Behavioral Health Workforce Shortage

Written Testimony

House Mental Health & Addiction Committee
Senate Behavioral Health Committee

February 23, 2024

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Illinois House of Representatives
Mental Health and Addiction Committee
Chair Lindsey LaPointe
Vice Chair Maurice A. West III
Republican Spokesperson Jackie Haas
401 S. 2nd Street
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Members of the Committee:

CBHA is pleased to provide this testimony regarding the behavioral workforce shortage in Illinois. CBHA represents community-based mental health and substance use providers across the state who provide critical on-the-ground services to Medicaid-eligible adults, children, and families as well as uninsured individuals. They offer full continuums of services including outpatient services like counseling and therapy, case management, group homes for adults with mental illness, and crisis services for children and adults, among other services.

As you heard in the first hearing on this issue, behavioral health providers across the state are overworked, underpaid, and undervalued. CBHA members are facing critical levels of burnout and many are unable to keep up with basic life expenses despite having full-time careers. Our providers are so dedicated to the well-being of their clients that they endure inadequate reimbursement for services, extreme and duplicative documentation requirements, and systemic barriers that make clinical practice inaccessible for many. To address the issues and strengthen the behavioral health workforce, CBHA recommends that the legislature focus on three policy areas:

#1. Reducing administrative burdens for providers. Providers are currently experiencing burnout at levels never before seen, leading to deep job dissatisfaction in the field. A study by the National Council for Mental Wellbeing found that 93% of surveyed providers experienced burnout as a result of onerous, duplicative, time-consuming administrative requirements. These unruly tasks, such as duplicative paperwork and reporting requirements, harm providers and clients alike. Over two-thirds (68%) of providers report that the amount of time they spend on repetitive administrative tasks takes away from the time that they could be providing direct client support. A 2024 internal survey conducted by CBHA found that providers spend precious time on administrative tasks, with the average CBHA provider spending 3 hours *each day* on paperwork. Simply put, excessive administrative burdens create a worse behavioral health system where providers are at capacity and clients' needs go unmet. *To address this issue, CBHA offers the Workforce Direct Care Expansion Act (HB 5094), which*

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would create an administrative burden work group to combat unnecessary administrative tasks on a more granular level.

#2. Simplifying the licensure process. Attaining licensure as a mental health professional in the state of Illinois is confusing. The licensure process itself relies on outdated technology, which IDFPR is currently in the process of updating. However, even with modern technology, the licensure process must be simplified. For example, Illinois is not part of any interstate compact recognizing the behavioral health licenses of other states. It takes 6-8 months, on average, for the Department to process an application for a behavioral health license, which prevents Illinois from meaningfully addressing the workforce shortage. There are many professionals who are ready to begin practice, such as former licensees and military spouses, but with Illinois's inflexible evidentiary requirements for licensure, the Department is forced to review unnecessary information, which slows the entire system down. *CBHA offers a licensure simplification omnibus (HB 5353) to help the Department prioritize those applications that will get professionals working as quickly as possible.*

#3. Expanding access to bilingual services and diversifying the behavioral health profession. More than one-in-five Illinois households (23.2%) speak a language other than English at home. An estimated 1.8 million people, or 14.1% of Illinois residents, were born outside of the United States. However, despite having such a high bilingual population, there is a severe shortage of bilingual providers in the state. The ability to express oneself, particularly when trying to explain emotions or analyze/interpret life events, is crucial to the successful provision of behavioral health services. Studies show that the delivery of services in the client's own language is foundational for building trust and comfort with the client. However, due to the shortage of bilingual professionals, clients must rely on translators (which takes precious time from the client's appointment) or wait months and travel great distances to see bilingual providers. Bilingual clients often opt to receive services in English due to severe availability gaps of services in their language of origin, particularly in rural or underserved areas. *CBHA offers HB 5457, which will allow licensing exam accommodations for those whose first language is not English, to increase the availability of bilingual practitioners in the state.*

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In addition to the three policy areas discussed above, CBHA recommends that the legislature prioritize funding in two specific areas within the behavioral health field: (1) appropriations for the supervision and training of those seeking licensure and (2) supporting the implementation of CCBHCS.

FUNDING PRIORITY 1:
Supervision and Training Reimbursement

Please fund the provision in Public Act 102-1053 to increase the pipeline and diversity of the behavioral health workforce by supporting dedicated training and supervision of interns and clinical staff, including behavioral health providers-in-training pursuing licensure as a Licensed Clinical Social Worker (LCSW), Licensed Clinical Professional Counselor (LCPC), or Licensed Marriage and Family Therapist (LMFT). CBHA recommends an appropriation of $2.9 million for dedicated training and supervision.

Community-based mental health agencies often serve as training and supervision sites for interns and new entrants to the workforce seeking supervision hours to meet licensure requirements. Prior to obtaining their license as a LCSW, LCPC, and LMFT, these professionals are mandated to complete up to 3000 hours of supervised clinical experience. This places financial and time-resource hardships on these already lean agencies to provide the supervision.

If a person ends up working for an employer that does not provide clinical supervision, then the individual will need to find a supervisor and pay for supervision on their own. Many new mental health clinicians will have to pay over $10,000 in fees for supervision. The amount is unaffordable for many students, particularly lower-income students, who graduate with tens of thousands of dollars in debt.

Community mental health agencies frequently serve the most complex and chronically ill behavioral health clients, which can be a challenging population for new entrants to the workforce. Many times, professionals leave for private practice or better-paid opportunities with lower acuity patients after completing their facility-sponsored supervision requirements.

The lack of support for serving as a training and supervision site and staff turnover adversely impact the ability of agencies to better prepare the workforce and meet the needs of their behavioral health clients. Therefore, recognizing and providing support for this function will help community-based agencies provide more training and supervision opportunities, assist with recruiting and retaining professionals at these sites, help to address reductions in standard clinical productivity as a result of time spent supervising new staff, enabling better absorption of the costs of high turnover, and/or allowing for these settings to staff appropriately to support training and supervision of this critical workforce.

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CBHA Grant to Boost IL Children's Mental Health Workforce: In July 2022, CBHA awarded six mental health providers a total of $106,000 each over two years to fund dedicated clinical supervision time and a stipend for eight, second-year master's degree-level interns. Funding also supported enhanced supervision for two early career clinicians to improve the clinical skills of staff and enhance the quality of services to youth and families seeking services. The grant was focused on children's mental health services as a requirement of the foundations that provided the funding.

Goals:

- Build supervisory capacity and a culture of training and support
- Build a diverse workforce pipeline
- Increase clinician competency and confidence
- Increase access to children's mental health services

Program Components:
6 agencies across the State were funded to support 0.5 FTE of dedicated supervisor time to provide training and supervision for 4 interns per year, at least 2 early career clinicians per year to support advancement to licensure. $2500 stipend per intern.

First Year Successes:

- Interns felt valued, supported and more confident to serve highly complex youth and families.
- Dedicated training and supervision allowed the opportunity for interns to be more quickly incorporated into the team and begin providing services to youth and families and made for a more robust internship experience.
- Offering stipends allowed grantees to be more competitive in onboarding interns and early career staff.
- Dedicated supervision time allowed early career clinicians to more quickly achieve needed supervision hours and move more quickly to licensure, positively impacting the whole agency by increasing LPHA staff.
- Grant funding has allowed agencies to create a more sustainable infrastructure focused on training and support which in turn creates a new generation of more confident and competent clinicians.

Access:

- In the first year of grant 2350 additional youth and families received services.
- Grantees were able to reduce or eliminate waitlists.
- Opportunity for increased community outreach and engagement.
- This grant program expires in 2024 but serves as a proof of concept for the value of supervision and intern stipends.

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FUNDING PRIORITY 2:
Support CCBHC Implementation

Illinois is in the process of implementing Certified Community Behavioral Health Clinics (CCBHCs), a new form of provider within the Medicaid program, established by the Excellence in Mental Health Act. CCBHCs are designed to provide whole-person care by integrating physical health with a comprehensive range of mental health and substance use disorder services to vulnerable individuals.

In addition to a full array of treatments and therapies, they provide community outreach and support for an individual's health-related social needs like transportation, food security, and housing. They can do this because CCBHCs are paid using a prospective payment system which is based on the actual investments that go into providing the care. This structure supports the costs of expanding services and increasing the number of clients they serve and gives clinics the flexibility to be innovative and deliver client-centered care.

Effects on Workforce Recruitment and Retention. According to a 2022 survey by the National Council for Mental Wellbeing, which included responses from 249 CCBHCs and grantees, amid the ongoing mental health and substance use workforce shortage, CCBHCs and grantees have been able to leverage their Medicaid payment structure to recruit and retain highly qualified staff. On average, survey takers said they have hired 27 new staff members per clinic since becoming a CCBHC. Additionally, 11,240 new staff positions were added across all 450 active CCBHCs and grantees.

The most common strategy CCBHCs and grantees are using to mitigate the effects of the workforce shortage is raising salaries or offering bonuses. Many respondents noted that their CCBHC funding has enabled them to offer more competitive pay relative to other providers and industries in their area.

The survey findings also noted that beyond addressing staff pay, the vast majority of CCBHCs and grantees are also actively engaged in a variety of other strategies to mitigate the effects of the workforce shortage, including engaging in staff wellbeing efforts, revamping employee benefits, and other strategies to improve staff satisfaction and retention. Other strategies include partnerships with clinician training programs, revising job descriptions and care teams to allow staff to practice at the top of their license, and enhancing provision of integrated behavioral health and primary care so more needs can be addressed in a single visit.

Beyond their ability to increase hiring, numerous respondents shared comments about the impact of CCBHC status on workforce retention. By providing a source of funding for critical client care activities such as outreach, client engagement, care coordination, and internal team consultation/support, the CCBHC model supports flexibility in how staff engage with clients and with one another. Many respondents commented that this contributes to a more desirable

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working environment and has reduced staff turnover. *CBHA supports appropriations to community-based providers that will support the implementation of a robust CCBHC program across the state.*

CBHA believes legislation in these areas is crucial to the success and well-being of the behavioral health field. We are confident that Illinois will emerge from the current workforce shortage as a leader in behavioral health, and we look forward to working with the General Assembly to accomplish these goals.

CBHA appreciates the opportunity to provide these comments. We welcome any questions or further discussion about the recommendations described here. Please feel free to contact Blanca Campos, CEO of CBHA, at bcampos@cbha.net. Thank you for your time and consideration.

Sincerely,

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Appendix A:

Letter from Anne Tyree, CEO, Centerstone of Illinois

CENTERSTONE

I am pleased to provide this written testimony for the Illinois legislature's hearings about the behavioral health workforce shortages. Centerstone is a nonprofit health system operating in four states and specializing in mental health and substance use disorder treatment for people of all ages. In Illinois, Centerstone provides mental health, addictions, crisis and residential services across nine counties in Southern Illinois. Last year we served over 9,000 Illinoisans with our nearly 600 staff through our noble purpose, "Delivering Care that Changes People's Lives."

In 2022, Centerstone of Illinois secured a $3 million workforce resilience grant from the US Health Resources and Services Administration *(Centerstone's Workforce Resilience Program (C-WRP),* HRSA grant #U3MHP45380). The grant, which covers our entire system, is the first of its kind to focus on behavioral health staff wellness; its information is critical given the current behavioral health workforce shortages.

