolkit: Licensing and Regulation*, NAT'L GOVERNORS ASSOC., https://www.nga.org/state-health-workforce-toolkit/licensing-and-regulation/ (last visited Oct. 24, 2024).
[115] *See* OFF. OF RECOVERY, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., PEP23-10-01-001, NATIONAL MODEL STANDARDS FOR PEER SUPPORT CERTIFICATION 9 (2023).
[116] Ann M. Nguyen et al., *Impact of the New Jersey COVID-19 Temporary Emergency Reciprocity Licensure Program on Health Care Workforce Supply*, 41 HEALTH AFFS. 1125 (2022).
[117] *See Home*, COUNSELING COMPACT, https://counselingcompact.org/ (last visited Oct. 24, 2024).
[118] *See About*, SOC. WORK LICENSURE COMPACT, https://swcompact.org/ (last visited Oct. 24, 2024).
[119] *See APRN Compact*, NAT'L COUNCIL OF STATE BDS. OF NURSING, https://www.aprncompact.com/index.page (last visited Oct. 24, 2024).

reciprocity compacts through the International Certification and Reciprocity Consortium.[120]

In addition to federal immigration hurdles, foreign-born professionals can face challenges in obtaining recognition of foreign education or credentials, often requiring a complex and costly re-accreditation process that can impede foreign-born workers from joining the workforce.[121] Recognizing these barriers, Illinois created a task force to address licensing challenges for internationally licensed healthcare professionals.[122] The task force reports to the governor and general assembly on strategies to reduce barriers to employment for this group of licensed professionals. Some states, such as Colorado,[123] Oregon,[124] and Illinois,[125] have passed legislation allowing the use of a Taxpayer Identification Number, rather than a Social Security number, for licensing of foreign-born professionals. States can also fund programs to aid foreign-born professionals with improving English proficiency[126] and achieving vocational skills to meet licensing or training requirements.[127]

Scopes of practice for many members of the SUD workforce vary widely across jurisdictions,[128] making providing care across state lines, or after a change in residence, difficult. Some states, however, have been able to build functional, multidisciplinary teams using hub-and-spoke models that take advantage of health care professionals' expertise at all levels of education and training.[129] In 2022, the Centers for Medicare and Medicaid Services released a new roadmap to support behavioral care integration across the continuum of care, to provide "the full spectrum of integrated, equitable, evidence-based, culturally appropriate, and person-centered behavioral health care to the populations it serves."[130] States can follow suit in identifying best practices of health care teams that support individuals with SUD at all stages of their disease.

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[120] *See Reciprocity/International Certificates: Prevention, Substance Use Disorder and Recovery Credentialing*, INT'L CERTIFICATION & RECIPROCITY CONSORTIUM, https://internationalcredentialing.org/reciprocity-international-certificates/ (last visited Oct. 24, 2024).
[121] *Barriers to Work: Improving Access to Licensed Occupations for Immigrants with Work Authorization*, NAT'L CONF. OF STATE LEGISLATURES (Aug. 7, 2023), https://www.ncsl.org/labor-and-employment/barriers-to-work-improving-access-to-licensed-occupations-for-immigrants-with-work-authorization.
[122] H.R. 5465, 102nd Gen. Assemb., Reg. Sess. (Ill. 2022).
[123] S. 21-077, 74th Gen. Assemb., 2d Reg. Sess. (Colo. 2021).
[124] S. 854, 80th Leg., Reg. Sess. (Or. 2019).
[125] S. 3109, 100th Gen. Assemb., Reg. Sess. (Ill. 2018).
[126] Massage Therapy Council, AB-2687, Cal. Leg. Assemb. (2022).
[127] H.R. 22-1050, 74th Gen. Assemb., 2d Reg. Sess. (Colo. 2022).
[128] *See* ASSISTANT SEC'Y FOR PLAN. & EVALUATION, U.S. DEP'T OF HEALTH & HUM. SERVS., CREDENTIALING, LICENSING, AND REIMBURSEMENT OF THE SUD WORKFORCE: A REVIEW OF POLICIES AND PRACTICES ACROSS THE NATION 13–17 (2019) [hereinafter CREDENTIALING, LICENSING, AND REIMBURSEMENT OF THE SUD WORKFORCE].
[129] https://www.ruralhealthinfo.org/toolkits/moud/2/systems-of-care/hub-and-spoke.
[130] *HHS Roadmap for Behavioral Health Integration*, U.S. DEP'T OF HEALTH & HUM. SERVS. (Dec. 2, 2022), https://www.hhs.gov/about/news/2022/12/02/hhs-roadmap-for-behavioral-health-integration-fact-sheet.html.

SECTION VII. IMPLEMENTATION OF STATE STRATEGY FOR SUD WORKFORCE.

