Therapists' Work Conditions as Patients' Treatment Conditions: A Qualitative Study of Unionized Public Mental Health Therapists

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Acknowledgements

The authors would like to express gratitude to the unions and labor advocacy groups that supported recruitment on this project. The authors would also like to sincerely thank Emily Iwamato for her recruitment support and invaluable feedback on the draft; Matthew Borus for his support of recruitment; Ursula Wagner and Victoria Fleck for piloting the interview guides; Madeline Kiefer for her editorial support; and Ahnaf Annur, Akshita Arora, Iris Chiou, Cristian Farias, Rosena Petit Homme, Samantha Morreale, Solanyi Paulino, Maria Ryding, and Samantha Seibert for their helpful transcriptions. Finally, the authors would like to thank Joanna Wuest for her sharp insights and comments on the manuscript.

Funding

Dr. Danielle Adams undertook this study during her postdoctoral fellowship, funded by the NIMH (5T32MH019960). The authors did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors to conduct this research study.

Declarations of Competing Interests

The authors have no competing or financial interests to declare.

Abstract

As mental health treatment seeking has increased recently, U.S. public mental health therapists have been asked to do more with less. Facing growing work demands, many have left the workforce, exacerbating existing mental health workforce shortages and mental health inequities. However, a growing share of therapists have sought to improve their working conditions through labor organizing. This qualitative study explored how unionized public mental health therapists in New York City and Chicago experience and seek to address their workplace challenges. Participants (N = 30) were interviewed for 60-90 minutes to gain their in-depth perspectives; interviews were analyzed using thematic analysis. The research team identified four main themes. First, public mental health therapists described that their under-resourced and diverse patients have complex social service and clinical needs —needs therapists are highly motivated to address. Second, therapists described significant workplace challenges (*e.g.*, staffing shortages, demanding workloads, low pay, insufficient clinical support). Third, therapists described that these workplace challenges negatively impact them emotionally and negatively impact the care their under-resourced patients receive. Fourth, therapists described reasons for and benefits to labor organizing including improving their work conditions and the quality of services. Findings revealed that public mental health therapists are intrinsically motivated to support their under-resourced patients, but that their labor conditions often hinder them from offering the high-quality care they feel their patients deserve. Public mental health therapists across both cities view labor unions as a vehicle through which they can improve their working conditions and the treatment conditions of their patients.

Keywords: mental health workforce; labor unions; organizing; public mental health services

Impact Statement

The United States is facing an unprecedented mental health provider shortage crisis, which is more severe in public mental health settings that serve Medicaid-insured, uninsured, and under-insured individuals. Therapists are leaving the mental health workforce, particularly the public sector, due to demanding work conditions. This study documents public mental health therapists' perspectives of these work conditions and how these conditions negatively impact them and their under-resourced patients. It also explores how therapists' grassroots labor organizing can improve their work conditions and the treatment conditions of their patients.

Therapists' Work Conditions as Patients' Treatment Conditions: A Qualitative Study of Unionized Public Mental Health Therapists

Therapists working in the U.S. public mental health system face challenging labor conditions (Last et al., 2022; Luther et al., 2017). Over 50% of public mental health therapists work overtime each week (Fukui et al., 2020; Luther et al., 2017) and one study found that 22% of public mental health therapists met symptom cut-off criteria for posttraumatic stress disorder due to secondary or vicarious trauma— symptoms of distress associated with working with traumatized patients (Baird & Kracen, 2006; Last et al., 2022). Due to chronic underinvestment and infrastructural fragmentation, the public mental health system (a patchwork system of organizations that serve largely uninsured and publicly insured patients) does not have the resources or capacity to adequately remunerate, support, or expand its workforce (Tikkanen et al., 2020). As demand for mental health services has grown in recent decades, therapists have been asked to do more with less (Lipson et al., 2019; Luther et al., 2017; Mojtabai & Olfson, 2020). A robust literature now documents public mental health therapists' occupational burdens: economic precarity resulting from public mental health organizations increasingly hiring therapists as independent contractors (Beidas et al., 2016); financial strain due to low wages and growing educational debt burdens (Council on Social Work Education, 2023; Last et al., 2022); onerous documentation (Hallett et al., 2024; National Council for Mental Wellbeing, 2023; Zhu & Eisenberg, 2024); overwork (Luther et al., 2017); and the negative emotional and service quality impacts of these burdens (Hallett et al., 2024; Last et al., 2022; Salyers et al., 2015).

Due to these conditions, many therapists have left or forgone entering the public mental health workforce just as their services are needed most (Adams et al., 2019; Bureau of Health Workforce, 2023; Hallett et al., 2024; National Association of Community Health Centers, 2022;

National Council for Mental Wellbeing, 2023). Public mental health organizations experience high turnover, with 6-50% of the workforce leaving each year (Brabson et al., 2020). A 2022 survey of federally qualified health centers found that 68% of these centers had lost 5-25% of their workforce in the past six months, with mental health providers being among the top providers to leave (National Association of Community Health Centers, 2022). The current exodus has exacerbated preexisting mental health workforce shortages across the United States (Brabson et al., 2020; Hallett et al., 2024; Health Resources & Services Administration, 2023; National Council for Mental Wellbeing, 2023). Mental health workforce shortages have not only led to significant access problems for those seeking services, but they have also been associated with lower quality care as fewer therapists see more patients (Baker et al., 2019). These challenges exacerbate mental health inequities given that under-resourced populations do not have the financial means to seek services outside the public system.

Though many therapists have opted to exit the public mental health system and the mental health workforce altogether, others have sought to improve their working conditions through labor organizing. Since the coronavirus pandemic, there has been a surge in union activity among U.S. workers, particularly among healthcare workers (Bronfenbrenner, 2023; Lazaro & Lancaster, 2024). In October 2023, for instance, 75,000 workers at one of the United States' largest healthcare nonprofits went on strike, making it the largest healthcare worker strike in U.S. history (Delouya, 2023). In their labor organizing efforts, healthcare workers have argued that improving their labor conditions improves patient care (Clark & Clark, 2006; Zelnick et al., 2022). In negotiations with employers, many clinicians have also specifically advocated for better treatment conditions for their patients. Despite low unionization rates among therapists—at around 15% of the mental health workforce (Ahmed et al., 2022) in the context of low

unionization rates in the United States overall (Bureau of Labor Statistics, 2024) —many unionized therapists have collectively organized with other healthcare workers to demand better mental health service conditions. For example, in a 10-week strike in 2022, 2,000 mental health clinicians walked off the job to fight for reduced workloads as well as more time with patients and reduced treatment wait times (Mensik, 2022).