The grant's purpose was to establish, enhance, and expand evidence-based programs and protocols to promote resilience, positive mental health, and wellness among Centerstone's diverse behavioral health care workforce. The grant included a Workforce Wellness survey, along with focus groups, to identify areas of focus. Staff and supervisor training modules were developed and deployed to staff and supervisors with the goal of promoting wellness skills in the workplace. Evidence based models (Penn Resilience Model) and supportive activities address burnout and manage workplace stressors.

Below are themes and direct quotes from Illinois staff members on the Workforce Wellness surveys about the quality of their work lives.

- 2022 and 2023 Workforce Wellness Survey data indicated that demanding productivity expectations, large caseloads/workloads, and inadequate supervision were top stressors among employees with intent to leave the organization.
- A top theme was that IL staff feel burdened by "shadow work" – documentation, case management, returning calls, etc. The current system rewards time providing a "service to the client" and not all of the items included in providing quality care.
- When staff depart, managers step in to fill-in for staff shortages, which both overburdens them and decreases the amount of supervision they can offer (and the quality of the supervision).
- Consider the difference between private practice clinicians and those in CMHCs – private practice clinicians have the luxury of controlling the volume of clients coming in and the simplicity of paperwork whereas CMHC clinicians have little control over volume and Medicaid documentation is extremely complex.

Direct quotations from the survey included:

- "There just isn't enough time in the day to help everyone who needs it." (2022)
- "There is no time to go to the bathroom because clients are literally scheduled back to back to back." (2022)
- "I struggle with expectations related to hours of care/direct service, which is constantly demoralizing." (2023)
- "I work long hours." (2023)

In 2023, among Illinois survey respondents in a clinical service provision role…

- More than 20% reported insufficient (i.e., poor or marginal) time for documentation.
- More than 26% reported frequent (i.e., moderately high to excessive) electronic medical record use at home.
- More than 34% reported that the electronic medical records added to the frustration of their workday.
- Almost 40% reported experiencing a great deal of stress because of their jobs.

Because of staff feedback, Centerstone has:

- Connected staff with leadership to better assess and meet workforce needs, rather than prescribing top-down solutions to the workforce problem.
- Leadership has focused efforts on widespread compensation increases, EAP/mental health benefit expansion, resilience trainings, and increased communication with staff overall.
- The grant helped develop strategies to facilitate two-way communication and problem-solving (partnering executives with frontline staff) within existing meeting infrastructure and workflows.

The good news is that 53% of staff with more than one year of tenure agreed, in the 2023 Workforce Wellness survey, that they felt more support from Centerstone leadership. Voluntary staff turnover the first seven months of FY 2024 was 13.77% compared to 20.43% for the same period in FY 2023.

Sincerely,

Anne Tyree, MPA
Chief Executive Officer
Centerstone of Illinois, Inc.

February 6, 2024

Appendix B:

Materials for Further Reading

Further Reading

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Behavioral Health Workforce Shortage

Testimony Before the House Mental Health and Addiction Committee
And
Senate Behavioral Health Committee

February 23, 2024

Submitted by
Gerald (Jud) E. DeLoss, J.D.
Chief Executive Officer

Good afternoon, I am Jud DeLoss, the CEO of the Illinois Association for Behavioral Health. IABH represents more than 80 community-based substance use disorder and mental health prevention, treatment, and recovery organizations and more than 7,000 individual clinicians and certified individuals in Illinois.

Like many in the behavioral health profession, I became interested in this field because of the compassion and the passion that behavioral health professionals and other providers and peers have for serving those in need. Folks enter the behavioral health field because they want to serve those with mental health or substance use disorders. It is a devotion based upon a mission not upon becoming rich.

So it is particularly troublesome that we have lost so many from the behavioral health workforce to other employers and it has become so difficult to attract high quality workers into the field. We are losing workers to other types of employment not because the mission has changed or the desire to serve is no longer there. The drain on the behavioral health workforce is because employers are not able to pay them even a livable wage to permit workers to continue to do or to have an opportunity to join a provider and do what they love and because the burdens placed upon workers have become overwhelming.

We heard at the last hearing about the tremendous demand for mental health and substance use disorder services. Across the age and cultural spectrum we are seeing unprecedented demand for behavioral health treatment; among children, adolescents, adults, and the elderly. Each race, sexual orientation, and ethnicity has been hit hard. Anxiety, depression, addiction, overdose, suicide, and deaths are at all-time highs. There is no argument whatsoever that Illinois is in desperate need of behavioral health services and treatment.

At the same time, we are experiencing not only an insufficient number or entrants into the behavioral health workforce, we are also seeing the behavioral health workforce drain away. New mental health and substance use disorder staff along with veterans in the field are departing.

The question we face about the insufficient and dwindling behavioral health workforce is <u>why</u>?

There are two short answers to that question. The first is burnout. The second is insufficient reimbursement. Let me address each in turn.

The behavioral health workforce has always been stretched to its limits. The Covid pandemic saw workers risking their lives to continue to provide necessary services. Since then we have seen continued heightened demands on workers to prepare unnecessary and duplicative paperwork and to deal with managed care organizations with teams of professionals intent on making simple requests for service authorization difficult.

Behavioral health workers must complete the Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS). The IM+CANS is a comprehensive, lifespan tool for assessing the needs and strengths of individuals who require mental health treatment in Illinois. It contains a complete set of core items that assess function across multiple life domains such as risk behaviors, trauma exposure, behavioral/emotional needs, substance use, and cultural factors, as well as a physical health risk assessment.

Generally, behavioral health workers complete the IM+CANS with a new client before they are able to get to the heart of the matter and reason for the client's visit. The numerous questions that must be asked of the client along with the completion of pages of documentation cause tension with the client relationship and unnecessarily slows the provision of treatment.

I am not a clinician but my viewing of the IM+CANS is of a 13-page document plus 4 multiple-page addendums all in tiny 9 point font that must be completed by the clinician. While much has been improved with the advent of the IM+CANS Workgroup and its diligent efforts, there still remains too much paperwork and too much red tape. The IM+CANS must be reduced even further or replaced.

The frustrations of dealing with monolithic managed care organizations has caused many behavioral health workers to give up and leave the field. There is no question that Medicaid managed care increased the workload pushed upon the behavioral health field. Prior to MCOs, frontline staff and clinicians could provide service without unneeded and unduly burdensome documentation and paperwork. Since the introduction of Medicaid managed care there has been an increasing imposition upon both clinical and non-clinical staff to deal with managed care staff and in some cases Artificial Intelligence (AI) bent on limiting or reducing treatment or simply putting up so many barriers that patients and providers give up. At the same time as these new roadblocks were implemented, the behavioral health field saw no accompanying funding increase to offset the time spent

by clinical and support staff seeking to obtain necessary coverage along with the engagement of billing and insurance staff needed to take on the MCOs.

Second, the behavioral health workforce has been historically underfunded and underpaid. Even with recent increases in reimbursement rates for mental health and substance use disorder treatment, we are still playing catchup. The field has been underfunded for so long that even double-digit rate increases do not get providers to the place they should be in comparison with the physical medical field. Equitable funding in parity with medical-surgical reimbursement rates are needed for behavioral health workers to earn a livable wage, to attract high quality workers into the field, and to permit existing workforce members to continue to do what they love.

In addition to the two crucial areas I have identified above in need of improvement, the behavioral health workforce can be buttressed with two additional strategies:

- Workforce Diversity Initiatives: Implement initiatives to recruit and retain a diverse behavioral health workforce that reflects the communities we serve. This includes targeted recruitment efforts, cultural competency training, and addressing systemic barriers to entry.
- Peer Support Programs: Expand peer support programs where individuals with lived experience of behavioral health challenges provide support for others. This enhances the workforce by leveraging the unique perspective and expertise of peers.

Thank you for your consideration of my testimony. I would be happy to answer any questions.

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About IABH

The Illinois Association for Behavioral Health (IABH) is a statewide organization representing more than 80 community-based substance use disorder (SUD) and mental health prevention, treatment and recovery organizations, behavioral healthcare affiliates, related corporations and over 7,000 individual clinicians, counselors, and therapists across the State. Our mission is to advocate for sound public policies in the behavioral health field, on behalf of the clinicians, consumers, families, individuals in recovery and youth who are in need of services. We educate the general public about addiction and mental health; sharing the message that addiction can be prevented, mental health wellness opportunities exist, there are effective treatment strategies for those struggling with addiction and mental illness, that recovery is possible for everyone.

Hello My name is Michael Gaytan and I would like to say thank you to the IDHS leadership team for inviting me to speak here today with the Joint House-Senate Committee. I am honored for this privilege to be a voice for the future of the CRSS Success Program here in Illinois. Thank you, Chairs Sen. Fine and Rep. LaPointe, and members of the Mental Health & Addiction Committee and Senate Behavioral Health Committee, for the opportunity to provide testimony today.

Thank you also to Director Albert, Secretary Quintero, and their entire team for taking this initiative seriously and creating opportunities for people like me to make a life for themselves. This program is the ultimate second chance for those who have survived mental health challenges and substance use disorders. This much needed expansion of peer support is empowering individuals doing well in their recovery to share their stories with others that are still struggling, being an example of what is possible for themselves. Thank you to the state and this administration for being a model for the country and the world, showing us all that investing in our communities, being inclusive, and valuing the experiences of individuals will benefit the entire society.

I've always attempted to see my past as preparing me for the future, and I always tried to keep the faith that things would get better. Unfortunately, the trauma, abuse, and neglect I experienced growing up led to extreme mental health concerns. The stigma, exclusion, and demonization I dealt with through the years led to self-hate, fear, feeling unsafe, inability to know who to trust, and ultimately hopelessness. Throughout my childhood I faced sexual, physical, and psychological abuse which led to self-sabotage, self-harm, codependency, and misuse of substances to cope later in my teens. Trauma took me from a straight A student to almost flunking out of high school because I became overtaken by depression, anxiety, flashbacks, and an inability to concentrate. Finally, when I was assessed, I was diagnosed and misdiagnosed with everything from PTSD to ADHD, from Major Depression to panic disorder and everything in between.

I unsuccessfully tried every form of treatment I could think of from hospitalization to rehab, from Partial Hospitalization to Intensive Outpatient programs, from therapist to psychiatrist, from therapeutic groups to mutual support. Nothing seemed to be helping me besides community, but it got to a point that I was unable to hold a job, unable to perform in college, and unable to support myself financially. I was consistently ruining relationships by lashing out at people that were trying to be supportive but just didn't understand what I was going through. This left me without the support of my family and friends and I ended up unhoused, alone, addicted, and fighting for my life for many years. Though I struggled, I was always able to bring my faith, hope, determination, love, and light into dark places and help to improve other people's predicament while unable to see the value in myself. I gave so much to others that I struggled longer than necessary, and I lost myself completely. It took complete strangers to see that there was a valuable person under all that trauma. Outside of a safe home and nourishment, it was their compassion, kindness, non-judgement, and empathy that created a supportive recovery environment for me to truly find myself, find healing, and find a way to get back to living again.

