Health Workforce Council

April 2026

Supporting Indiana's Behavioral Health Workforce to Strengthen Community Wellness

Indiana Department of Health

Contents

Acknowledgements

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Supporting Indiana's Behavioral Health Workforce to Strengthen Community Wellness

The Health Workforce Council (Council) was established in 2024 based on a recommendation from the Governor's Public Health Commission Report. The council's mission is "to create and lead an integrated and intentional framework for strengthening Indiana's health workforce capacity." Comprised of clinicians, educators, employers, and state leaders from various geographic locations across the state, the Council seeks to integrate a diverse range of perspectives, while remaining united in their mission of supporting the health workforce.

To further this work, the Council formed subcommittees, which met throughout the 2024-2025 fiscal year, convening monthly or every other month depending on the intensity of the topic and the availability of members. Members of the subcommittees include experts in their respective fields who are dedicated to finding solutions for Indiana's healthcare workforce. The three subcommittees focused on the following areas:

- Behavioral and mental health (B & MH)
- Family medicine and pediatrics
- Obstetrics/gynecology

The following report summarizes the actions completed by the B&MH subcommittee and recommendations focused on expanding and improving Indiana's B&MH workforce.

B & MH Subcommittee

The B & MH subcommittee's mission is to review recent state-level initiatives and identify synergistic recommendations that strengthen Indiana's workforce.

Context

Each of Indiana's 92 counties contain a federally designated shortage of mental health providers, making B & MH workforce development a key strategy for supporting the wellness of Hoosiers. The workforce involved in B & MH service delivery is broad and diverse and can include professionals such as psychiatrists, psychologists, psychiatric advanced practice registered nurses, clinical social workers, mental health counselors, and marriage and family therapists, among others. The range of strategies available to support the development of this workforce is equally varied. To ensure focused research into opportunities for Indiana, the subcommittee narrowed its scope into two categories:

1. **Psychiatry residencies**: Indiana's licensed psychiatrists are required to complete medical residencies, making in-state residency positions a critical component of workforce development. This focus area examined opportunities to expand graduate medical education (GME) programs in psychiatry.

2. **Continuing education for selected clinicians:** This focus area centered on professionals licensed by the behavioral health and human services (BHHS) board. This board oversees multiple licenses for several different professions including social workers, mental health counselors, marriage and family therapists, and addictions counselors. Continuing education is one strategy states use to ensure professionals remain current with industry developments and continue to strengthen their skills. This focus area explored opportunities to modify continuing education requirements for professionals licensed by the BHHS board.

Psychiatry Residencies

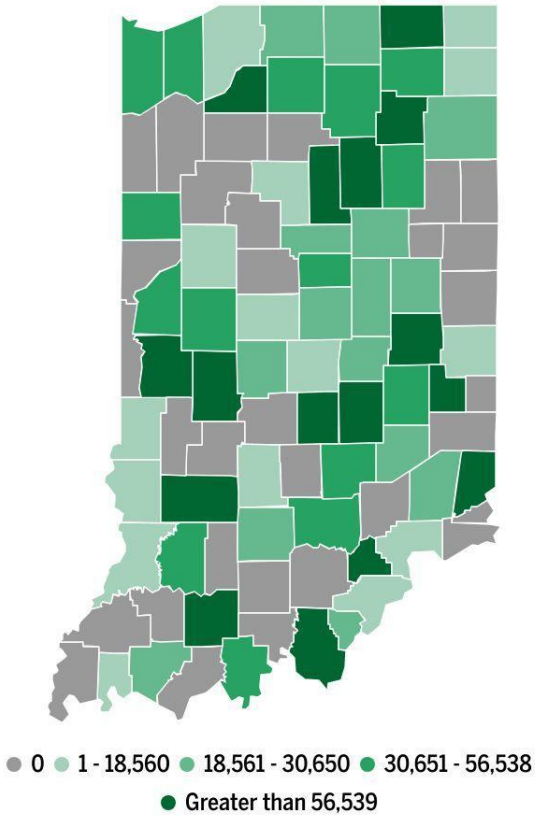
Background

Psychiatry Supply and Demand

When looking at the current capacity of psychiatrists in Indiana, the latest data shows 782 actively practicing physicians reporting a psychiatry specialty. Of these, 558 (71.4%) had at least one practice location within Indiana, with several reporting more than one practice location.

Looking at the distribution of psychiatrists across the state in Figure 1, there were 31 counties in Indiana without any reported psychiatry full-time equivalency (FTE). On top of this, 33 additional counties had a population-to-psychiatrist ratio that exceeded the federal threshold for sufficient capacity.

Figure 1: Population to Psychiatrist FTE Ratio



Indiana is expected to experience worsening psychiatry shortages, based on federal projections. According to the Health Resources and Services Administration (HRSA), the supply of psychiatrists in Indiana is expected to decline 4.3% while the demand is expected to increase more than 50%.