Amid a worsening mental health workforce shortage, it is necessary to empirically investigate how public mental health therapists experience their work conditions and how they have sought to improve these conditions (for themselves and for their patients) through labor organizing. Though there has been increasing research demonstrating the positive impacts of unions for healthcare workers and patients (Dean et al., 2022, 2023a, 2023b; Dube et al., 2016), to our knowledge, no study has examined the perspectives of healthcare workers. Nor have studies focused on the mental health workforce, a sector experiencing unique workforce challenges. The objective of the present qualitative study was to examine the perspectives of unionized public mental health therapists working in diverse American cities (New York City and Chicago) to gain an in-depth understanding of therapists' work conditions and labor organizing efforts.

Methods

Study materials (i.e., the study eligibility screener, participant background questionnaire, and interview guide) are available on *Open Science Framework* (Last, 2024).

Participants

Participants were eligible for the study if they were: 1) union members; 2) providing direct outpatient mental health services; 3) had completed graduate training; 4) served mostly Medicaid or uninsured patients; and 5) worked in New York City or Chicago. New York City

and Chicago were selected because both cities share similar features that make them amenable to comparison. New York City and Chicago are relatively pro-labor and diverse cities in the United States that have both witnessed their public mental health systems lose capacity in recent decades (Moreno, 2021; Weaver et al., 2023). In addition, all authors have worked clinically and researched the public mental health systems of each city and, thus, have substantial knowledge about each system and the workforce challenges they both face.

Participants were recruited using purposive sampling methods including stratified, criterion-based, and snowball sampling methods (Palinkas et al., 2015). In terms of sampling stratification, our research team decided *a priori* that an equal number of therapists from New York and Chicago would be recruited to ensure equal representation of therapists' contexts. We primarily recruited through social media. To support additional recruitment, we presented at a New York City union meeting and a Chicago social worker labor group meeting to recruit participants and used snowball sampling, a common qualitative sampling technique well-suited for hard-to-reach participants, in which participants who completed the interviews were encouraged to share the study flyer with coworkers (Parker et al., 2019). People interested in participating in the study were invited to complete a screener via the secure web-based survey platform REDCap to ensure they met our study eligibility criteria. If eligible, participants were invited to review the study procedures, consent to the study, and complete a 5-minute background questionnaire on REDCap that assessed participants' demographics, training experiences, and work-related experiences as well as to schedule the interview.

Procedures

Interviews occurred individually via *Zoom* in Spring 2023. The first author, a clinical psychology faculty member, and the second author, a social work faculty member, conducted the

interviews using a semi-structured guide; see the interview guide available online (Last, 2024). Before initiating the study, the research team sought feedback on the guide from therapists and healthcare union staff and piloted the guide with a therapist who had previously been a union shop steward in a community mental health center. We iteratively adjusted the guide based on feedback and the pilot interview.

After each 60–90-minute interview and throughout data collection, our research team kept field notes to document preliminary codes and themes. Each interview was video recorded, transcribed verbatim by trained research assistants, and reviewed by interviewers for accuracy. All study procedures were approved by The Stony Brook University and Washington University in St. Louis Institutional Review Boards. Participants were compensated a $100 gift card for their time.

Sample Size

Throughout interviews, we made sample size determinations as a team. Due to the nature of qualitative studies, breadth or generalizability of the findings are not considered criteria for sampling determinations. Rather, the depth and richness of the data are primary sample size considerations. In our study, sample size determinations were based on whether participants' responses achieved sufficient information power (Malterud et al., 2016). Information power is a recommended standard to determine the sample size of qualitative research studies (Malterud et al., 2016). As outlined by Malterud and colleagues (2016), information power is achieved if: (1) the findings address researchers' study aims; (2) the sample is specific; (3) theoretical and empirical research guide the study; (4) the quality of the interview dialogue is high; and (5) the study focuses on an in-depth, rich analysis of selected participants. Throughout the study process, our team used these criteria to determine the sample size. That is, we noted whether our

specific sample of New York City and Chicago unionized public mental health therapists' responses adequately addressed the study aims, whether the findings aligned with the theoretical and empirical literature on labor organizing among healthcare workers (Clark & Clark, 2006; Zelnick et al., 2022), and whether the quality of the interview dialogues were high. Once all criteria were met, we stopped recruiting additional therapists.

Analytic Plan

Background Questionnaire

Participants' demographic characteristics and professional experiences were characterized descriptively.

Interviews

Interviews were analyzed using thematic analysis (Braun et al., 2017). Our research team analyzed the data in the qualitative software program, MAXQDA (VERBI Software, 2021), using six recursive phases: 1) data familiarization; 2) code generation; 3) theme construction; 4) theme review; 5) theme definition and naming; and 6) final conceptualization and writing.

First, three research team members reviewed the video recordings and transcripts and documented our initial reflections. We developed preliminary codes and themes as a group. Then, we analyzed the transcripts using a line-by-line open coding approach, generating codes inductively and deductively. Next, we developed themes by identifying central organizing concepts among code clusters. We coded ten transcripts together during which codes and themes were further reviewed, defined, and named. The remaining 20 transcripts were coded individually, and the team checked in regularly to ensure consistent code application and to refine codes and themes. When writing the manuscript, we reviewed all coding and finalized our conceptualization.

Results

Background Questionnaire

Participants' demographics and professional experiences are depicted in Table 1.

Interviews

We identified four main themes that capture therapists' experiences in public mental health settings: 1) under-resourced patients' significant needs and therapists' desire to support them; 2) workplace challenges; 3) emotional and service impacts of workplace challenges; and 4) reasons for and benefits to labor organizing. See Figure 1 for the thematic map.

Under-resourced Patients' Significant Needs and Therapists' Desire to Support Them

This first theme describes the significant needs of the under-resourced patients that public mental health clinics serve and therapists' desire to support them. It includes two subthemes: 1) public mental health patients' significant needs; and 2) therapists' desire to make a difference.