After two years of hard work, dedication, and determination in recovery and sobriety, I was offered an opportunity to give back to the community. I took a job at an overnight warming center alongside peer recovery support workers. This was my first exposure to the field and my first time working with a community that I am passionate about helping. This quickly became the most fulfilling job that I ever had. At this time, I was unable to believe how far I had come and would often struggle with my confidence thinking that I belonged using the services but not providing them. However, I put that all aside to help guests feel comfortable and supported. I was referred to the CRSS college program by other peers who recognized what I could bring to the table when I didn't even realize that I belonged in the room! Just as the strangers that took me in, my supervisors recognized my potential and helped to push me in a direction that was in alignment with my true purpose in life.

When I found out what peer support really meant and the scope that it covered, I wanted to be a part of it any way that I could. At first, I was hesitant to do the program because previously I had really struggled with college courses due to my instability with housing, environment, lifestyle, and mental health conditions. When I found out the requirements of the program, I wasn't sure if I would be able to pass the classes, pay the tuition, balance working while in class and doing an internship, keep my mental health balanced, or even meet the prerequisites for being involved. I felt deeply that this role was created for someone like me that knows firsthand the value of sharing hope, perspective, support, experience, resources, and empowerment with others in recovery, and I wouldn't let anything hold me back!

College of DuPage and the CRSS Success Program made the process attainable, enjoyable, inclusive, thorough, and supportive. The program director Bruce Sewick and the CRSS staff and instructors always made themselves fully available to the students. They made sure that they presented the information in a way that could be understood by all types of learning styles to include as many people in the conversation as possible. Their lived experiences as clinicians and program directors brought so much valuable insight and useful scenarios to the table and it has helped to prepare me in every way for this endeavor. I am grateful for the education we received on the potential applications of peer recovery support services because it really empowered me to see a future in this career and a future in which more people will be able to get the support they need no matter where their challenges lie. I am also honored I was able to work with a team of teachers and students that were so passionate about advocacy and pushing for the expansion of the program. They made every part of the process approachable from the initial screening to the exam application. College of DuPage also provided us with success coaches to help navigate the program so that we had support at every turn. The program also helped me to form connections with multiple organizations that they partnered with for the internship program, helping to shape my future with job references and access to recovery training. The education program goes in so much depth that it covered most of the training I was provided in my internship, ensuring that I was deeply prepared for my future position. All my fears were turned into excitement, determination, and ultimately success because of the support of this program and all that were involved in making this happen. With the support of the grant from IDHS, we were provided financial support along the way to cover childcare, transportation, professional clothing, a personal laptop, tuition, books, cost of the

exam, as well as compensation for the hours spent interning. This took a major weight off my shoulders and made this feat attainable for someone like me that lives paycheck to paycheck. Next month I will have achieved four years in my recovery and sobriety. I am one week away from moving into a beautiful rental property that before I could have only dreamed of living in. I am working full time for NAMI Metro Suburban at their Living Room in LaGrange as a Recovery Support Specialist seeing people have breakthroughs every day. I have completed the CRSS Success Program at College of DuPage as of the end of 2023. I have been chosen as a student ambassador for the education program and was honored to speak with Secretary Hou and her team at the college and during IDHS's "Motivational Monday" meeting to share my lived experience, bring more awareness to the value of this program, and to promote advocacy for future students. I have been volunteering my time to speak with as many people as I can about the potential of this career path, mentoring interns, running peer support groups, helping to train new staff members, and forming partnerships with resources in the community to help broaden the reach and familiarity of Recovery Support. I was empowered to create a pilot online social network for CRSS students and alumni from College of DuPage to connect, collaborate, and celebrate with each other well into our careers. I am in the process of creating a peer support virtual group for peers to connect, form partnerships, and share their experiences with each other.

This program has empowered me to change my life in a way that no one who knew me four years ago could have imagined possible. The program has given me a renewed sense of hope, a fresh start, a second chance, and purpose in life! I am empowered to take my story and use it to help support someone in their crucial moments, just as people have done for me throughout my journey. I truly struggled to put all my thoughts into a cohesive format to express what this program truly means to me, but it really is the difference between life and death for someone like me. I didn't think I had options until I found this program, now I feel that the options that I have are endless!

Thank you all for your time today and allowing me to share part of my story with you. Thank you all for believing in the value of my lived experience and giving me the opportunity to make a difference. I urge you to continue this program and to never stop fighting to end the silence, end the stigma, and empower all people into their ultimate wellness!

NAMASTE

ILLINOIS PSYCHIATRIC SOCIETY
A DISTRICT BRANCH OF THE AMERICAN PSYCHIATRIC ASSOCIATION
113 McHenry Road, Suite 239 • Buffalo Grove, IL 60089

Testimony Submitted to Joint Committee Hearing
House Mental Health and Addiction and the Senate Behavioral and Mental Health
Submitted by Dr. Andrew Lancia, President, Illinois Psychiatric Society, February 23, 2024

HISTORY

Illinois Becomes First State to Pass APA's Model Collaborative Care Legislation in 2019. Pursuant to Public Act 101-0574, the Department of Healthcare and Family Services started implementing coverage of Psychiatric Collaborative Care Model services in both the fee-for-service and managed care service delivery systems in 2022. Illinois also became the first state to pass legislation for Medicaid coverage for CoCM and that coverage was implemented in 2023.

OVERVIEW

Psychiatric Collaborative Care Model Overview (CoCM) is an evidence-based model for integrating behavioral health into primary care settings using a person-centered, team-based approach. The CoCM team is led by a primary care provider (PCP) and includes a behavioral health care manager (BHCM) and a psychiatric consultant. The team develops, implements, and regularly monitors a person-centered care plan, making referrals to specialized services when necessary. The model requires the use of validated screening tools and a patient registry, typically maintained by the BHCM, that is accessible to the PCP and psychiatric consultant. Five core principles define collaborative care and are necessary for an effective implementation of the model:

- Person-centered care: the customer is part of the treatment team and makes the ultimate decision regarding their treatment.
- Measurement based treatment-to-target strategy: validated tools are used for the measurement of customer symptoms and needs.
- Population-based care: the use of a patient registry to allow the team to monitor the customer's outcomes over time.
- Evidence-based treatment: treatments offered to customers are evidencebased (e.g., medications, brief interventions).
- Accountable care: the team is accountable for the customer's care, including the quality of care and clinical outcomes.

CoCM is a covered service for customers whose diagnosed behavioral health disorder requires systematic management, regular monitoring, and the provision of brief interventions to ameliorate their behavioral health symptoms. CoCM services must be recommended by the customer's PCP or treating physician and must be delivered consistent with the person-centered goals established on the customer's care plan.

CoCM is intended for customers with common behavioral health conditions that require systematic follow-up due to their persistent nature, including but not limited to mild to moderate depression, anxiety, post-traumatic stress disorder (PTSD), and substance use disorders (SUD). Customers who need help engaging in treatment, have not responded to care delivered in a traditional primary care setting, or who require further

assessment and engagement prior to consideration of a referral to more specialized behavioral health services may particularly benefit from CoCM services. These services are not intended to manage complex, severe, and/or persistent conditions which may require more specialized care from a Community Mental Health Center (CMHC), Behavioral Health Clinic (BHC), or licensed SUD provider.

Service Components:

- An initial assessment conducted by the primary care team, inclusive of the administration of at least one validated measurement tool (e.g., PHQ-9 or GAD-7);
- Person-centered care planning done the primary care team jointly with the customer, with revisions as needed;
- Proactive, systematic follow-up conducted by the BHCM documented in a patient registry that includes an assessment of treatment adherence and clinical progress and the monthly administration of the validated measurement tool(s);
- Provision of brief evidence-based psychosocial interventions;
- Regular case load review with the psychiatric consultant; and,
- Referrals to specialty services and social services as needed.

CoCM services may be delivered face-to-face, by video, or phone; however, at least one face-to-face meeting is required every 90 days (a PCP visit can fulfill this requirement).

CoCM Team Roles and Qualifications:

- **PCP:** a licensed physician,Advanced Practice Nurse (APN), or Physician Assistant(PA) who is enrolled as a provider in the HFS Medical Programs. The PCP serves as the team lead and is responsible for:
    - Directing and supervising the BHCM;
    - Providing and directing the customer's behavioral and physical healthcare;
    - Prescribing and managing medications based on psychiatric consultant recommendations; and
    - Making referrals to specialty care as needed.

- **BHCM:** an individual who meets any of the following qualifications:
    - A bachelor's or master's degree in counseling and guidance, rehabilitation counseling, social work, education, vocational counseling, psychology, pastoral counseling, family therapy, or related human service field;
    - A bachelor's degree in any field with two years of documented, supervised clinical experience in a behavioral health setting; or
    - Registered Nurse (RN).

  The BHCM must work under the direction and supervision of the PCP and is responsible for:

    - Providing care management services;
    - Customer engagement and education;
    - Assessing customer needs;
    - Developing, reviewing, and updating person-centered care plans;
    - Administering validated screening tools (e.g., PHQ-9 or GAD-7) for each customer at least monthly;
    - Delivering evidence-based brief interventions;
    - Collaborating with team members, including facilitating communication between the PCP and the psychiatric consultant;
    - Maintaining the patient registry;
    - Consulting weekly with the psychiatric consultant; and,
    - Facilitation of referrals to social services.

- **Psychiatric Consultant:** A licensed psychiatrist or an APN with a current certification in Psychiatric and Mental Health Nursing. The psychiatric consultant is responsible for:
    - Consulting weekly with the BHCM on complex cases and customers who aren't improving as expected;
    - Recommending treatment strategies and medications, including changes based on the customer's status;
    - Recommending referral to specialty services when needed; and
    - Be available to consult with and advise the PCP as needed.

  In cases where a substance use disorder is being treated, medical professionals who specialize in addiction medicine and are qualified to prescribe the full range of medications may function in the consultant role, for purposes of meeting the billing requirements for the CoCM services.

THE OPPORTUNITY

The CoCM model of care presents health care providers in the state of Illinois with an opportunity to significantly **increase access to mental health care** by integrating it into primary care settings.

- Primary care physicians already serve as managers of psychiatric disorders; two-thirds of patients with depression receive treatment for their depression in the primary care setting.
- Integrating psychiatric care into primary care is a cost-effective and systematic approach to improving health outcomes for patients with both physical and behavioral health conditions.
- The tradition of siloes for mental health has created a tremendous impediment for patients, and integration provides an opportunity to address it.
- Collaborative Care (CoCM) is a specific type of integrated care to treat common mental health conditions in medical settings such as primary care.
- Illinois became the first state in the country to enact a law that requires private and public insurance programs to reimburse such collaboration by implementing the Psychiatric Collaborative Care Model (CoCM).
- There is strong evidence that integration of care can also improve access, achieve parity, address stigma, and decrease disparities in psychiatric care.
- CoCM has specified CPT Codes that can be used to bill for services reimbursed in Illinois by Medicaid, Medicare, and commercial insurance.

THE CHALLENGE

Most Illinois health care providers and institutions are not yet aware of the CoCM and only a few have moved toward implementation. What can the state of Illinois do to greatly increase access to mental health care by promoting widespread CoCM adoption?