Psychiatry Graduate Medical Education

GME positions are essential to building a sufficient supply of psychiatrists to meet these anticipated increases in demand. There are currently five GME programs in psychiatry accredited in Indiana (Figure 2), with one new program obtaining accreditation in 2025. A total of 132 positions are approved across these five locations. A full list of programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) is included in Table 1.

Figure 2: Psychiatry Residency Programs

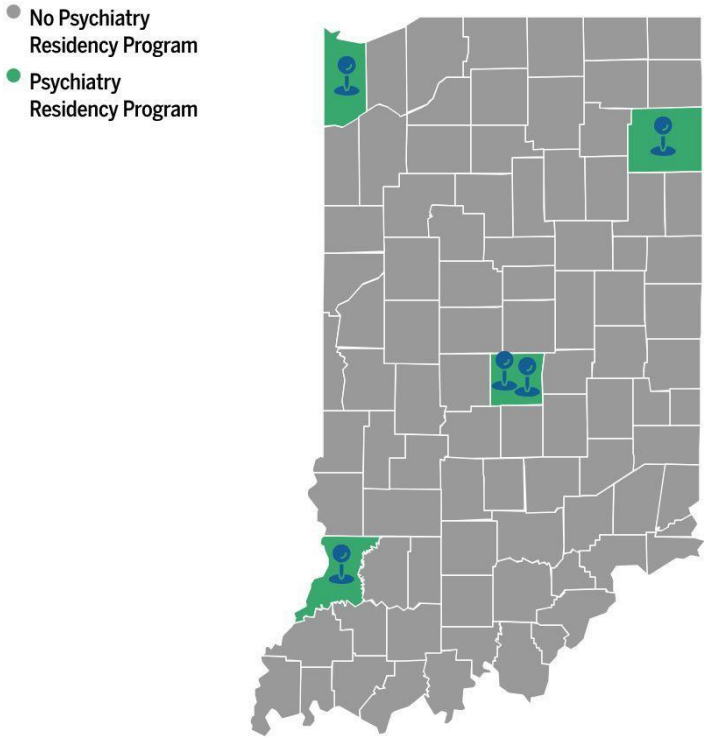


Table 1: ACGME-Accredited General Psychiatry Residency Programs in Indiana

Program Name	City	Total Approved Positions
Parkview Health Program	Fort Wayne	16
Community Health Network Program	Indianapolis	24
Indiana University School of Medicine (Vincennes) Program	Vincennes	24
Indiana University School of Medicine (Merrillville) Program	Merrillville	24
Indiana University School of Medicine (Indianapolis) Program	Indianapolis	44

While Indiana-specific retention data for psychiatry residents are limited, the Association of American Medical Colleges provides national insights. Psychiatry has the highest percentage of individuals who are practicing in the state where they completed their residency at 67%, followed by family medicine (66.4%), pediatrics (59.5%), and obstetrics/gynecology (54.2%). This underscores the strategic value of investing in GME, specifically in psychiatry, to address statewide workforce shortages.

Actions to Date

The following highlights key steps taken under this focus area.

- **Reviewed foundational Indiana B & MH reports.** To avoid duplication and build on prior work, subcommittee members reviewed key statewide behavioral health initiatives, including the 2024 Playbook for Enhancing Indiana's Mental and Behavioral Health Workforce, the 2022 Behavioral Health Commission Report, and the 2024 Behavioral Health Commission Report. This review identified several recommendations focused on expanding psychiatry residency programs and ensuring sustainable funding for them. According to the Playbook, a psychiatry residency program received notice that grant funding for three positions would be discontinued as of June 30, 2024. With no alternative funding identified, those positions were not offered in the subsequent match (the standard process through which programs and medical students are matched together). This highlights a broader vulnerability. Several other psychiatry residency positions across Indiana are also reliant on grants, meaning shifts in the grant environment may threaten the long-term stability of the state's residency capacity.
- **Mapped the current psychiatry residency landscape statewide.** Subcommittee members mapped the current landscape of psychiatry residency programs statewide, finding that a new program had been established and accredited in Fort Wayne since the publication of the previously reviewed resources. Subcommittee members reviewed all five of the residency programs shown in Table 1. Discussions centered on the spread of these programs across the state and the distribution of rural and urban programs. There were also detailed discussions about current barriers to obtaining state, national, or private funding to support psychiatry residencies and potential opportunities to align existing state investments, such as those from the GME Board, with the priority of psychiatry.
- **Explored rural training models to strengthen rural communities.** Research shows that rural training experiences during residency are associated with higher rates of subsequent rural practice. With this in mind, the subcommittee explored models for integrating rural rotations into psychiatry residency programs. Information about the Wisconsin Collaborative for Rural GME (WCRGME) was reviewed as a compelling model. The WCRGME illustrates how collaboration among health systems, medical schools, and community hospitals can meaningfully expand rural training capacity.

Solution

Based on research, stakeholder engagement, and strategic planning, the subcommittee presents the following recommendation for the Council's consideration.