Public Mental Health Patients' Significant Needs. Nearly all interviewed therapists described that the patients seeking care at their clinics face significant structural and clinical challenges. They described that their Medicaid or uninsured patients often face housing instability, food insecurity, legal challenges related to their immigration status, and chronic, untreated physical healthcare issues. Therapists frequently noted that their patients are chronically exposed to trauma and adversity that perpetuate their mental health challenges: "The population that we work with at our organization tends to be a pretty traumatized population—just people who didn't have their basic needs met at different points, let alone higher-level needs" (Participant 11).

Therapists' Desires to Make a Difference. Therapists reported that supporting under-resourced patients is a major reason why they work in public mental health settings and that they

value making a meaningful difference in people's lives: "Despite how difficult the work can be, I think what makes it feel exciting or meaningful is that it [the public hospital] really is an open door for anybody" (Participant 9). Most therapists described that serving under-resourced patients best aligns with their values and reasons for joining the profession: "I find that really rewarding to…work with people who don't have a lot of power or resources—to empower and resource them on their own terms" (Participant 10). Therapists often voiced "valuing social justice and valuing everyone's need for care" (Participant 26). Some therapists explained that their personal experiences of adversity motivate them:

> Our clinics provide free services for people who are undocumented. They don't have to pay for anything. I think that has been the number one thing that I love about this position…I've walked the path that they walked, and we just weren't aware of those services back when we came here (Participant 28).

Therapists' Workplace Challenges

This second theme describes therapists' workplace challenges and includes six subthemes: 1) staffing shortages; 2) demanding workloads; 3) low pay and exploitation; 4) clinics' prioritization of the bottom line; 5) lack of transparency and collaborative decision-making; and 6) not enough training or supervision.

Staffing Shortages. Nearly all therapists described the challenges of meeting high service demands when clinics are short-staffed. Therapists emphasized that turnover has recently reached unprecedented levels, with many leaving for private practice settings: "This summer…we lost so many clinicians and administrative staff…it's bare bones right now" (Participant 3). Others described clinics "hemorrhaging people" (Participant 8). Therapists often explained the vicious cycle of turnover begetting more turnover—when therapists leave, the

remaining therapists are tasked with additional responsibilities and receive less support: "The turnover creates big feelings of demoralization, especially when supervisors are absent or spread thin. You would want to rely on your co-workers for support, and sometimes that's not available" (Participant 1). Therapists recounted how turnover negatively impacts patient care:

> So many of my patients say, 'You're the tenth social worker I've had. I don't want to talk about my trauma anymore because I've started new so many times,' and some people become disengaged from therapy and then leave. When I inherited my caseload, a fair amount of people left because they didn't want to start over with a new therapist (Participant 9).

Several therapists also mentioned that staffing shortages are particularly acute for bilingual staff, which results in some bilingual therapists not only taking on more patients but also filling in administrative roles at their clinics:

> The previous clinician left in 2021, so it's going on two years that I've had to hold it down for the Spanish community…it's been so difficult because we lost our administrative staff also that is bilingual…so I was an administrator. I was the clinical person doing the intake. I was the person taking their insurance, making copies of it, translating. There was a slew of things outside of therapy that I was doing…As a bilingual individual you're just stretched even thinner. (Participant 28)

Demanding Workloads. Due to high service demands and staff shortages, most therapists reported facing "massive" (Participant 3) caseloads and productivity requirements that are "not possible" (Participant 10); case management demands; and "very overwhelming" and "complicated" (Participant 26) documentation requirements. One therapist described: "They don't close the waitlist, so we are just getting new patients every week. I have one of the smaller

caseloads, and I have 115. Some people have up to 150" (Participant 9). Many therapists shared that their clinics have increasingly emphasized "revenue-based models and increase[ing] productivity. That's been their solution to everything…when the answer is we need to increase staffing and address these turnover issues" (Participant 1). Therapists expressed feeling like their clinics are "revolving door[s]" with leadership wanting therapists "to just get people in and out" (Participant 9). Therapists indicated that some clinic leaders advise double-booking appointments in case one patient does not attend to ensure therapists meet "productivity" without addressing the possibility that both patients could show up.

Many therapists explained that they also face increasing demands to provide other non-billable supports (e.g., case management and care navigation) to patients including:

> Trying to make sure people are getting what they need from other providers, or other parts of the clinic or the hospital. It is also not a billable service and hard to quantify how much of that work we're doing, but it is a lot, and it's been increasing recently. (Participant 10)

Many therapists described that they also face documentation burdens. Several indicated that Medicaid requires a "ton of documentation" (Participant 30) that is "time consuming" (Participant 18) and "labor intensive" (Participant 26). Nearly all therapists said they are behind on case notes and that they often complete documentation after hours: "I'll either do it at night or on the weekends, and we're not getting paid for that time. I just don't understand how anyone is able to accomplish that during the workdays" (Participant 11). Finally, therapists spoke about being required to complete patient questionnaires that are "time consuming" but don't "actually benefit the patient" (Participant 30). Overall, therapists indicated that their work demands have increased recently.

Low Pay and Exploitation. Nearly all therapists reported feeling "underpaid" (Participant 30) due to their low wages and feeling economically "exploited" (Participant 5). Many therapists described that their pay is often insufficient for them to meet their material and psychological needs, particularly in their high cost-of-living cities. One therapist noted that when they first started working at their clinic, everyone at their workplace had a second job: "There was someone on my team who's been a therapist there for a decade, who was waiting tables on the weekends" (Participant 1). One therapist described their economic situation succinctly: "We're therapy providers who can't afford our own therapy" (Participant 5).

Many therapists expressed feeling "replaceable" and like "cogs in a wheel" (Participant 6). Several therapists explained the exploitative nature of the public mental health infrastructure, which is highly dependent on newly graduated social workers who need supervised hours to meet licensure requirements. This dependency enables clinics to offer low wages. Therapists' low wages make them feel that clinics devalue them and their under-resourced patients: "Why don't we get more money? We do a lot of work. We serve a lot of people…It makes me feel like people don't value these individuals [patients] as much because of them not being able to pay" (Participant 5).

Clinics' Prioritization of the Bottom Line. Therapists frequently spoke about perceiving that clinic administrators increasingly focus on the financial bottom line, as opposed to patients' health. One therapist said, "I feel like our focus is too much on the profit margins…really just losing that the central mission is providing services" (Participant 26). Several therapists suggested that clinics are less concerned with service quality and are more concerned with billable time: "They're looking at numbers, money, and we're not able to provide the proper care to the patient. It is bothersome" (Participant 15).