LEGISLATION TO PROPELL CoCM FORWARD

HB 5045: Appropriates $5,000,000 from the General Revenue Fund to the Department of Public Health for Collaborative Care Demonstration Grants, as defined in the Psychiatry Practice Incentive Act, and related expenses.

HB 5046: Amends the Psychiatry Practice Incentive Act. Provides that the Department of Public Health shall establish a Collaborative Care Demonstration Grant program and set criteria for the program. Provides that the Director of Public Health may establish a program, and criteria for the program, to provide grants, training, and technical assistance to eligible primary health care practices to support implementation of the program.

Establishes the purposes and use of the grants. Provides that grants awarded under the program shall be for a minimum amount of $100,000. Provides that the minimum award amount shall increase by $1,000 per 1% share of patients to be seen by the awardee during the applicable grant period that are expected to be enrolled in Medicaid, up to $500,000 total per award. Provides that the Director of Public Health may solicit proposals from and enter into grant agreements with eligible collaborative care technical assistance centers to provide technical assistance to primary health care practices on providing behavioral health integration services through the psychiatric Collaborative Care Model, including, but not limited to, recipients of grants under the program. Provides that the Director of Public Health may develop and implement a public awareness campaign to raise awareness about the psychiatric Collaborative Care Model. Provides that the program is subject to appropriation. Defines terms.

NASW ILLINOIS CHAPTER
National Association of Social Workers

Kyle Hillman, Director, Legislative Affairs National Association of Social Workers- Illinois Chapter, NASW is the largest professional association for social workers dedicated to the advancement of social work and advocates for our clients in Illinois.

The mental health profession in Illinois is presently confronting a critical workforce shortage, significantly impacting the accessibility and quality of mental health services within the state. This crisis is marked by a pronounced scarcity of qualified mental health professionals, a situation that has been further aggravated by the escalating demand for mental health services.

- **Reduced Access to Care:** A shortage of professionals means that many individuals may not receive timely or adequate mental health services, leading to worsening mental health conditions.
- **Increased Wait Times:** With fewer professionals available, individuals seeking help often face long wait times, which can be detrimental during a mental health crisis.
- **Greater Reliance on Non-Specialists:** Primary care providers and emergency departments may need to fill the gap, despite not always being equipped to offer specialized mental health care.

The growing demand for clinical social workers in non-traditional roles, such as care coordinators, crisis response teams, and municipal offices, has intensified the challenge for agencies to recruit fully qualified clinical professionals, thereby escalating the competition for talent. To enhance talent retention, it is imperative to consider measures such as increased compensation and benefits, potentially through rate adjustments. However, it is equally important to acknowledge that without expanding the talent pool, we are merely reallocating resources based on the ability of different sectors to invest in competitive salaries and work environments. Elevating pay in one mental health sector may attract talent to that area, yet the overarching shortage of professionals means that another sector will inevitably experience a deficit.

Moreover, our efforts to enrich the mental health sector must include a commitment to diversifying the workforce to more accurately reflect the demographics of Illinois and the diverse clientele served. Our organization urges this body to adopt a dual approach in strategies aimed at enlarging the talent pool: not only should we focus on growth, but we must also prioritize diversification. This approach will ensure a more inclusive and effective mental health service landscape across the state.

NASW Illinois proposes the following recommendation broken into three tiers.

Tier 1 Recommendations – Moving existing Master's Level Professionals into Illinois Licensure

Recommendation: Evaluate licensure test requirements and eliminate barriers that no longer protect the public nor provide effective measurements of competency.

In 2022, under the leadership of sponsors Representative Lindsey LaPointe and Senator Villa, Illinois distinguished itself as the pioneering state to eliminate the foundational licensure examination requirement for Licensed Social Workers (LSWs). This legislative initiative represents a significant advancement, markedly diminishing entry barriers and substantially augmenting the pool of qualified professionals within the state. The abolition of the LSW examination prerequisite has demonstrated encouraging outcomes, evidenced by a remarkable 100% increase in the number of LSWs within

Illinois—from just over 5,000 to more than 10,000—in the first licensure cycle following the law's implementation. Additionally, 12% of these newly licensed professionals originated from outside the state, contributing to Illinois' workforce either through telehealth services or by relocating to Illinois for practice.

In 2023, the general assembly enacted a measure introducing a testing alternative for Licensed Clinical Social Workers (LCSWs), which has recently been implemented. Preliminary feedback indicates a strong interest in this alternative pathway, and it is anticipated that Illinois will experience significant benefits from this new option in the current year.

It is highly unlikely that high-stakes tests for other mental health professionals aren't also providing an unnecessary barrier to access and it is likely removal of those barriers would result in similar gains for the state. These are masters-level professionals denied access to the profession due to testing barriers and removal of barriers would cost the state zero dollars but have the most significant gain in the shortest time. We strongly encourage the state to consider ways to move these masters level professionals to licensure before investing dollars into new professions with a decreased level of education.

Recommendation: Enhance the Efficiency of IDFPR Licensure Procedures for Inbound Clinicians To facilitate the timely licensure of mental health professionals relocating to Illinois, it is recommended that the Illinois Department of Financial and Professional Regulation (IDFPR) simplifies its licensure process and requirements. The current process can be complex and discouraging for skilled practitioners considering a move across state lines. Streamlining these procedures would not only expand the availability of mental health care providers in Illinois but also demonstrate the state's dedication to supporting mental health practitioners and effectively addressing the needs of its residents. A proposed solution is the establishment of a fast-track licensure pathway for mental health professionals from states with analogous licensure standards, thereby eliminating unnecessary barriers to entry.

Recommendation: Invest in the recruitment of highly trained professionals from states that are placing new political barriers to practicing ethically.

Illinois is at a critical juncture in its capacity to attract highly trained mental health professionals, particularly against the backdrop of restrictive policies in other states. Demonstrating a commitment to inclusive and progressive practices, along with providing supportive work environments, positions Illinois as an appealing destination for professionals seeking to practice freely and without limitations. Such a strategy not only enhances the diversity and expertise of our workforce but also guarantees that our communities benefit from high-quality, culturally sensitive care. In parallel with the state's current initiatives to recruit corporations, there is a pressing need for Illinois to develop strategic incentives and recruitment programs aimed at enticing highly skilled professionals to relocate here.

Moreover, while it remains vital for Illinois to continue expanding its behavioral health workforce through university education—a process that typically spans 5-6 years from high school graduation to initial licensure—the immediate opportunity lies in attracting established behavioral health professionals from across the country. These individuals, currently facing new challenges including political litigation and unethical mandates, represent a valuable pool of talent that Illinois should actively and purposefully seek to recruit.

Tier 2 Recommendations – Pre-Licensure/Supporting Students in Academic Programs

Recommendation: Fund a bridge program for Associate Level Community Health Workers to become Social Workers. The introduction of a bridge program that facilitates the transition of Community Health

Workers (CHWs) to social work roles represents a strategic and innovative approach to capitalizing on the existing skills and expertise found within our communities. By establishing clear pathways for CHW certification within social work educational frameworks, this initiative directly contributes to enhancing the diversity and inclusivity of the profession. It recognizes the significant contributions of CHWs by offering them well-defined and accessible avenues for career advancement within the field of social work. To effectively implement this program, the state will need to ensure additional financial and educational support is available to enable CHWs, particularly those with associate degrees, to transition smoothly into Bachelor of Social Work (BSW) programs. Additionally, collaboration with universities to align CHW qualifications with BSW program requirements is essential to facilitate a seamless and expedited pathway for CHWs aspiring to roles in social work.

Recommendation: Create a program to fund group supervision of post-graduate mental health professionals. Independent clinical professionals are experiencing unprecedented demand from healthcare providers, attributed to their expansive scope of practice and billing privileges. Achieving independent status, however, is hampered by a significant barrier: the acquisition of clinical supervision, particularly when a candidate's current employer lacks a qualified clinical professional to provide such supervision. As a result, candidates are often compelled to seek external supervision, which, according to our internal data, can cost between $15,000 and $18,000—a cost frequently not reimbursed. To address this issue, it is recommended that the state initiate a grant program aimed at enabling large agencies and associations to establish group clinical supervision programs. This would facilitate the provision of free or cost-effective clinical supervision for candidates who do not have access to internal supervision options.

Recommendation: Fund paid field placements and other supports for students in behavioral health programs. In the demanding journey to attain degrees in behavioral health, students are required to complete field placements alongside their academic studies. These placements, crucial for practical experience, often take the form of unpaid internships under the mentorship of licensed professionals. A survey conducted by the National Association of Social Workers (NASW) revealed that over 40% of students managed full-time graduate studies and unpaid field placements, while also engaging in part-time to full-time employment to meet their financial needs. This level of commitment presents a significant challenge for many students, particularly those with financial responsibilities and without familial financial support.

To alleviate these burdens, several states have pioneered the implementation of paid field placement grant programs that universities can administer based on student need. Additionally, there is an opportunity for the state to consider augmenting support for these students through the expansion of childcare, housing, and transportation assistance, in line with services provided by the Office of Economic Opportunity. Such measures would not only support the educational aspirations of behavioral health students but also enhance their well-being and academic success.

Tier 3 Recommendations – Pre-University

Recommendation: Create a Grow Your Own for Mental Health Professional. The imperative to diversify the mental health profession is not just a matter of enhancing representation but is critical to addressing the nuanced needs of diverse populations. Efforts to mitigate the current workforce shortage within the mental health sector must therefore be strategically aligned with initiatives aimed at diversifying the workforce. This dual approach is essential for fostering a more inclusive and effective mental health care system that is capable of delivering culturally competent care across a broad spectrum of communities.

To achieve this, recruitment and training programs must be intentionally designed to be inclusive and to break down barriers that historically have limited access to careers in mental health for individuals from

underrepresented groups. This includes, but is not limited to, offering scholarships, creating mentorship programs, and providing targeted support services to students and professionals from diverse backgrounds.

Recommendation: High School Recruitment and Workforce Awareness Educational Program. We recommend the Illinois General Assembly allocate funding and resources for the development and implementation of a High School Recruitment and Workforce Awareness Educational Program for Mental Health Professionals. This program should be developed in collaboration with educational institutions, mental health organizations, and professional associations to ensure it is comprehensive, accessible, and effective. Key components of the program should include:

- Develop educational materials and resources for high school students, educators, and counselors that outline the scope of mental health professions.
- Partner with universities, colleges, and professional mental health organizations to facilitate guest lectures, workshops, and interactive sessions.
- Establish mentorship programs linking students with mental health professionals and create internship opportunities to provide hands-on experience.
- Provide information on scholarships, grants, and financial aid available for students pursuing mental health degrees to address financial barriers to entry.
- Offer specialized career counseling services for students interested in mental health professions, including guidance on educational pathways and licensure requirements.

Caution: Compacts are not Workforce Development but a Workforce Shift.