- **Expand the pipeline of psychiatry residents by prioritizing GME funding.** To align GME funding decisions with statewide workforce needs, the GME Board should prioritize psychiatry residencies for funding, particularly those offering rotations at rural or community-based sites. Indiana policymakers, informed by this research, have already worked to advance parts of this recommendation. House Enrolled Act 1358 was signed into law in 2026 and requires all Indiana medical schools to ensure medical students complete a rural health rotation, a key step toward cultivating a workforce equipped to serve rural Hoosiers. Policymakers have also implemented incentives through Indiana's Rural Health Transformation program for clinical preceptors to bring students to rural communities for training. This expanded funding is critical to ensuring adequate training to support the psychiatric medicine pipeline.

Continuing Education for Master's-Level Clinicians

Background

Expanding access to high-quality behavioral healthcare is a priority of Indiana's Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA). One way the state aims to achieve this is by expanding evidence-based care through a shift to a certified community behavioral health clinic (CCBHCs) model.

CCBHCs are specially designed clinics that provide integrated and coordinated mental health and substance use services and have been proven to ensure access to services while meeting strict quality and coordination criteria. In June 2024, Indiana was one of 10 states selected to participate in a federal demonstration program, securing funds for the implementation of the CCBHC model at eight pilot sites. Indiana's long-term goal is to implement the CCBHC model as the primary community behavioral healthcare mechanism statewide.

Along with this, FSSA, through its DMHA, is seeking to establish a Center of Excellence. This Center would enhance the delivery of evidence-based practices (EBPs) across the eight CCBHC pilot sites, with a goal of providing training and fidelity monitoring in state-prioritized EBPs.

Table 2: Indiana's CCBHC Evidence-Based Practices.

Evidence Based Practice	Population	Status
Motivational Interviewing (MI)	All	Required
Cognitive Behavioral Therapy (CBT)	All	Required
Dialectical Behavior Therapy (DBT)	Adults and adolescents	Required
Trauma-Focused Cognitive Behavioral Therapy (tfCBT)	All	Required
Integrated Dual Diagnosis Treatment	Adults	Required
Assertive Community Treatment (ACT)	Adults	Required

While the CCBHC model will strengthen quality within participating clinics, there is currently no mechanism to ensure evidence-based standards are adopted more broadly. Based on workforce data collected at the time of license renewal in 2024, 31.5% of licensees who report actively providing services to Hoosiers also reported private practice as their primary work setting[1]. It is important to consider how to ensure comparable care quality for Hoosiers in non-CCBHC settings. The subcommittee's research into continuing education as a potential lever to address this gap is summarized below.

Actions to Date

- **Reviewed foundational Indiana B & MH reports.** Subcommittee members reviewed previous statewide mental and behavioral health initiatives to ensure no duplication of efforts and a deep understanding of relevant recommendations. These materials included the 2024 Playbook for Enhancing Indiana's Mental and Behavioral Health Workforce, the 2022 Behavioral Health Commission Report, and the 2024 Behavioral Health Commission Report. This review led to a discussion of the complex and interconnected factors driving behavioral health workforce challenges and exploration of continuing education approaches as an area for further consideration.
- **Conducted research on continuing education as a workforce strategy**: Members reviewed evidence on continuing education and workforce outcomes and found a limited body of evidence that suggested:

- Continuing education may reduce burnout. Learning new skills can be invigorating for healthcare professionals and has been demonstrated to be associated with lower burnout rates. This research also showed that healthcare professionals may find it difficult to stay up to date with the latest knowledge.
- Educational meetings, commonly used as continuing education, either alone or when combined with other continuing education strategies, can improve professional practice and healthcare outcomes, but the ultimate effect is modest.
- Engaging in regular or mandatory training and supervision can help develop skills in behavioral health workers and is particularly important given the increasingly complex needs of clients. However, there can be challenges implementing educational trainings in rural areas.

Overall, the available research suggests some potential benefits of continuing education, but this evidence is limited in scope and strength. Additional research is needed before implementing large-scale workforce changes.

- **Catalogued continuing education requirements in Indiana and contiguous states:** A review of continuing education requirements in Indiana and its contiguous states was completed. Overall, Indiana is similar to contiguous states in the number and timeframe to obtain continuing education units. However, Indiana is the least restrictive in defining specific topics and content as only ethics is outlined as required. Other states have mandated continuing education in specific topics such as implicit bias in Illinois, domestic violence in Kentucky, and human trafficking in Michigan.
- **Evaluated potential continuing education approaches:** After weighing two approaches for continuing education, EBPs and clinical supervision, given Indiana's shortage, the subcommittee found that neither was sufficiently supported by evidence or practically viable. The first raised concerns about regulatory burden and cost, and the second about impacts on supervisor availability. Following extensive discussion, the subcommittee concluded that mandating topic-specific continuing education would likely create additional barriers rather than reduce them. This conclusion and supporting data were presented to and approved by the Council on Sept. 18, 2025.