Lack of Transparency and Collaborative Decision-making. Therapists often spoke about clinic leaders' failures to transparently communicate and collaborate when making decisions: "There's just not a lot of transparency from the higher-ups" (Participant 26). Some therapists said this may partially be due to the disarray caused by turnover:

> There's a lot of failures in communication…No one knows who the actual supervisor is. That has been happening a lot because some people have left. We have one supervisor covering many programs…it's really getting lost in translation when something needs to be addressed (Participant 7).

Therapists indicated that many service changes are determined by people removed from clinical work. Therapists expressed concern that these decision-makers' interests are not always aligned with therapists' and patients' interests: "These decisions are made from people who don't understand, or they don't get it" (Participant 25). One therapist recounted how hospital leadership imposed unattainable productivity thresholds: "We don't really know who is making these decisions...if they're social workers or therapists, or are they someone with an MBA [master's in business administration]?" (Participant 27) Many therapists expressed feeling disrespected by clinic leadership communication: "I think how out of touch they are with workers...and these emails they send to us are just *so* bad" (Participant 21). Altogether, therapists described feeling disempowered by the processes in which executive decisions are typically made.

Not Enough Training or Supervision. In line with therapists' perceptions that care quantity, not quality, drives leadership decisions, therapists decried the lack of clinical support they receive. When one therapist first started their job, they reported that they did not receive any training: "We have very little supervision…I didn't even really get trained properly at all"

(Participant 29). Other therapists said their supervision time is often largely devoted to administrative check-ins rather than clinical learning, leaving therapists feeling unsupported:

> There's so much more that we could be learning. Having actual tools and techniques, and having actual interventions, and someone training us, it would just be so much more beneficial for the patients…It's not clinical supervision...It's more administrative supervision (Participant 23).

Therapists described that the lack of clinical support relates to turnover: "I decided that I want to leave in about a year…the supervision is not great. I thought it would be better" (Participant 19). Many therapists described that their supervisors are so overworked that they must regularly cancel supervision, leaving therapists with less support: "I've had weeks where he had to cancel our supervision or cut it short…it's not because he was just slacking off doing nothing…he was being pulled in a million different directions." (Participant 11). Altogether, therapists emphasized needing more clinical support.

Emotional and Service Impacts of Workplace Challenges

This third theme describes therapists' perceptions of the emotional and service impacts of workplace challenges. It includes four subthemes: 1) burnout and vicarious trauma; 2) moral injury and perceptions of delivering lower quality care; 3) resignation and hopelessness; and 4) not enough time for patients.

Burnout and Vicarious Trauma. Nearly all therapists described experiencing burnout, a syndrome characterized by exhaustion, depersonalization, and diminished self-efficacy (Maslach & Leiter, 2016). Therapists described feeling "stressed out," "overwhelmed," (Participant 3) and "very not effective" (Participant 7). Other therapists said burnout depletes their ability to listen in sessions: "When you're so burnt out, you can't really pay attention. You can't really give your

best to your client" (Participant 5). Therapists frequently reported experiencing secondary or vicarious trauma: "Hearing back-to-back, all of the trauma…it's a lot to take in" (Participant 16). Several therapists mentioned the emotional difficulty of learning about their patients' adverse experiences: "This is heavy, sometimes very heavy, work" (Participant 24).

Moral Injury and Perceptions of Delivering Lower Quality Care. Therapists frequently related that their workplace challenges negatively impact care. Therapists said they experience moral injury—the harm and distress that occurs when people must carry out, witness, or comply with actions that violate their values (Amsalem et al., 2021). Because therapists value improving under-resourced patients' lives, they expressed feeling pained that their work conditions force them to deliver sub-optimal care:

> When people are turning over and [clinics are] under-staffed, and your pay is too low to attract new people…it creates this cycle of people getting worse care. People are stretching themselves further to provide care that they don't feel as good about, so there's moral injury there, and then they probably leave. Then there's even more turnover, and then two people are doing eight people's jobs, and management isn't paying you any more…it's just a recipe for worse quality care for people who don't really have that many other places to go. (Participant 2)

Many therapists conveyed feeling more protective of their patients than they are of themselves: "The moral injury of not being able to give clients the quality of service that they deserve…you could treat me like shit all day long, but *don't* fuck with my clients" (Participant 10). Therapists frequently reported that low wages negatively impact patients: "If you're not getting your basic needs because you're not making enough, then, how much are you really able to put into the work?" (Participant 27).

Therapists also mentioned that frustrations with management can sometimes be wrongly displaced onto patients:

> If you feel exploited already, a lot of times that gets taken out on the therapy. It's like, "Well, they—the bosses—don't care about me, or they exploit me, or they're already asking too much of me so I'm not going to do this extra piece for my client, because I'm already being taken advantage of." But the *client's* not taking advantage of you, *your bosses are*. The clients get scapegoated a lot for the exploitation that we experience... The clients aren't prioritized, the staff aren't prioritized. You have exploited under-resourced people working with exploited under-resourced people. (Participant 6)

Therapists often recounted that rising turnover results in under-resourced patients being served by inexperienced therapists:

> You have a therapist who has been at a place for a while, gains a lot of experience, and then they leave. Then the next people coming in—who are the people that are willing to work for that salary or the people that need supervision—are newer in the field…That's a bummer in terms of the quality of care that someone gets if they're on Medicaid. (Participant 26).

Many therapists expressed feeling dismayed that workplace challenges impact care for under-resourced patients.

Resignation and Hopelessness. Therapists frequently described feeling defeated and demoralized by the enormity of their workplace challenges and their patients' problems. Many recounted that their experiences sometimes lead them to feel hopeless and resigned to the status quo: "It can feel so hopeless and dark, and I think one of the long-term traumas and corrosive effects…is that a lot of people end up having to give up their values or leave something that

speaks to an important part of who they are so that they can survive" (Participant 6). Therapists also described feeling daunted by their patients' seemingly intractable problems: "The biggest thing of all—it's the helplessness…when you can't do anything for someone. If you could just hand them some money, you could fix it. But you can't" (Participant 14). One therapist, who planned to quit shortly after the interview, described feeling stuck and discouraged by the choices before them: "I was feeling very overwhelmed and recognizing that something's got to give here…But how could I ever make a change? How can I leave…feeling kind of trapped" (Participant 26). Many therapists reported that their working conditions cause them to lose hope that change is possible.