While the implementation of mental health compacts offers several benefits, including enhanced continuity of care, it is imperative for the state to recognize that these compacts should not be viewed as a panacea for addressing workforce shortages within the mental health sector. Mental health compacts primarily aim to improve the mobility of mental health professionals, facilitating their ability to practice across state lines, thereby potentially increasing the accessibility of mental health care services. However, it is essential to critically assess the implications of such initiatives on the distribution of the mental health workforce, particularly with regard to the availability of in-person services in regions that are already underserved.

Moreover, as investor-led for-profit entities continue to expand, and the utilization of telehealth to refer patients to practitioners in states with lower reimbursement rates becomes more common, there is a tangible risk that rural areas and safety-net providers may experience a notable decrease in insured clients. Such developments could lead to the closure of practices and a further diminishment of options for in-person care in these communities. It is crucial to understand that the adoption of mental health compacts results in a redistribution of the existing workforce rather than an increase in the total number of mental health professionals available. Therefore, the notion that a significant surplus of mental health professionals exists in other states, ready to serve Illinois through compact participation, is a misconception. The reality is a shift in workforce distribution, necessitating careful consideration and strategic planning to ensure that all regions, especially those most in need, maintain access to comprehensive mental health services.

Joint House Mental Health and Addiction Committee & Senate Behavioral Mental Health Committee

Subject Matter: Behavioral Health Workforce Shortage
February 23, 2024, 10:00 a.m.

Good morning,

My name is Nanette Larson, and I serve as Deputy Director for Wellness and Recovery Services for the Illinois Department of Human Services' Division of Mental Health.

Thank you, Chairs Fine and LaPointe, and members of this committee, for the opportunity to provide testimony today.

For the past 25 years I have worked within the Division of Mental Health (DMH) to assist in supporting the development of what is now commonly known as the peer recovery support workforce. Peer recovery support is an innovative, evidence-based solution to addressing the behavioral health workforce shortage, and peer recovery support specialists play a vital and essential role in recovery-focused systems of care.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "Peer recovery support workers are people who have been successful in the recovery process who help others experiencing similar situations. Through shared understanding, respect, and mutual empowerment, peer support workers help people become and stay engaged in the recovery process and reduce the likelihood of relapse."

Research shows that individuals who have access to peer recovery support services have improved quality of life; improved engagement and satisfaction with services and supports; improved whole health, including chronic conditions like diabetes; decreased hospitalizations and inpatient days; and reduced overall cost of services.

Peer recovery support specialists have been shown to be effective in serving people in various settings, including in the community; the crisis care continuum; hospitals and emergency departments; jails and prisons; and treatment and recovery agencies.

For over two decades, DMH has championed the role of individuals with lived expertise in Illinois' behavioral health workforce. In recent years, we have increased our efforts and investment by focusing on a three-pronged approach: (1) expanding training opportunities; (2) centering the role of trained persons with lived expertise in the programs we fund; and (3) providing technical assistance to both employers and employees.

Training

We are especially excited about the new DMH CRSS Success program that is already showing significant positive outcomes. This program supports individuals with lived

expertise in recovery from mental health or substance use challenges to successfully complete all requirements necessary to obtain either the Certified Recovery Support Specialist (CRSS) or Certified Peer Recovery Specialist (CPRS) credential and enter the behavioral health workforce. Not only does the program cover the costs of tuition and pay stipends for students completing unpaid internships, it also advances workforce equity by providing supports to remove barriers that are known to prevent students from pursuing careers in behavioral health, such as childcare, transportation, and legal support to address barriers related to criminal history or citizenship status. DMH has invested over $11 million in grant funding to colleges, universities, and technical schools to administer the program. To date, 760 students have been enrolled, and we anticipate over 800 students will be enrolled by the end of the FY22-FY24 grant cycle. The program is being comprehensively evaluated by the University of Illinois at Chicago.

Employment opportunities

In addition to training, DMH has invested in the development of employment opportunities for those who desire to enter the peer recovery support workforce.

For example, one of the exciting new additions to the system of care are Living Room programs. Rather than going to an emergency department, where the environment itself can contribute to making a crisis worse, Living Room programs provide a safe, welcoming, home-like atmosphere for individuals experiencing crisis. Living Room programs are staffed by peer recovery support specialists who support guests – the preferred terminology in Living Room programs – to learn and apply wellness strategies that aid in de-escalating the current crisis and preventing future ones. DMH has invested over $25 million in grants to 21 providers to develop and expand access to Living Room programs across the State.

Additionally, DMH has included a significant role for peer recovery support specialists as part of Mobile Crisis Response Teams that provide in-person, on-location support for individuals in crisis. DMH has invested over $68 million to expand access to this key component of the crisis continuum for anyone in Illinois need of this level of crisis support.

Technical assistance

Last but not least, DMH recognizes the need for technical assistance and support for behavioral health providers that are seeking to expand the unique role of peer recovery support specialists. Like the Peer Recovery Toolkit published by the City of Philadelphia, DMH developed the CRSS Provider Workbook, designed to assist providers in laying the appropriate groundwork for successfully employing individuals with lived expertise. It is published on the DMH website at https://www.dhs.state.il.us/page.aspx?item=106207.

Additionally, the Behavioral Health Workforce Center, funded by DMH and led by Southern Illinois University and the University of Illinois Chicago, is also developing

technical assistance tools for providers that employ peer recovery support specialists, including a job board and asynchronous learning opportunities.

Looking ahead to the future, DMH intends to continue to invest in the expansion of peer recovery support services. This expansion includes the development of a career ladder with varying levels of peer providers with different credential requirements, specialty areas, and diversity of experience, such as youth and young adults; family members; criminal legal system reentry; housing; employment; and others. We recognize the need for adequate and appropriate supervision of peer professionals by peer professionals and look to develop training to meet this specific need. We also look forward to collaborating with local, state, and federal partners to identify strategies for promoting living wages for the certified peer workforce and more clearly defining peer professionals' scope of practice based on national practice guidelines and core competencies for peer providers.

Summary

Many thousands of people have experienced the potency of peer recovery support. It has been shown to help empower individuals to make the best decisions for themselves and to strive toward achieving their own self-directed goals. The Department of Human Services and the Division of Mental Health support the broad implementation of peer recovery support services as a sustainable, cohesive, and replicable component of mental health and substance use treatment and recovery services and as a significant strategy to addressing the behavioral health workforce shortage.

January 23, 2024

Representative Lindsey LaPointe, MSW
Chair, House Mental Health and Addictions Committee
275-S Stratton Office Building
Springfield, IL 62706

Senator Laura Fine
Chair, Senate Behavioral and Mental Health Committee
121 A Capitol Building
Springfield, IL 62706

Written Testimony Re: Illinois Behavioral Health Workforce Shortage

Dear Chair LaPointe, Chair Fine, Vice Chair Simmons, Vice Chair West, Minority Spokesperson Haas, Minority Spokesperson Bryant, Members of the House and Senate Behavioral and Mental Health Committees:

Thank you for holding this important discussion of issues surrounding the state's behavioral health workforce shortage and for the opportunity to submit written testimony on behalf of NAMI Illinois, which is the statewide organization of the National Alliance on Mental Illness, the nation's largest grassroots network working on behalf of people and families impacted by mental health concerns. Through a network of 19 local affiliates whose NAMI signature programming reaches roughly 40,000 Illinoisans each year. NAMI Illinois takes a holistic lifecycle approach to career pathways which invite and support all communities into the sector and sustaining investment in people and the behavioral health systems.

Illinois, like most of the country, is experiencing a deep and growing shortage of behavioral health professionals, further exacerbating mental health and substance use treatment systems unable to fully meet the needs of communities across the state. More than 9.8 million Illinoisans live in a designated mental health shortage area and the state's current workforce can only meet 22% of the need, though not all communities experience this shortage equally and care can be difficult or impossible to access regardless of geography.

Over the last 40 years, NAMI has prepared people with lived mental health experience to deliver evidence based mental health education, support and advocacy programs. Many NAMI facilitators go on to join the behavioral health workforce. Through NAMI's statewide network of 19 affiliates, we hear every day the real-world impact of the lack of available mental health care and lack of access to mental health support and services. To address the large and growing need for mental health support across the state, we need to not only fill today's gaps in the workforce, but also create a broad front door into the field and clear pathways to advance, creating a career trajectory that supports individuals to attain and maintain professional credentials.

Start early - growing and diversifying our behavioral health workforce begins before degree seeking programs. Workforce diversity, expansion across talent pools, and fiscal and human capacity-building are not abstract, future issues – these are strategic needs that are addressed by design, and which are inextricably linked to the immediate concerns we obviously must address. Building a diverse, talented workforce requires early career exposure and skill development. Programs in the state, including those under development by NAMI IL, develop mentoring relationships between middle and high school students and mental health professionals, building early interest in the profession while growing mental health awareness among our state's youth. Developing connections and supports, like scholarships, between these programs and credential and degree seeking programs will reduce barriers to workforce entry. Policymakers and the Behavioral Health Workforce Center should support and integrate these types of programs into the larger development of workforce development strategies.

The gaps in both diversity and scale of the MH workforce are well documented. As we all know, in times of shortage and crisis, inequities can grow, unless we do something about it. People who perceive more discrimination directed at themselves or other members of their racial or ethnic group are at greater risk for negative mental health outcomes and are more likely to underutilize MH/SUD care. Nationally, only 1 in 3 Black adults who need care receive it. In a field defined by trust and relatability, Latinx and other immigrant-rich communities consistently report severe shortages of bilingual practitioners. People who identify as LGBTQ are twice as likely to experience mental health challenges as those who do not identify as LGBTQ. In 2021, the nation's three leading pediatric organizations to declare a state of emergency on children's mental health. In rural Illinois, finding any support is a challenge - 93.7% of rural hospitals are in designated mental health shortage zones.

With quickly growing community health worker and certified peer professional workforces, the state has an opportunity to connect these passionate, talented professionals to a workforce pipeline into clinical positions. Providers of violence intervention, youth mentors, other community health workers, and peer support professionals should be integral to discussions about behavioral health career pathways.

Recommendations

Immediate opportunities exist to enhance mental health support in Illinois while concurrently expanding and diversifying the behavioral health career pipeline. Areas of focus include:

1. **Establish a Behavioral Health Equity Scholarship** to increase access to higher education and advanced training for individuals who commit to work in underserved communities. HB2838, currently under consideration in the Illinois General Assembly, creates a scholarship that can foster interest in various behavioral health professions by breaking down financial barriers to these professions.
2. **Fully implement recently passed legislation to fast-tracking the collection and release of data identifying diversity gaps, expose equity challenges, and increase access.** Gaps in data about demographics, vacancies, wages, and available training/education programs contributes to fragmented strategies and leaves resources on the table, such as workforce funds that are contingent on a shortages being declared for key positions. First steps include:
    a. Release existing IDFPR data on demographics and credentials of the current workforce.

b. Inventory peer/community training and education programs in all state agencies.
c. Require IDFPR to conduct biennial surveys to identify critical workforce needs and gaps in key behavioral health positions, similar to other health professions like nursing.