(a) Creation of the Office for Substance Use Disorder Workforce Transformation.—Upon development of the strategy, the Governor shall create the Office for Substance Use Disorder Workforce Transformation ("the OSWT") which shall be a Cabinet-level department within the Office of the Governor.

(1) The OSWT shall:

(A) Implement the strategy;

(B) Ensure that [state] accomplishes the objectives and goals delineated by the Commission;

(C) Promote concordance in the SUD workforce;

(D) Evaluate, assess, and revise the strategy as set forth in Section VI; and

(E) Promulgate rules, define terms and standards, and perform any other act that the OSWT deems appropriate and necessary to implement the SUD workforce strategy, consistent with the purposes of this Act.

(2) The Governor shall appoint a Director of SUD Workforce Transformation ("the Director") to lead OSWT.

(3) Duties and powers.—The Director of the OSWT shall have the following duties and powers:

(A) To implement the strategy outlined in Section VI to close the gaps set forth in Section V;

(B) To issue public reports on at least an annual basis describing progress toward the goals, objectives, actions, and policies set forth in the strategy;

(C) To coordinate with other states, state agencies, and local governments, as appropriate;

(D) To request and receive timely and complete information from state agencies, board, commissions, courts, and legislators.

(E) To ensure that any necessary data is current in order to adjust and implement the strategy, as appropriate;

(F) To hire and manage all necessary staff;

(G) To contract with outside subject matter experts, as needed; and

(H) To evaluate and reassess the strategy in consultation with relevant stakeholders.

(4) The OSWT shall implement the strategy and shall seek relevant stakeholder input as necessary and appropriate.

(5) In implementing the strategy, the OSWT shall engage and educate members of SUD-adjacent workforces, including, but not limited to, housing, primary care, public assistance, economic development, and other sectors regarding SUD to increase overall community SUD competency and facilitate cross-workforce collaboration and access to services as well as work to address community members' social determinants of health.

(b) Timeline.—After the Commission transmits the strategy as required in Section VI, the OSWT shall begin implementation of the strategy. For the first year following development of the strategy, the OSWT shall work collaboratively with the Commission.

(c) Creation of the Center for SUD Workforce Excellence.—

(1) This Act hereby creates a Center for SUD Workforce Excellence ("the Center") to be located at [state university program in this state].

(2) The Center shall provide technical assistance to both service providers and job seekers in the SUD field and technical support to the OSWT as needed.

(d) Executive branch agencies may promulgate rules and perform any act deemed appropriate and necessary to implement the SUD workforce strategy, consistent with the purposes of this Act.

Commentary

This section establishes the OSWT and tasks its director with implementing the strategy. The Act places the OSWT in the governor's office to vest it with the authority and backing of the full executive branch and to increase the likelihood that the strategy will receive appropriate time, attention, and funding. The OSWT overlaps with the Commission for the first year of its existence to ensure a smooth transition from planning to implementation.

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The requirement that the OSWT seeks stakeholder input is critical to ensure that implementation steps are meeting the diverse needs of the workforce as well as the evolving needs of the public. The requirement can be fulfilled through listening sessions, surveys, opportunities for public comment on any regulatory or legislative changes, and consultation with local governments, workforce members and associations of workforce members, and members of the public, including those with SUD or family members with SUD. The state may want to include progress toward concordance of the SUD workforce alongside the OSWT's performance metrics for progress toward implementing the strategy.

During the implementation period and beyond, the OSWT should work closely with the SSA and other state and local partners to incorporate their knowledge and expertise and to build on existing initiatives. Similarly, many states have workforce development offices and boards; the OSWT should collaborate with those efforts to coordinate their efforts and include their knowledge, networks, and experience.

The purpose of the Center for SUD Workforce Excellence is to help employers and job seekers throughout the state navigate and take full advantage of the changes in policy that the OSWT achieves. Ideally, the Center will be located in a university or other institution with a history of advising the SUD workforce and employers in the state, such as the Behavioral Health Education Center of Nebraska (BHECN), housed at the University of Nebraska Medical Center.[131] BHECN supports the development of career pathways for behavioral health professionals, conducts research on the state workforce, and provides education and training to Nebraska behavioral health workers.[132]

SECTION VIII. MECHANISMS FOR EVALUATION, REASSESSMENT, AND REVISION.

(a) Progress review.—Within [x] months of the Commission transmitting the strategy to the OSWT, the [state auditor or external reviewer] shall review progress toward its implementation, including low-barrier opportunities and immediate action toward fulfilling them.

(b) Public hearing.—Within [x] months of the progress review in subsection (a), the [state legislative body] shall hold a public hearing including representatives of the executive branch and the Director of the OSWT, to discuss the legislative, regulatory, and budgetary needs for implementation of the strategy.