Not Enough Time for Patients. Therapists frequently described that the increasing pressure to see more patients makes them feel like they don't have enough time for each patient. They indicated that productivity pressures translate into less time between sessions to prepare: "If I'm seeing people back-to-back it's probably like two minutes that I'm using to prep…I think ideally ten minutes would be nice" (Participant 12). Other therapists mentioned that the lack of preparation time means that they have less time to think deeply about each case:

> The feeling like you're being rushed takes you out of being able to sit with patients, and give them full attention, full energy, prepare for (reading even the notes beforehand or looking at their charts)…the level at which they're wanting us to see people—just makes you feel like you can't really go deeper or be with people in the way that I think most of us would like to and think our patients deserve. (Participant 9)

Therapists also reported facing increasing pressure to see patients biweekly as opposed to weekly to see more patients. They described that this frequency is often not clinically appropriate or desired: "I even saw someone today who was like, 'Please can we meet next week?' For them,

two weeks can feel like a lifetime when you're going through something hard…the bi-weekly thing is tough for them" (Participant 13).

Other therapists recounted feeling pressured to see patients for 30-minute instead of 45-minute sessions to increase revenue, even though many prefer to see patients for longer: "I don't think you get much more reimbursed for a 45-minute appointment than you do for a 30-minute session, so they don't want me to do that. But I know a lot of my coworkers have probably, I would imagine, because they just feel like it's better for the patients" (Participant 11). In general, therapists expressed feeling like it is "not fair" (Participant 8) that patients are deprived of needed time.

Therapists' Reasons for and Benefits to Labor Organizing

The fourth theme encompasses therapists' stated reasons for labor organizing and the benefits they reap from being unionized. Therapists described that unions improve and enhance: 1) wages; 2) voice, agency, and hope; 3) respect, transparency, and fairness; 4) solidarity; 5) benefits; 6) job security; 7) clinical care; 8) workload; 9) health and safety; and 10) retention.

Wages. When asked to explain how their unions impact their lives, therapists most often reported that unions raise wages—one of the most significant workplace challenges they described facing: "The biggest issue is wages. We are an anti-poverty organization, but we pay some of our workers poverty wages" (Participant 20). Therapists indicated that increasing wages is one of the most important reasons that members become involved in unionization or contract negotiating efforts: "We want to be paid more, and that's what we're fighting for in the unionization [effort] right now" (Participant 4). Members of longstanding unions described that their union-fought wage increases have been a major benefit to their current jobs.

Many therapists explained that their unions fight for pay equity and fair compensation. Several therapists discussed instances when their employer was unwilling to compensate them for work. With the weight of the union, they were able to demand compensation: "The union has really supported making sure that we don't get abused, because it is easy to get abused as a mental health professional, because you want to help" (Participant 7). Some therapists also described that their unions have fought to address wage inequities between bilingual and monolingual therapists by advocating for enhanced compensation for bilingual therapists' larger workloads.

Voice, Agency, and Hope. Therapists indicated that their unions offer them voice, agency, and hope for the future. Many therapists said their unions have enabled them to speak out against bad leadership decisions: "Being involved in the union has taught me you can speak up for yourself…You don't have to worry about retaliation" (Participant 7). Many therapists contrasted their current positions to former non-union therapist positions, where they felt powerless and unable to advocate for themselves or their patients: "I'm more vocal now. Compared to my other positions, I would just eat it. Now it's like, 'No, I have rights, you have to respect them'" (Participant 16).

In the face of these worsening public mental health conditions, many therapists described that labor organizing instills them with optimism:

> Management has given us nothing to give us hope. I think if we didn't have a union, a lot of people would feel pretty powerless and pessimistic. Even if we don't get everything we want, there's an avenue to make change, and people feel like maybe it's possible. Maybe it's worth a try…I think that gives people hope. (Participant 1)

Many therapists expressed that the agency and hope they feel are antidotes to the futility and powerlessness they often experience:

> A necessary part of self-esteem is feeling like you are a person that has influence over your environment, and when we don't feel that way, when we feel hopeless and like we don't have influence over our environment, and we are impotent, it takes from us. It depletes, and it corrodes, and it disrupts who we are in the world, it disempowers us…But a union is real citizen participation. We have influence over outcome. I think having influence over outcome with the union—it's strength giving, and it's promoting, and it's nourishing. (Participant 6)

Altogether, therapists expressed that labor advocacy helps them feel more capable of making a difference in their and their patients' lives.

Solidarity. Therapists frequently described that unions foster connection, solidarity, and community among workers. Many therapists identified their unions as vital social support systems:

> It's so nice to feel supported and feel like you have a solid group of people to have your back…to be validated and to be heard by people who are doing the same work as you and can really empathize with your experience and not make you feel little. It's really nice to feel powerful in a space where you feel little, even though you know you're not. (Participant 3)

Many therapists recounted that unions provide them with comfort that they are not alone in their struggles, improving their job satisfaction: "It does help me, my job satisfaction, in that if I need someone to back me up, there will be someone there" (Participant 25). Many therapists expressed feeling less isolated at work: "I just like to know that there's a collective looking out for us, that we're not in it all alone. And there's a place to go to not just vent, but vent and plan" (Participant 26). Many therapists described that their unions connect them with other clinic

workers: "[It] definitely strengthened my connections with the agency and with people I worked with. I got to know people across different departments that I probably never would have met because some of the programs are really siloed" (Participant 1).

Respect, Transparency, and Fairness. Many therapists reported that unions are important vehicles through which workers combat unequal treatment and abuse. Several therapists explained how their experiences in unionized mental health clinics differ from their past experiences in non-unionized community mental health centers:

> Having a union makes a difference. You're not messed with…your job responsibilities are your job responsibilities. It's not that they're going to change your job description out of nowhere, and you suddenly have to shift what you're doing. That happened a lot when I worked in non-profits that did not have unions" (Participant 16).

Another therapist, who identifies as transgender, described that their identity feels more respected at their unionized workplace because their union makes them feel that "there's a higher baseline for civil rights [protections]" (Participant 10). They contrasted this with their past experience in a non-unionized community mental health agency, at which they were frequently "deadnamed [others used their birth name] and misgendered" (Participant 10). Many therapists described that the collective support, advocacy, and legal arbitration their unions offer can powerfully combat unfair treatment and workplace inequities.