3. **Scale-Up Existing Models to Establish New Points of Entry and Expand the Career Pipeline.** While expansion of peer training programs such as the CRSS Success Initiative is a positive first step, the talent base that feeds this pipeline can be expanded by investing in high-potential models such as:
    a. Expand Community Health Worker programs specialized in Behavioral Health. CHWs are a growing field with a robust support network. Replicable pilot projects have already demonstrated the viability and interest in training CHWs to specifically focus on mental health.
    b. Invest in Peer Support Workers Involved in Violence Prevention. Efforts to reduce violence have created a strong talent pool that has direct experience handling crises and trauma, and is backed by rapidly improving models for training, mentoring, and professional growth.
    c. Build Capacity to Place and Advance Peer/Community Talent in the Existing Workforce. As the CRSS Success program prepares more people for careers, next step support is needed for mentoring, job placement, on-the-job training, and professional advancement.

Thank you for your leadership which is advancing the conversation on addressing our behavioral health workforce shortage and for the opportunity to provide comment on this important topic. I look forward to working closely with you to realize our collective vision of a strong, diverse workforce that meets the needs of everyone in the state.

Warm Regards,

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February 12, 2024

Public Equity
2019 W. 63rd Street
Chicago, IL 60636

Greetings, everyone; my name is Tony Woods. I am the founder and Executive Director of Public Equity, a Public Health organization focusing on Violence Prevention and Community Violence Intervention (CVI) in Greater Englewood and Auburn-Gresham.

Chicago saw a surge in violence following the COVID-19 pandemic. In 2020, we saw close to 800 homicides; in 2021, we exceeded 800 homicides. In the last two years, the homicide levels lowered but are still not close to the pre-COVID levels. Being on the front lines of community violence work forced me to see the desperate need for more Behavioral Health Professionals who have shared experiences and understand the culture of communities like Englewood and Auburn-Gresham. The degrees of trauma these communities are contending with are astounding.

I, too, have had my share of indirect trauma, also known as "compassion fatigue." Though I am not a Licensed Behavioral Health Professional, our Participants trust me enough to confide in me. My shared experience of growing up in the nearby community of Auburn-Gresham, being street-involved as a youth, and losing four childhood friends to gun violence by the age of 14 gave me an unspoken "pass."

Being involved in day-to-day CVI work requires me to interact personally with our high-risk Participants. My organization feels the effects of the BH shortage daily because of our growing list of Participants needing more specialized help.

The shortage in the BH workforce compelled me to enroll in Northeastern University and pursue a bachelor's degree in social work. After completing my undergraduate degree, I plan to enroll in a graduate-level social work program. I do not have the credentials to offer "professional counseling, yet I've sat with grief-stricken families and individuals, mourning the loss of loved ones to gun violence and those traumatized by being witnesses to the act. I'll never forget one particular conversation I had with a father who felt helpless after his five-year-old daughter watched someone murdered right in front of their living room window. These experiences are not uncommon, so many countless others working in violence prevention sit with folks every day and act as counselors, creating a safe space for the least-trusting individuals to open their lives to them.

I knew I had to do my part in helping to expand the BH workforce – and that came at a substantial financial cost. If I can be candid, earning a Social Work or Human Services degree is more of a sacrifice

than an investment. The earning potential does not come close to making up for student loans taken out or the amount of tuition paid from personal savings.

I am fortunate enough to make the sacrifice; many Street Outreach Workers, Case Managers, or Victims' Advocates don't have the privilege to make that financial sacrifice. The average salary range for non-supervising Violence Prevention Professionals lies between $36,000 and – 48,000.

Another challenge Violence Prevention Specialists face is their short career span. The LTO (License to Operate) of VP Professionals phases out as they age. To be an effective VP Professional, one must have influence among high-risk youth. Forty-something-year-old VP professionals don't carry as much weight with high-risk groups between 16 and 24 years old as someone closer to that age does. The 40-something-year-old VP Professional is far removed from the new crop of young people. Each year, new groups of adolescents, teenagers, and young adults emerge in communities, which furthers the gap among older VP Professionals.

As a VPS Provider, we're constantly thinking about how to transition our VP Professionals into more sustainable careers"? I believe one solution is to pragmatically streamline VP Professional into the BH workforce.

Community-based organizations doing violence prevention and CVI work need funding to send staff to school to earn degrees that will lead to professional careers in behavioral health, thus helping reduce the workforce shortage. We know existing initiatives are allocating funding for graduate-level studies, but we must be more intentional about transitioning Violence Prevention Professionals into the BH workforce. Most VP professionals have not earned beyond a high school diploma or GED. Support for sending VP professionals must begin at the bachelor's level. In our organization, 8% of direct-service staff have associate degrees (2 case managers), and 92% have only a high school diploma or GED. (Violence Prevention Workers and Victims' Advocates).

Along with considering how to allocate funding for Street Outreach to enter the behavioral health workforce at the undergraduate level, we also need to consider removing other barriers to entering the BH workforce. The backgrounds of most VP Professionals may prevent them from being licensed after completing graduate studies. The State of Illinois enforces restrictions for individuals who have forcible felony convictions. Much of the violence prevention workforce has a forcible felony conviction. CVI work can only exist or produce outcomes with a workforce of former-street-involved people. Forcible felony convictions include:

• First Degree Murder • Robbery, Armed Robbery, & Aggravated Robbery • Second Degree Murder • Vehicular Hijacking & • Intentional Homicide of an Unborn Child Aggravated Vehicular Hijacking • Home Invasion • Voluntary Manslaughter of an Unborn Child • Drug-induced Homicide • Kidnapping & Aggravated Kidnapping • Unlawful Restraint & • Forcible Detention Aggravated Unlawful Restraint • Involuntary Servitude • Trafficking in Persons • Aggravated Battery • Compelling Organization Membership • Compelling Confession or Information by Force or of Persons Threat • Causing a Catastrophe • Possession of a Deadly Substance • Making a Terrorist Threat & • Material Support for Terrorism Falsely Making a Terrorist Threat • Hindering Prosecution of Terrorism • Boarding or Attempting to Board an • Armed Violence Aircraft with Weapon • Attempt of any of the above offenses

An applicant with a forcible felony conviction seeking licensure must undergo an additional review under the law. So even after applicants have met all the education requirements for obtaining a license, there is still a strong chance that their license will be denied. Bringing up a past conviction as a factor in determining someone's advancement in life can be re-traumatizing to a person who has already spent years trying to redeem themselves from a society that has stigmatized them. It reinforces the notion to society that their lives aren't redeemable, even though they're risking lives every day to prove that they are redeemable and have changed.

Furthermore, applicants with a forcible felony conviction that qualifies for review are given a document entitled "Notice of Intent to Permanently Deny Licensure." This document is the first step in the forcible felony review process. Receiving such a document is highly discouraging and emphasizes their past mistakes. If I may, I would like to ask everyone in this room this question. "Are these individuals not deserving of proper redemption and tangible opportunities that will further them along the path of being productive members of society like everyone here today"?

In this restorative process, we talk about reducing recidivism, but are we genuinely allowing our returning citizens to be productive citizens? Or do they have to continue to bear the proverbial scarlet letter, i.e., a forcible felony conviction that will prohibit them from earning a respectable living?

The most vulnerable communities where BH Professionals are needed are also where CVI Professionals are already working. These communities urgently need more healers. Their shared experiences allow them to connect with vulnerable communities in a profoundly empathic way. Their unique perspective has the power to add relevant responses to the rapidly changing societal challenges we're experiencing throughout Chicago and surrounding areas. Opportunities must be created for VP Professionals to earn undergraduate degrees and eventually advance to becoming licensed BH Professionals.

In service,

Tony Woods

Tony Woods
Executive Director
tony@equityiskey.org

Testimony Request for Workforce Shortage Solutions Hearing February 23, 2024
Ashley DeGarmo, MA, LSW

My name is Ashley DeGarmo, and I am a lifelong Illinois resident, University of Illinois alumni, licensed social worker, behavioral health care payment expert, and, most importantly, consumer of mental health care services in the state; I am deeply passionate about this difficult issue the committee is tackling in today's hearing.

Our country, and the state of Illinois, has a severe behavioral health workforce shortage. 91 of our state's 102 counties had fewer than 13 licensed professionals per 60,000 residents. There is no singular approach that will address this crisis. However, professional behavioral health careers require talent, training, and commitment in the same way we admire, respect, and ultimately compensate physical health professionals. We cannot afford to even begin to expect to solve this crisis without increasing pay for these highly skilled health care workers, and therefore, it is critical that we address the way behavioral health services are paid for in Illinois.

Currently, the most common reimbursement model for providers of behavioral health services is based on incentivizing volume – or the number of clients served- through a fee-for-service model. These public and private fee-for-service reimbursement rates for behavioral health services are often lower than comparable physical health care rates, and our behavioral health professionals' salaries become a product of the associated inadequate billings they are able to generate. While there have recently been rate increases in our Medicaid program, a fundamental shift in how we pay for behavioral health services is needed since fee-for-service is at the heart of this crisis. Whether someone is suffering from a mental health condition or substance use disorder – these are most often chronic conditions, much in the same way diabetes, heart disease, and asthma are viewed and treated in communities. Of course, we stabilize the crises when they happen for conditions, but we manage treatments and services over time. Our behavioral health services needed to be organized and structured accordingly, not dominated by crisis services or 3-day, 7-day, or even 30-day acute care episodes like today.

Illinois must promote new payment models that drive increased access to care and better outcomes over time for these chronic conditions. Physical health is already fairly far down the road on this journey in primary care and hospital medicine. Unfortunately, we haven't even started the transition in behavioral health while we continue to find ways to plug the holes on a sinking ship. Alternative payment models are becoming more prevalent in behavioral health, as evidenced by the promotion of certified community behavioral health clinics, addiction recovery medical homes, and, most recently, a new CMS value-based care model to drive integrated behavioral health services.

Among other benefits, shifting to a value-based care model can offer providers more predictable payments, which helps ensure patient-centered care where not every person receives the same exact services. The care can flex according to the diverse needs of the individual. This kind of approach can support workforce recruitment and retention. For instance, moving from fee-for-service to a bundled or capitated payment arrangement can reduce

administrative burden by removing cumbersome prior authorization and utilization management processes since the payers and providers become more aligned. This decrease in administrative responsibilities allows clinicians to work at the top of their license and can reduce associated burnout by allowing them to focus on clinical and relational work. Some value-based arrangements allow providers to share in savings or earn incentives for achieving quality measures. These funds can be used to reinvest in increased wages and fringe benefits to support employees' well-being, professional development training, and certifications in evidence-based practices.

Thank you for your solicitations of innovative solutions. I stand ready to support you to drive behavioral health payment reform in order to increase wages that can help drive more dedicated and talented individuals into the behavioral health workforce.

Resources:

- How Can Payers Support Providers Through Workforce Challenges?
- Exploring Value-Based Payment for Substance Use Disorder Services in the United States
- Value-Based Care Can Transform The Treatment Of Patients With Substance Use Disorder
- CCBHC Designation Leads to Massive Patient, Workforce Gains for Many Programs
- An Outcomes-Focused Approach to Mental Health Care

UNIVERSITY OF ILLINOIS CHICAGO

Jane Addams College of Social Work

Joint Hearing of
Illinois Senate Behavioral and Mental Health Committee and
Illinois House Mental Health & Addiction Committee

Michael A. Blandic Building – 160 N. Lasalle St. - Chicago, IL
Friday, February 23, 2024

Subject Matter: Behavioral Health Workforce Shortage

The Need to Increase African American Males in the Behavioral Health Workforce

On behalf of the University of Illinois Chicago (UIC), Jane Addams College of Social Work's We Are Men (WAM) program, I would like to thank Chairperson, Lindsey Lapointe, Laura Fine, Minority Leader Jackie Haas and members of both committees for the opportunity to provide written testimony on an important solution to demonstrating improved outcomes and improving access to behavioral health care and for many African Americans.