(c) Public dashboard.—The OSWT shall create and regularly maintain a public dashboard disclosing progress toward the actions recommended in the strategy. The dashboard shall

[131] *Developing Nebraska's Behavioral Health Workforce*, UNIV. NEB. MED. CTR.: BEHAV. HEALTH EDUC. CTR. OF NEB., https://www.unmc.edu/bhecn/ (last visited Oct. 24, 2024).
[132] *Id.*

include progress toward concordance of the SUD workforce and the populations it serves. This dashboard shall also make available any non-confidential data or metrics that the OSWT has collected or acquired that are shareable with the public or with researchers, including SUD workforce numbers and demographics.

(d) Evaluation and reassessment.—The OSWT shall evaluate and reassess the strategy's targets, actions, and policy recommendations no later than five (5) years after implementation and shall implement updates and/or changes as needed and after input from stakeholders, including members of the public. Any updates or changes, and the reasons for them, shall be based on evidence and fully transparent to all three branches of government, local governments, and members of the public.

(e) Annual report.—The OSWT shall report annually on progress toward achieving the strategy's goals and objectives to [state legislative bodies], the Office of the Governor, the [chief judge/justice], and the State Tribal Committee/Commission.

Commentary

The purpose of this section is to establish protocols for evaluation, reassessment, and revision of the strategy as needed over the course of its implementation. Given the role of the OSWT in implementing the strategy, having an independent state auditor or another external reviewer conduct a review of the OSWT's progress in implementing the strategy is critical to ensuring objectivity when assessing such progress. Similarly, holding public hearings and creating a public dashboard will enable both transparency and accountability throughout the process of executing the strategy. States can revisit the landscape review, needs assessment, and gap analysis process as a method of evaluation if they have the capacity and want fully updated information.

The timing of the progress review, public hearing, and evaluation and reassessment are at the discretion of the state legislature but should strive to balance the urgency of the SUD workforce challenges with the need to wait long enough to have work to review. The working group suggested five years post-strategy for the formal evaluation and reassessment by the OSWT; the progress review could follow to verify the OSWT's findings.

Public input is critical for maintaining valuable feedback with the OSWT which is tasked with refining and updating the strategy's goals, taking into consideration public feedback, the results of the state auditor's review, and other indicators to measure the states' progress in meeting the goals and priorities of the Commission for the SUD workforce.

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SECTION IX. FUNDING AND FINANCING.

(a) Budget allocation.—

(1) Unless otherwise fully funded through another funding source, the legislature shall appropriate sufficient funds for each fiscal year to the Commission for the purposes of completing its duties under this Act, including all stages of the creation of the preliminary report and strategy development.

(2) Unless otherwise fully funded through another funding source, the legislature shall appropriate sufficient funds for each fiscal year to the OSWT, Center for Excellence, and relevant government agencies for implementation of the strategy.

(b) Pursuit of funding.—

(1) The legislature shall identify new or existing funding sources to pay for the policies and actions recommended in the strategy, including federal, state, local, and private funds.

(2) The Commission, the OSWT, the Center, and other agencies with SUD workforce responsibilities may pursue all federal funding, matching funds, and foundation or other charitable funding to fund such activities.

(c) Acceptance of gifts.—The Commission, the OSWT, the Center, and other agencies with SUD workforce responsibilities may accept such gifts, grants, and endowments, from public or private sources, as may be made from time to time, in trust or otherwise, for the use and benefit of the purposes of this Act and expend the same or any income derived from it according to the terms of the gift, grant, or endowment, as allowed by state and federal law.

Commentary

Funding sections in model laws can be complicated, as states fund projects through legislation in a variety of ways, and there is no "one size fits all" approach. However, if the Model Act omits the funding discussion altogether, the legislation could give the appearance of an unfunded mandate.

This section makes clear that there are three distinct phases of required funding: (1) funds for the Commission's preliminary report and strategy development activities; (2) funds for the work of the OSWT in implementing the strategy; and (3) funds for the actual implementation of the

strategy. This third stage is likely to be the most challenging due to the much larger scale of funds needed to transform the SUD workforce. States can look for new funding sources such as opioid settlement funds,[133] HRSA grants (including opioid response grants),[134] and SAMHSA grants.[135] States can also try to maximize existing sources of funds such as Medicaid, through expansion (for states that have not yet expanded Medicaid under the Affordable Care Act[136]), or through waivers that enable states to use their Medicaid funds in innovative ways. Thirty-six states and the District of Columbia have had waivers approved by the Centers for Medicare and Medicaid Services to improve the continuum of care for people with SUD.[137]

Long-term, stable funding for the SUD workforce remains an ongoing challenge, while short-term grant funding leaves workforce members uncertain about their futures.[138] Some experts point to Medicare and Medicaid[139] as strong funding sources for services for low-income and senior people with SUD. Medicaid and many commercial plans, however, restrict reimbursement to licensed providers, omitting peer support specialists and community health workers in many states.[140] In addition, Medicaid does not comprehensively cover SUD services everywhere[141] and covers more people in some states than others. As of 2024, 10 states have yet to expand Medicaid coverage as allowed under the Affordable Care Act.[142] States should focus on how to pay for prevention as well as any non-certified components of the workforce (*e.g.*, peer support workers).