Benefits. Many therapists recounted their satisfaction with their union benefits (e.g., health insurance, parental leave, retirement benefits, and paid leave). One therapist explained that one of the major reasons they are happy to be in a union is because their "health insurance is really cheap, and it's really good, and that's huge" (Participant 11). Many therapists said that their

unions have enabled them to feel that their profession is sustainable due to the hard-fought benefits they receive:

> I feel much more secure in me and my family's future…In the 15 years that I worked in community-based not-for-profits, I didn't think I was going to retire. But here this is a job where the union has been able to fight for pension retirement plans, cost of living increases, Covid hazard pay. So much more money than I ever expected I would get in this field. And it's not about the money, but it is, cause you need money. You gotta pay the bills and send my kid to college hopefully. With the union, I definitely feel a lot more financially secure. (Participant 25)

Therapists also recounted fighting for benefits specific to the occupational hazards of the field. For example, one union recently won a bereavement policy that offers therapists paid time off to mourn the passing of patients.

Job Security. Therapists frequently mentioned feeling relieved about their union-fought job security. Therapists described that having a union means there's always somebody "in [their] corner," which frees them from feeling like they are "walking on eggshells" (Participant 16). Other therapists expressed feeling more secure that they have legally binding contracts that force their employers to play by the rules: "Just knowing that administration can't just do whatever they want. There are contracts…just knowing that if you were to be disciplined for any reason, the union will have your back. You're not just fending for yourself" (Participant 12). One therapist highlighted how this sense of job security empowers them to take care of themselves:

> Just the sense of job security and being able to advocate for myself and not fear some kind of retaliation or getting fired. It's pretty huge. I had a cold a week ago, and I think I would have been fine if I just called out the one day, but I was like, 'You know what? I'm going

> to call out another day because I'm still not quite better yet.' And it was fine…that's what you need to do to be able to sustain this kind of work. (Participant 11)

Many therapists conveyed that this sense of security enables them to compartmentalize work challenges and be more attentive to their patients' needs: "Being able to voice my concerns and talk about that and feel some sense of protection from the union does make me a better clinician because I don't have to be carrying all that shit into sessions" (Participant 21).

Clinical Care. Therapists often expressed gratitude that their unions advocate and pay for additional training and supervision, which improves clinical care. One therapist recounted that their union paid for training in dialectical behavioral therapy (DBT), which they found "super helpful" (Participant 7) for their specific patient population. Many therapists reported their unions allocate yearly funds for therapists to attend continuing education unit (CEU) courses to maintain their licenses: "It's nice to get reimbursed for CEUs" (Participant 8).

Many therapists described that unions improve the quality of clinical care they provide by improving work conditions: "The more quality of life I have, the more quality care I can give to others" (Participant 13). Many therapists explained that union advocacy promotes a virtuous cycle:

> Being part of a union helps me advocate for my clients better. And I think that's why I'm here. I'm here to help my clients and help them have better mental health. And everything is connected. If I'm doing better because my working conditions are good, I can help them. If they get the sense that the school…is staffed by people who are able to take care of their own needs, and are not projecting stress onto them, that makes things better for them… and then that makes things better in the world. That feels like a very big

> statement to make. But I think that's part of how we get healthier communities. (Participant 2)

Many therapists indicated that their unions facilitate more communication, improving patient care:

> Since the union…we communicate all the time, we communicate about our clients, we communicate about how we're providing care, we provide each other support throughout the day when we're feeling a little bit down or overwhelmed, or just need someone to talk to about work. Just improving relationships among staff improves the ability to provide client care. (Participant 6)

Many therapists expressed that they have imparted lessons to their patients about the health-giving effects of advocacy and solidarity:

> This experience has reinforced how important being an active participating citizen in my community is. Advocating for social justice is good for my mental health, promotes my sense of belonging and community in the world and gives me a way through futility. That has worked its way into my practice now... When I'm working with a client, that's now become an option for me to explore with clients. I think that's improved the quality of my clinical work, understanding that experience, understanding what it means to be exploited, and how that's impacted me, and what it means to promote change as a way through. It's given me something. It's added to my clinical practice. (Participant 6)

Altogether, therapists drew deep connections between improving their work conditions and improving clinical care.

Workload. Therapists frequently spoke about how being unionized empowers them to not overwork themselves, preventing burnout. Many therapists expressed relief that their legally

enforceable contracts specify their work hours: "You work from 8 to 4, don't overwork. That's helped me in setting my boundaries at work…and not feel bad about it, because this is what's in my contract" (Participant 22). Other therapists described that union protections make them feel comfortable taking lunch and small breaks each day. Several therapists explained that being unionized empowers them to not overbook themselves so that they can engage in important non-billable care such as case management.

Many therapists described that lowering (or maintaining current) productivity requirements has been on their union bargaining tables: "We're spearheading a lot of changes with productivity" (Participant 3). Many union members also mentioned engaging in contract enforcement related to work hours. One therapist mentioned that their union advocated for evening "on-call" shifts to be compensated: "Without a union we would still be doing that [on-call work] without any kind of compensation" (Participant 17). Overall, therapists largely credited their unions for supporting efforts to reduce workloads.

Health and Safety. Many therapists shared that their unions support their physical and mental health. Therapists cited examples of how their unions have advocated for worker wellness: "The other contract win…for in-network providers providing mental health services, the copay will be $0" (Participant 1). Several therapists shared that their unions fought for worker protections during the coronavirus pandemic's early phase, which helped them feel more comfortable working in-person: "During the most challenging time that I have been at this job and a union member, just knowing that they were fighting on our behalf made me feel better" (Participant 23). Therapists described how their unions also seek to address workplace safety concerns, which can arise when visiting patients' homes or working with patients who exhibit behavioral challenges.