The solution is the We Are Men (WAM) program at UIC Jane Addams College of Social Work. The WAM program began in 2020 and echoes the rallying cry ["I AM A Man"] of African American sanitation workers in 1968. The WAM program recruits African American males with demonstrated concerns about social and racial justice and the needs of impoverished communities. Many of the current and past WAM scholars are from these same communities.

We Are Men Program

The WAM program is within the college's Master of Social Work program and provides financial assistance, academic counseling, professional and personal coaching and mentorship, professional networking, and other supports. The WAM Program supports students who want to work in diverse areas, i.e. as school social workers, in the child welfare system, with justice involved populations, on community development and healthy community teams, etc. as well as in traditional mental health settings. However, **this year, enrollment in the program was halted and needs funds to continue.**

WAM addresses the low and declining number of African American males enrolled in Jane Addams College of Social Work programs and the low numbers in social work programs nationally despite the high need for men with social work expertise. The need is especially dire in poor urban communities where many social workers prefer not to work, are afraid to go, or do not have an informed understanding of the culture, needs or effective community engagement approaches.

Since the inception of the program, **the graduation rate has been 98%.** 17 WAM Scholars have received their MSW degree and four of the WAM graduates are currently social work PHD candidates while 10 of the remaining 13 graduates are working in community behavioral healthcare or child welfare organizations in Illinois. Currently, there are 14 WAM scholars in the MSW program and 10 have chosen mental health as their academic focus.

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Increasing Access to Care for African American Families

The lack of African American or Black males in the community behavioral health workforce limits access to care for many African Americans.

Access to behavioral health care is not just restricted to transportation barriers or the lack of facilities or stigma and bias or insufficient insurance coverage. In the case of African Americans, not being able to see people who look like them and have had similar life experiences becomes a huge barrier to access to care. Several research studies have shown that because of the historical distrust of the healthcare system, many African Americans prefer to see only African Americans providers and, in some cases, only an African American male. This is true in predominantly Black communities where a young male may need services and the father, or a male adult may not be in the life of the youth and the mother would prefer the youth to receive care from an African American male. This is by far not the only situation where a Black male behavioral health worker is requested.

Increasing Diversity

Currently, the community behavioral health workforce in Illinois comprises of between 83 -85% female, predominantly white. It is estimated that the number of Black male community behavioral health workers is between 3-5%. The community behavioral health workforce consists of psychiatrists, psychiatric nurses, psychologists, therapists/social workers, counselors, case managers, and peer workers. Most Black males working in behavioral health are employed in positions that don't require an advance degree. Many times, they languish in low paying jobs without any hopes of advancement and many of them eventually leave the field.

Lack of a coordinated effort to increase recruitment and retention because salaries and reimbursements are so much lower, some African American men are avoiding behavioral health professions altogether. Additionally, since many students graduate with significant student loan debt, many may be pursuing better reimbursed clinical specialties, so they can begin to pay off this debt.

In our research at UIC, we uncovered a significant number of African American males with bachelor's degrees working in community organizations who dedicated years of service to the field of behavioral health and human services. These men had dreams of obtaining their master's degrees so they could advance in their careers. We also found out in our research that the number one reason Black men had not pursue an advance social work degree was they couldn't afford it financially.

Improved Outcomes and Saving Taxpayer Dollars

The WAM program afforded these men the opportunity to not only fulfil lifelong dreams of obtaining their master's degree and create a pipeline of black men working in behavioral health and other disciplines, but these men have begun to impact the lives of African American families across Illinois and beyond.

According to two CEOs of behavioral health organizations, the benefits of having WAM Scholars as behavioral health staff in their organizations on the south and westsides of Chicago goes beyond just having a black person on staff. They are helping to achieve better outcomes in several metrics. For example, in one organization that receives referrals from the Circuit Court of Cook County, Cook County States Attorney and Illinois Department of Correction parole division, the recidivism rate of clients working with African American male clinicians is dramatically lower than the state average of 17% within one year and 38.5% within three years. This amounts to millions of dollars saved by the state.

Other metrics that have showed marked improvement in programs with African American males are improved school attendance, improved family attachments, maintaining secure housing and increased employment.

Recently, one of the organizations that a WAM graduate is employed sent me a letter describing his appreciation for the work that he is doing in the community. Here are parts of the letter:
"I am writing to you on behalf of Michael Doss [WAM Graduate]. He is a model employee and … during his time (3 years) at our organization, he has radically impacted the lives of over 1200 individuals and counting. He has placed 400 individuals into secure positions of employment, while facilitating workforce preparation courses and life skills for all that walk through the doors. To say that Michael has been a life-changer would be an understatement."

In another communication from the CEO of behavioral health organization on the westside of Chicago, he states that the benefits of having WAM scholars as behavior health staff and interns in their community behavioral Health organizations goes beyond just having a black staff person. According to the CEO, "*there has been a significant increase in client engagement, retention and a reduction in recidivism is most evident. Increased opportunities for a profound demonstration of cultural competency, commitment and genuine concern for community empowerment and uplift are also manifested as a result of this program [WAM] thrust.*"

Support Needed to Strengthen and Expand the We Are Men Program

In its four- and one-half years of existence, the We Are Men program is definitely demonstrating its valuable to increasing the number of African American males in behavioral health workforce, creating options for clients, showing the importance of operating from a cultural lens, improving access to care for many African Americans and is helping to de-stigmatize the behavioral health workforce as being a "woman only" field. Besides those positive outcomes, the program is also producing men who are having a positive impact in the community.

We request that the Illinois Senate Behavioral and Mental Health Committee and Illinois House Mental Health & Addiction Committee support funding of $2 million over 3 years to maintain the We Are Men program. In supporting this proven behavioral health workforce strategy, the state of Illinois and the people who have lacked access to services will greatly benefit from your actions.

Written Testimony-Illinois House Hearing 2/23/2024:
Potential Solutions to the Mental Health Workforce Shortage

Drafted by Patti Kimbel, Psy.D., Chair of the Student Financial Concerns Committee, Director of Training and Clinical Associate Professor, Roosevelt University and Anmol Satiani, Ph.D., Past President of ACEPT and Past Chair of the Student Financial Concerns Committee, currently the Training Director, Center Focused Therapy

Background of ACEPT Student Financial Concerns Committee:

The Association of Chicagoland Externship and Practicum Training (ACEPT) is a non-profit organization formed in 2003 to advance the quality of graduate level psychology training through increased communication, collaboration, partnerships and sharing of best practices between academic programs, training sites, and students and to create new practicum and clinical/counseling psychology predoctoral training opportunities in the Chicagoland area, especially those that serve minoritized or marginalized populations. ACEPT's focus is on doctoral programs, training sites, and doctoral students in Clinical or Counseling Psychology in the Chicagoland area.

The ACEPT Student Financial Concerns Committee was formed in 2020 due to the increasing financial distress and needs being expressed by students. The committee began surveying students from ACEPT sites in the Chicagoland area about their financial, medical, housing, food and other insecurities beginning in 2020 and found that students reported significant financial insecurities as well as a lack of resources from their academic programs and clinical training sites. Despite the end of lockdown and reduced impact of the COVID-19 pandemic, continued annual surveys demonstrate ongoing significant financial hardship and ongoing healthcare, housing and food insecurities. The committee has been raising awareness about the financial hardships and insecurities that graduate students in clinical and counseling psychology are facing, by sharing data at annual ACEPT conferences, speaking at ACEPT meetings, and discussing the topic with members of the Illinois Psychological Association (IPA). The committee has fostered discussions with Practicum Site Directors to increase awareness and opportunities for support. The committee began providing direct support to students by providing financial grants of $500 (3x annually), which drew more than 200 applicants in its inaugural year (2023) despite limited publicizing of the grant.

Summary of Psychology Doctoral Training and Student Financial Impact

Doctoral training in Clinical or Counseling Psychology programs in the United States generally requires four years of coursework and concurrently three years of clinical practicum training at multiple practice sites. This practicum training typically requires 20 hours of clinical work a week for 9-12 months and is usually unpaid. Many doctoral students maintain part-time employment to help support themselves on top of carrying a full-time course load and practicum training work. Some students look for income by conducting research, teaching, and/or functioning as a graduate assistant. Typically, in the 5th or 6th year of study, students complete a full-time

doctoral internship that is paid (average $35,000; APPIC, 2023). The rapidly increasing tuition costs for PsyD programs is causing increasing hardships for many students, with average tuition costs for a five-year PsyD program averages $132,000 (EducationData.org). The average debt load for predoctoral interns is $86,000 (APPIC, 2023). While some Ph.D. programs provide stipends for students, the majority of Psy.D. programs do not, with only a handful of Graduate Assistantships offered to a few select students. Following the internship year, students in Illinois must complete a Post-Doctoral Fellowship in order to accrue clinical hours for licensure in Illinois. Postdoctoral Fellows are at risk of being unemployed until being licensed or must remain in a low-wage Fellowship until they are able to be fully licensed, which can take months. Per the report of recent Post-Doctoral Fellows, it has been taking about 6 months after passing the licensing exam.

Concern:

Currently in Illinois Post-Doctoral Fellows are not permitted to take the Examination for Professional Practice in Psychology (EPPP) until they have accrued the necessary Postdoctoral hours which usually takes 1 to 1.5 years. Many Fellows take the EPPP in other states that allow students to sit for the examination immediately upon graduation. Given the chronic shortage of behavioral health professionals in underserved communities, this unnecessary delay only exacerbates the treatment availability crisis in Illinois, and further prolongs the period during which Post-Doctoral Fellows must survive without an income. ACEPT has just completed a survey in which there were overwhelming reports of Illinois Postdoctoral Fellows resorting to employment in other states because of this stricture.

Excerpt from the ACEPT Survey of Psychologists and Postdoctoral Fellows pending licensure (2024):

> "I believe now more than ever the public needs to have access to more resources. For example, I have the opportunity to open a clinic in an underserved area and provide training to first responders in a large town. These projects are on hold until I pass this exam. I am sure there are others like me out there who are not able to offer their talents to the community due to the difficulty in obtaining licensure".

Proposal:

The ACEPT Student Financial Concerns Committee (with support of the Illinois Psychological Association) is proposing that the Illinois Department of Professional Regulation change the current requirement that the EPPP-Part 1 can only be taken after completing the postdoctoral hours/year requirement. **Our recommendation is that the EPPP – Part 1 be permitted to be taken upon graduation.** The Illinois requirement of completing one year of supervised postdoctoral work would remain intact but Postdoctoral Fellows could be immediately licensed after completion of those hours. This change would allow graduates of programs in Clinical and Counseling Psychology to take the EPPP upon graduation and reduces the time it takes to become licensed, allowing them to practice more quickly. Besides the obvious public policy benefits of keeping Illinois-trained practitioners who want to practice in Illinois, this will provide a secondary benefit of additional revenue for Illinois by retaining those lost licensing fees. The state of Illinois is losing thousands of dollars every year in the licensing process due to applicants taking the exam in other states.