Funding is necessary for salaries as well as for training, recruitment, retention, and integration, as discussed throughout the strategy. Capital funding may be necessary to support and update aging

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[133] *See State Opioid Settlement Spending Decisions*, NAT'L ACAD. FOR STATE HEALTH POL'Y (May 17, 2024), https://nashp.org/state-tracker/state-opioid-settlement-spending-decisions/.
[134] *See*, *e.g.*, *Rural Communities Opioid Response Program—Rural Centers of Excellence on Substance Use Disorder*, HEALTH RES. & SERVS. ADMIN., https://www.hrsa.gov/grants/find-funding/HRSA-23-048 (last visited Oct. 24, 2024); *Integrated Substance Use Disorder Training* HEALTH RES. & SERVS. ADMIN., https://www.hrsa.gov/grants/find-funding/HRSA-23-090 (last visited Oct. 24, 2024); *Rural Communities Opioid Response Program-Implementation*, HEALTH RES. & SERVS. ADMIN., https://www.hrsa.gov/grants/find-funding/HRSA-22-057 (last visited Oct. 24, 2024).
[135] *See*, *e.g.*, *Community Mental Health Services Block Grant*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/grants/block-grants/mhbg (last updated Apr. 24, 2023); *Substance Use Prevention, Treatment, and Recovery Services Block Grant*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., https://www.samhsa.gov/grants/block-grants/subg (last updated Apr. 24, 2023).
[136] Patient Protection and Affordable Care Act of 2010, Pub. L. No.111-148, 124 Stat. 119 (2010).
[137] *Substance Use Disorder Section 1115 Demonstration Opportunity*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/section-1115-demonstrations/substance-use-disorder-section-1115-demonstration-opportunity/index.html (last visited Oct. 24, 2024).
[138] *See* CTR. FOR SUBSTANCE ABUSE TREATMENT, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., SMA12-4216, TIP 38: INTEGRATING SUBSTANCE ABUSE TREATMENT AND VOCATIONAL SERVICES 101, 106 (2012) (Chapter 6: Funding and Policy Issues).
[139] Anna Baily et al., *Medicaid is Key to Building a System of Comprehensive Substance Use Care for Low-Income People*, CTR. ON BUDGET & POL'Y PRIORITIES (Mar. 18, 2021), https://www.cbpp.org/research/health/medicaid-is-key-to-building-a-system-of-comprehensive-substance-use-care-for-low.
[140] CREDENTIALING, LICENSING, AND REIMBURSEMENT OF THE SUD WORKFORCE, *supra* note 128, at 30.
[141] Baily et al., *supra* note 139.
[142] Affordable Care Act of 2010. *See also Status of Medicaid Expansion Decisions: Interactive Map*, KFF (May 8, 2024), https://www.kff.org/affordable-care-act/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

facilities where SUD services are often provided and perhaps to build more facilities to meet projected needs, as Maine did in 2022.[143]

SECTION X. RULES AND REGULATIONS.

The department shall promulgate such rules and regulations as are necessary to effectuate this Act.

SECTION XI. SEVERABILITY.

If any provision of this Act or application thereof to any circumstance is held invalid, the remaining provisions of this Act shall not be affected nor diminished.

SECTION XII. EFFECTIVE DATE.

This Act shall be effective on [specific date or reference to normal state method of determination of the effective date].

[143] *Grant Funding Opportunity: Capital Funds for Residential Substance Use Disorder (SUD) Treatment Facilities*, STATE OF ME. DEP'T OF HEALTH & HUM. SERVS. (May 31, 2022), https://www.maine.gov/dhhs/oms/providers/provider-bulletins/grant-funding-opportunity-capital-funds-residential-substance-use-disorder-sud-treatment.

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The Legislative Analysis and Public Policy Association (LAPPA) is a 501(c)(3) nonprofit organization whose mission is to conduct legal and legislative research and analysis and draft legislation on effective law and policy in the areas of public safety and health, substance use disorders, and the criminal justice system.

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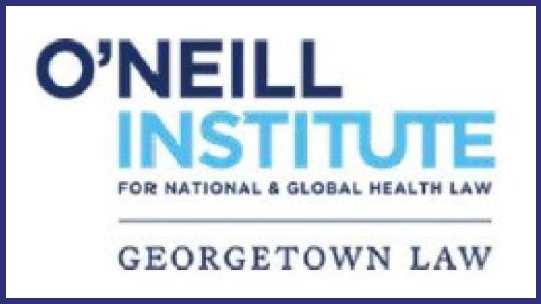
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