A PRAXISONE PERSPECTIVE

# The Workforce Cliff

*Behavioral health can't hire its way across the gap between soaring need and shrinking staff. The leverage is extending — and protecting — the workforce it already has.*

## Executive summary

Behavioral health faces a widening gap between how much care its communities need and how many people it has to deliver it. In the United States alone, 58.7 million adults had a mental illness in 2023 and 48.5 million people had a substance use disorder — and most received no treatment. Meanwhile the workforce is shrinking against that demand: the World Health Organization projects a global shortfall of roughly 11 million health workers by 2030, 122 million Americans already live in a mental health professional shortage area, and behavioral health carries the highest nurse turnover of any specialty. This is a cliff, not a slope — and it cannot be closed by recruiting, because the people simply are not there. The durable answer is to *extend* the reach of the workforce that remains, and to *protect* it, without trading away the safety and humanity behavioral health depends on. That requires two things working together: world-class AI infrastructure, and an operating intelligence layer built for behavioral health and governed by humans. This paper makes the case for both.

## 1 The cliff: soaring demand, shrinking supply

Two curves are moving in opposite directions, and behavioral health is caught between them. On one side, demand is enormous and rising.

> **58.7 million**
>
> U.S. adults had a mental illness in 2023, and 48.5 million people aged 12+ had a substance use disorder. Most received no treatment at all — roughly three in four adults with a substance use disorder went untreated.
>
> *SAMHSA, 2023 National Survey on Drug Use and Health*

On the other side, the supply of people to meet that demand is contracting.

> **11 million**
>
> is the global shortfall of health workers the World Health Organization projects by 2030. In the U.S., 122 million people already live in a designated mental health professional shortage area.
>
> *World Health Organization; U.S. Health Resources & Services Administration, 2024*

Where the two curves meet is not a gap that patience will close. It is a cliff — and behavioral health is already near the edge of it, with the highest nurse turnover of any specialty (22.5%) and a replacement cost of roughly $60,000 for every clinician who walks out the door.

## 2 Why you cannot hire your way across

The instinct is to recruit harder — raise wages, widen pipelines, add sign-on bonuses. All of that matters, and none of it is enough, for a simple reason: the workers do not exist in the numbers required. Training a behavioral-health clinician takes years; the shortage is measured in millions; and the demand is still climbing as need rises and stigma falls.

Worse, the shortage is self-reinforcing. Every departure raises the load on those who remain, which raises burnout, which drives the next departure. An organization can win its local recruiting battle and still lose the war, because it is bailing water out of a boat that is taking on more than any crew can carry. The math does not resolve by adding people the labor market cannot supply. It resolves only by changing what each person is able to safely do.

## 3 The real lever: extend and protect the people you have

If you cannot add enough people, the leverage moves to two places: the *reach* of each clinician, and the *retention* of every one of them.

**Extending reach** does not mean asking staff to do more with less. It means removing the friction that steals their time and attention — the documentation burden, the manual chart review, the hunt for the one patient among forty who needs them most right now — so that scarce expertise lands where it matters. When the right clinician is directed to the right patient at the right moment, a stretched team covers more ground without running faster.

**Protecting the workforce** is the other half, and it is not separate. The fastest way to deepen a shortage is to burn out the people who remain. Retention is the cheapest capacity a behavioral health organization can buy — and, as a growing body of evidence shows, burnout is driven less by individual weakness than by working conditions that can be seen and improved. Extending reach and protecting people are the same strategy, viewed from two sides.

## 4 But capacity without safety is a trap

Here is where behavioral health parts company with the generic promise that "AI will ease the shortage." In many settings, easing the shortage is framed purely as throughput — let one clinician oversee far more patients. In behavioral health, where patients are high-acuity and safety-sensitive, more patients per clinician *without* more visibility is not relief. It is risk.

Extending reach only helps if it also strengthens safety: surfacing the rising-risk patient sooner, not burying them in a larger caseload; making documentation more complete, not more rushed; keeping a human in control of every decision. Capacity that comes at the cost of oversight simply trades a staffing crisis for a safety one. The goal is not to stretch attention thinner. It is to aim it better.