Retention. Many therapists explained that unions increase staff retention. Despite the workplace challenges they face, many therapists expressed that they have stayed in their positions because of the support they receive from their unions:

> Others will tell me, 'You should quit'…and I'm like, 'I'm holding on for the union, I feel safe because of the union, I don't want to leave the union.' It feels so good to be part of it…I want to stay for my clients, and also because of the union. (Participant 3)

Therapists also expressed remaining in their positions to see how their hard work during contract negotiations will pay off: "If I wasn't in the union, I would've left a while ago…I want to stay to see the fruits of our work. To get to see that raise. It's mostly because of my clients, but I would have left before" (Participant 19). Finally, therapists explained that they see labor organizing as a strategy to make community mental health work sustainable:

> Being in a union allows me to mitigate my burnout. I love community mental health. I really want to spend my career in community mental health…the best thing I can do for my ability to stay in community mental health is to take care of my own well-being, both financially and mentally…And being able to protect my own earnings and my own emotions and my own workload both in terms of caseload and in terms of hours. That's how I protect myself, and that's how I protect my longevity in this field that I want to be in. (Participant 20)

Generally, therapists indicated that their unions increase their confidence that they can remain working in the public mental health system and shape it for the better.

Discussion

Our qualitative interviews with 30 unionized public mental health therapists in New York City and Chicago revealed that therapists are intrinsically dedicated to their work, but that their

working conditions often attenuate their ability to offer the high-quality care they feel their patients deserve. Therapists overwhelmingly view their unions as vehicles through which they can address the challenges of the public mental health system to improve their own work conditions and the treatment conditions of their patients. Many therapists described how they went into public mental health work to make a difference in their under-resourced patients' lives. Yet, across public mental health contexts, therapists described the challenges of this work: staffing shortages; demanding workloads; low pay and exploitation; clinics' prioritization of the bottom line; lack of transparency and collaborative decision-making; and not enough training or supervision. Therapists described how these workplace challenges negatively impact their own well-being and their patients' well-being. They described experiencing burnout and vicarious trauma; moral injury and perceptions of delivering lower quality care; resignation and hopelessness; and feeling like they were not offering enough time for their patients. Therapists described that their unions improve wages; workers' voice, agency, and hope; respect, transparency, and fairness; solidarity; benefits; job security; clinical care; workloads; health and safety; and retention.

Our findings add to the literature describing the growing challenges faced by those working and seeking care in the U.S. public mental health system. Public mental health systems are not sufficiently resourced to offer sustainable, meaningful, and well-compensated employment to workers (Covino, 2019). Though therapists are dedicated to those they serve, their workplaces do not enable them to do their best work (Last et al., 2022; Last & Crable, 2024). There is growing concern about the psychological toll these workplace challenges are having on the workforce and patients. Burnout and moral injury have increased among therapists, particularly since the pandemic (National Council for Mental Wellbeing, 2023).

Healthcare workers of all professions prefer workplace interventions that address the root causes of their burnout (e.g., staffing shortages, high caseloads) over minimally efficacious individual psychological interventions (Aiken et al., 2023; Fleming, 2024). It is therefore unsurprising that public mental therapists in our study have sought to improve their and their patients' well-being through collectively improving their work conditions.

Our findings also add to burgeoning research suggesting that labor unions are an effective strategy to improve workers' conditions as well as protect their health and well-being (Eisenberg-Guyot et al., 2021; Leigh & Chakalov, 2021; Parolin & VanHeuvelen, 2023). In healthcare specifically, research has shown that unionization is associated with improved health outcomes for patients (Dube et al., 2016), lower coronavirus infection rates for patients and staff, and lower staff turnover in U.S. nursing facilities (Dean et al., 2022, 2023a). Unionized nursing facilities are also more likely to comply with federal workplace safety reporting requirements than non-unionized facilities (Dean et al., 2023b). Our study is the first to explore how mental health workers' unions may impact worker and patient well-being. Findings from our study extend this growing area of research.

Limitations

Our study has several limitations. First, given that this is an exploratory, qualitative study, our findings are not generalizable to all unionized mental health workers. Our study's sample of 30 social workers and mental health counselors is small relative to the 665,838 social workers and counselors in the mental health workforce (Bureau of Health Workforce, 2023). Second, though not the primary strategy through which we recruited therapists, a small number of therapists were recruited after our research team presented at union and social worker labor group meetings. This strategy could have resulted in an oversampling of participants who were

more active in their unions. Despite this potential, our study nevertheless did recruit many participants who were inactive in their unions (e.g., had never attended a meeting). Additionally, two participants described several organizing challenges and some negative perceptions of being unionized (i.e., being unsure whether unionization improves their work conditions). Third, to minimize significant variation among therapists' roles, we exclusively recruited outpatient mental health therapists. We chose this recruitment strategy because outpatient therapists across settings and cities tend to have more similar schedules and workplace conditions making it easier to compare therapists across contexts. Thus, the study does not represent the experiences of therapists across treatment levels of care. Finally, and relatedly, our study examined the experiences of public mental health therapists working in two large, ethnically and racially diverse, and relatively pro-labor U.S. cities. The experiences of these public mental health therapists likely differ from the experiences of public mental health therapists working in rural or right-to-work states. More research across the United States is needed to extend the findings from our study.

Future Directions

This study is an initial examination of the experiences of unionized public mental health therapists. Guided by these research findings, it is necessary to conduct further large-scale quantitative work examining whether the theories and relationships explored in the present work are true at scale. In particular, our work's primary findings of the deep connections between therapists' work conditions and their patients' treatment conditions can be explored quantitively. One logical next step would be to study whether improving therapists' working conditions (e.g., reducing productivity requirements, increasing wages) through labor organizing is associated with better clinical and patient-centered outcomes. In addition, prior research has shown that

public sector unions are "equalizing institutions"—that is, public sector unions reduce race and gender wage inequities between workers (Kerrissey & Meyers, 2022). Future research should explore whether public mental health therapists' labor organizing efforts not only improve therapists' working conditions overall but also reduce wage and work inequities *among* therapists.

Many therapists in our study expressed that working conditions in the public mental health sector have worsened in recent years, even before the coronavirus pandemic. Researchers have comprehensively detailed how decades of privatization and public austerity have led to the closure of public mental health clinics, which has, in turn, substantially reduced the capacity of New York's public mental health system and contributed to persistent provider shortages (Kramer & Poblete, 2022; Weaver et al., 2023). Privatization and austerity have also led to the fragmentation of the public mental health sector and a significant reduction in union jobs among mental health workers (Weaver et al., 2023). Similarly, in the wake of the Great Recession, Chicago imposed significant budget cuts and closed six (i.e., half) of its public mental health clinics, also leading to the loss of union jobs (Quinn, 2018). These transformations to New York and Chicago's public mental health systems parallel national trends—publicly funded clinics have increasingly closed across the country (Hung et al., 2020; Lutterman, 2015). It is necessary to conduct further research elucidating both the sociopolitical and historical causes of public mental health clinic closures as well as the implications of these transformations for the workforce at a national level.

This rigorous, large-scale analysis may help explain whether—despite evidence that there is a resurgence of labor militancy among unionized healthcare workers to improve their working conditions— the political and economic transformations to the public mental health system have

done more to undercut labor unions and worsen the public mental health workforce's working conditions. For example, the increasing fragmentation and privatization of the public mental health system has likely made labor organizing among therapists even more challenging (Grogan, 2023; Morgan & Campbell, 2011). As public mental health services are increasingly delegated to private, non-profit organizations, therapists who were once members of a city-wide labor union that covered all public sector workers—offering strength in numbers and increased bargaining power—must now organize fellow workers at each of their individual, smaller workplaces. This makes collectively organizing public mental health therapists more difficult. Relatedly, a 2018 U.S. Supreme Court decision ruled that the obligation that union members pay dues to receive the benefits of union membership was unconstitutional (*Janus v. AFSCME*, 2018). This decision has weakened the financial security of labor unions and their bargaining power (Eisenberg-Guyot & Hagopian, 2018). Thus, future research must comprehensively examine the multiple challenges public mental health therapists face when collectively organizing and attempting to improve their labor conditions.

In light of these organizing challenges, developing and implementing policies that improve the public mental health workforce's working conditions and facilitate their organizing efforts can complement therapists' collective actions on the shopfloor (Last & Crable, 2024). For example, professional mental health associations such as the National Association of Social Workers and the American Psychological Association have successfully lobbied the federal government to increase Medicare reimbursement rates and for increased coverage of mental health services provided by therapists (American Psychological Association, 2023; National Association of Social Workers, 2023). State chapters of these organizations have also pushed state governments to increase Medicaid reimbursement rates and therapists' salaries; have

advocated for student debt relief; and have also firmly opposed state mental health budget cuts (NASW-NYS Chapter, 2023). In Chicago, grassroots organizations and public sector unions successfully pushed the city's mayor in May 2024 to commit to reopening three of the six public mental health clinics that were closed in the wake of the Great Recession and to expand public mental health services, which will increase the number of unionized therapist positions (Sheridan, 2024). These advocacy successes reveal that multipronged efforts—in politics and in the workplace—are needed to support the public mental health workforce and the patients receiving their care.

Conclusions

Public mental health therapists face challenging work conditions. Though many are leaving the public sector, and the workforce altogether, other therapists have engaged in labor organizing to improve their work conditions and the quality of services they deliver to under-resourced patients. To better understand the challenges therapists face, how these challenges impact clinical care, and how therapists have sought to address these challenges through labor organizing, we interviewed 30 unionized public mental health therapists across two cities (New York City and Chicago). Qualitatively analyzing the interviews, we identified four main themes: under-resourced patients' significant needs and therapists' desire to support them; therapists' workplace challenges; emotional and service delivery impacts of these workplace challenges; and therapists' reasons for and benefits to labor organizing. Altogether, therapists across both cities overwhelmingly view labor unions as an opportunity to improve their lives and the lives of their under-resourced patients.

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Table 1

Participants' Demographic Characteristics and Professional Experiences

Characteristic	*M* or *N*	*SD*, range or %
Age	34.0	8.3, 25.0-64.0
Gender[a]		
Woman	22	73.3%
Man	4	13.3%
Genderqueer	2	6.7%
Genderfluid	2	6.7%
Non-binary	3	10.0%
Transgender	1	3.3%
Cisgender	12	40.0%
Race[b]		
American Indian or Alaska Native	2	6.7%
Asian	3	10.0%
Black or African American	3	10.0%
Middle Eastern or North African	1	3.3%
White	23	76.7%
Other: "White & Latina"	1	3.3%
Not reported	2	6.7%
Hispanic or Latino/a/x	9	30.0%
Hispanic Identity		
Central or South American	3	10.0%
Mexican	3	10.0%
Puerto Rican	1	3.3%
Other: ("Dominican Republic"; "Venezuelan")	2	6.7%
Current Position		
Primarily a provider of direct services	28	93.3%
Primarily a supervisor of direct service providers	2	6.7%
Primary Workplace Setting		
Community mental health organization	12	40.0%
Federally qualified health center	4	13.3%
Public hospital	11	36.7%
School	2	6.7%
Other: ("Outpatient Dialysis")	1	3.3%
Professional Specialty		
Counseling	4	13.3%
Social work	26	86.7%
State Licensed		
No	3	10.0%
Yes	27	90.0%
Years of Clinical Experience[c]	3.4	3.4, 1.0-20.0
Type of Clinician[d]		
Child/Adolescent Therapist	10	33.3%
Adult Therapist	26	86.7%
Family Therapist	5	16.7%
Couples Therapist	1	3.3%
Years at Current Workplace[c]	1.5	2, 0.5-18.0
Active Cases[c]	26.5	30.3, 3.0-135.0
Number of Clients Seen Per Week	21.1	7.4, 4.0-35.0
Hours Worked Per Week	38.2	4.7, 19.0-45.0
Previously Worked in a Non-Union Setting		
Yes	23	76.7%

Characteristic	*M* or *N*	*SD*, range or %
No	7	23.3%
Years in Current Union[c]	1.3	2, 0.5-18.0
Leadership Position in Union		
Not leadership	22	73.3%
Leadership (e.g., shop steward, bargaining committee member, contraction action team member)	8	26.7%
Union Formally Recognized		
Yes	30	100.0%
Union Contract Status		
Never had a contract, in negotiations	5	16.7%
Has had a contract, in negotiations for a new contract	13	43.3%
Currently has a contract	12	40.0%

Note. $N = 30$.

[a] Participants could endorse multiple options for the gender identity question, which is why responses do not add up to 30 or 100%.

[b] Participants could endorse multiple racial identity options, which is why responses do not add up to 30 or 100%.

[c] Responses are not normally distributed; medians, interquartile ranges, and ranges are presented.

[d] Participants could endorse multiple options regarding which populations they serve, which is why responses do not add up to 30 or 100%.

Figure 1

Thematic Map