## 5 The stack: infrastructure and intelligence

Delivering that — more reach, more protection, no loss of safety — takes two distinct layers working together, and it is worth being precise about which is which.

The first is **AI infrastructure**: the cloud, the compute, the foundation models, and the machine-learning operations that make modern AI possible and affordable at scale. This is demanding, specialized work, and it is the domain of dedicated infrastructure providers — companies such as Nebius that exist to deliver the raw horsepower of AI reliably and efficiently.

The second is the **operating intelligence layer**: the software that sits at the point of care, in a specific clinical domain, and turns that horsepower into something a clinician can actually use and trust — connecting the fragmented signals of a behavioral health environment, surfacing what needs attention now, and attaching it to accountable, auditable, human-governed action. This is PraxisOne's domain.

Neither layer eases a workforce shortage on its own. Infrastructure without a domain-specific intelligence layer is horsepower with nowhere to go; a clinical intelligence layer without serious infrastructure cannot scale to meet the need. The frontier — the thing that actually extends and protects a behavioral health workforce — is the two working as one: world-class infrastructure beneath, human-governed operating intelligence at the bedside. Silicon to bedside, as a single system.

## 6 Human-first, and governed

Any technology introduced into this gap has to earn the trust of the very workforce it is meant to help — a workforce that is, understandably, wary of being told a machine will do its job. The framing that works, and the only one that is true, is augmentation, not replacement:

- Intelligence **informs**; licensed clinicians and administrators **decide**. The system never acts on a patient by itself.
- It exists to **give time back** to caregivers — for preventive work, for the human connection that is the point of the work — not to squeeze more tasks into the same hour.
- It is **explainable and auditable**, so a clinician can weigh its signals rather than simply obey them.
- It handles sensitive data with the privacy, consent, and governance a behavioral health setting demands.

Built this way, technology becomes something staff advocate for rather than fear — which is also, not coincidentally, what determines whether it is ever adopted at all.

## 7 What adoption takes

The barrier to easing the workforce cliff is rarely the technology itself; it is everything around it. Three conditions decide whether a solution reaches the bedside:

- **Fit for purpose.** Tools designed with frontline behavioral health teams — for their real workflows — earn use; tools bolted on from outside do not.
- **Interoperability.** Value depends on connecting to the systems an organization already runs, not adding one more island of data for overstretched staff to reconcile.

- **Incentives that reward outcomes.** When payment models pay only for tasks performed by people, they quietly penalize the very efficiencies that could relieve the workforce. Aligning incentives to patient outcomes is what lets adoption scale.

## 8 Capacity with humanity

The workforce cliff is real, it is widening, and it will not be recruited away. But it is not a sentence. The organizations that come through it will be the ones that stop trying to hire a workforce the market cannot supply and start extending and protecting the workforce they have — on infrastructure they can trust, with intelligence built for behavioral health, and with a human in control of every decision.

Done right, this is not a story about doing more with less. It is a story about letting scarce, exhausted, irreplaceable people spend their time on the part of the work only a human can do — and reaching more of the people who need them. Capacity, with humanity intact. That is the whole of the goal.

## About PraxisOne

PraxisOne is the operating intelligence layer for behavioral healthcare. We connect the clinical, operational, and behavioral signals that already exist across an organization's environment, identify what requires attention, and turn intelligence into accountable, auditable action — with human oversight at every step. Our platform, Haleux, is delivered through Haleux Care, which brings governance to the front line of patient care and documentation, and Haleux Assure, which operationalizes QAPI as a continuous, evidence-backed discipline.

To discuss how operating intelligence could extend and protect your workforce, visit **praxisoneinc.com** or request a demonstration.

**A note on references to third parties**

*Third-party companies named in this paper, including Nebius, are referenced illustratively to describe categories of technology. Their mention does not imply any partnership with, endorsement of, sponsorship by, or affiliation with PraxisOne, Inc.*

## References

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