ACEPT
Association of Chicagoland
Externship and Practicum Training

The Association of State and Provincial Psychology Boards (ASPPB) will be implementing both an EPPP (Part 1-Knowledge) AND an EPPP (Part 2-Skills) nationwide in January 2026. Given that the EPPP Part 2 will need to be implemented in 2026, implementing our proposed change to the EPPP Part 1 examination would be well-timed.

Our proposal is well within the mainstream of the Association of State and Provincial Psychology (ASPPB) recommendations, which advise "that the timing of the EPPP (Part 1 Knowledge) be shifted to the point of knowledge acquisition: when all foundational coursework is completed and prior to or during internship. This has some advantages in that pass rates tend to be higher at this point in training, and this eliminates delays at the culminating point of licensure" (ASPPB Frequently Asked Questions).

EPPP State Comparison Data:

Number of States that allow EPPP to be taken upon graduation: 26
Number of States that allow EPPP to be taken during postdoctoral year: 10
Number of States that allow EPPP to be taken after postdoctoral year: 11
Unknown States policy: 3

By implementing this change, Illinois will be more closely aligned with the practice of 36 other states to allow the EPPP Part 1 to be taken upon graduation or during the postdoctoral year.

We appreciate your consideration of our proposed change for the EPPP Exam in Illinois. The Illinois Psychological Association also fully supports this change. We would welcome the opportunity to provide in person testimony on February 23, 2024 and for any additional future consultation or collaboration. This change would have a significant impact not only for those seeking licensure as a psychologist in Illinois but for the many individuals in need that could be more quickly served by this change.

Additional Testimonials:

"I felt very disappointed in my licensure journey in Illinois. I chose to take the EPPP in Michigan in order to speed the process, which did reduce my unlicensed time by I'd say at least 3 months (likely more given the abysmal turn around times through IDPFR). Michigan's system was much more user friendly and prompt than Illinois. Even with my decision to go through Michigan, I calculated that I missed out of at least $6000 of income while waiting for my license to be approved. There was no transparency about the process through IDPFR. This lost income is significant to anyone, but especially to the professionals who are already financially disadvantaged by a training process that requires students to work for free for years, pay high tuition, take out immense loans and pay for expensive testing materials. I would have been out of medical debt as soon as next month had licensure turn-around times been faster".

"I was licensed in Illinois but moved out of state and am now licensed in Michigan. Taking the EPPP in Illinois was made more difficult because I had to wait for my postdoc to complete - I would have preferred to take it sooner and it would have given me more job opportunities in Illinois".

"I know many psychologists who have taken the EPPP in another state for this very reason. It would make sense to offer the test earlier and would not have any negative clinical outcome".

ACEPT
Association of Chicagoland
Externship and Practicum Training

Appendix A

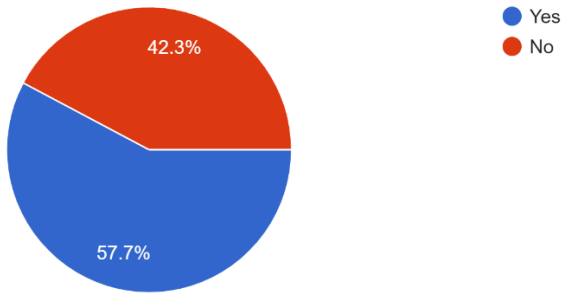
ACEPT-Illinois Licensure (EPPP) Process Survey, February 2024

Distributed to Alumni of the ACEPT Academic Member Programs (172 Responses of both Licensed Clinical Psychologists and Postdoctoral Fellows Pending Licensure)

Question of currently Licensed Clinical Psychologists:

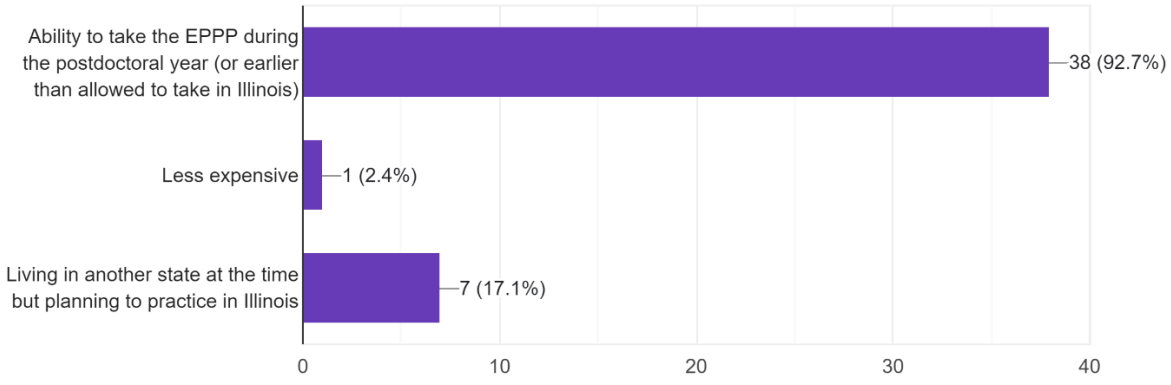
2.1) Did you take the EPPP in another state in order to take it during your postdoctoral year or prior to when you would be eligible to take it in Illinois?

71 responses

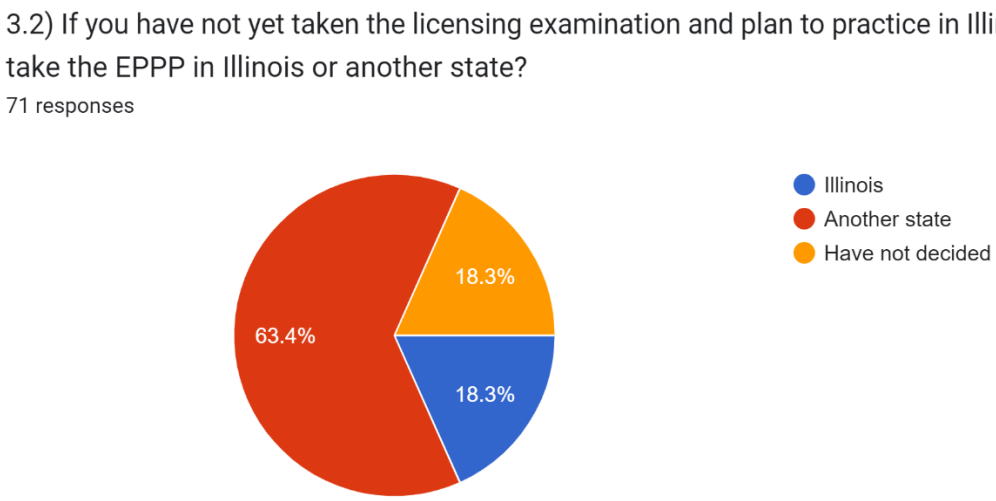


2.3) Why did you decide to take the EPPP in another state when seeking licensure in Illinois?

41 responses



Postdoctoral Fellows who are not yet licensed:



Testimonials shared regarding the process to become licensed in the state of Illinois:

I completed the EPPP in another state during my postdoctoral year. This allowed for a smooth transition and minimized financial hardship to my family. Had I been forced to wait in a state such as Illinois, I would have lost my job. This was a factor in leaving Illinois and seeking licensure/employment in a different state.

It was much easier to speak to a representative in the state of Kentucky, who was so helpful with the process vs. Illinois. Illinois being a state that has so much need, especially in Chicago, should be in full support of getting clinical psychology candidates ready and licensed to be able to practice and help relieve the mental health needs in our city and state.

I wish the fees that I paid to Kansas in order to get licensed had been able to stay in the state I live and practice

Thank you for letting me be a part of this conversation. I am so encouraged that this is a topic being discussed and seriously considered. I do hope the state does more to help people pass this exam because the public needs it and so do the doctors that are trying to pay off loans. I think that could be accomplished partly by letting people take this during graduate school. I wish you all the best!

Many other professions are licensing clinical therapists with far less training and they are able to do and bill for what clinical psychologists are trained to do. Without licensure we are unable to bill for and provide services for patients, which in turn limits opportunities for postdoctoral positions. This ends up

limiting our profession at many levels, while allowing space for masters-level therapists to swoop in and take jobs that are more appropriate for psychologists.

I would take the EPPP in IL if allowed to take it during postdoc year

The Illinois postdoc requirements to take the EPPP are restrictive and a barrier for new clinicians to enter the field. It is also a barrier for practices, hospitals, etc. to retain and provide licensed practitioners to patients when there is a severe shortage. Many states (CA, MA, etc.) have higher course requirements and restrictions for licensure, however do not have the post-doc requirement for licensure. To my knowledge, there is no research indicating that requiring post-doc hours be completed before taking the EPPP/pursuing licensure increases clinician performance, fidelity to treatment protocols, treatment success, or patient satisfaction, nor does it increase the frequency or severity of ethical or legal issues compared to clinicians who have not been required to do so. It only appears to serve as a barrier to increased income for new clinicians, often leading to financial stressors and increased burnout, resulting in new clinicians leaving the field in order to make enough money to pay of student loans/debt that was acquired during the many years of training. This then compounds the issue of the shortage of clinicians. This post-doc requirement policy does not have sufficient/substantial (if any) research backing to support it's continuation. It is antiquated, out of date, and detrimental to the field in Illinois.

The process is slow and communication is cumbersome with the state. Meanwhile organizations and patients must wait for care provision.

I am licensed in Arizona and Colorado. Neither required a post doc year. Many states allow the applicant to use predoctoral training hours accrued prior to internship for the hours requirement. I support a similar approach in Illinois.

I completed the EPPP in another state during my postdoctotoral year. This allowed for a smooth transition and minimized financial hardship to my family. Had I been forced to wait in a state such as Illinois, I would have lost my job. This was a factor in leaving Illinois and seeking licensure/employment in a different state.

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Appendix B
EPPP Nationwide Data

State	When is the earlies time EPPP Part 1 can be taken? (Q25 under Jurisdiction Data)	Total Number of Hours of Supervised Experience Required (Q8 in Jurisdiction Data)	Postdoctoral Hours required for licensure (State Snapshot Page)
Alabama	After degree is granted	0	No
Alaska	Board Approved	1500	Yes
Arizona	After degree is granted	3000	No (Accepted)
Arkansas	During Post Doc Year	4000	Yes
California	After degree is granted	3000	Yes
Colorado	After degree is granted	1500	Yes
Connecticut	Upon completion of all supervised experience	1800	Yes
Delaware	Upon completion of all supervised experience	1500	Yes
Florida	After degree is granted, when applying and approved under the Bifurcation/Exam application method.	4000	Yes
Georgia	After degree is granted	1500	Yes
Hawaii	Upon completion of all supervised experience	3800	Yes
Idaho	After degree is granted	2000	Yes
Illinois	Upon completion of all supervised experience	3500	Yes
Indiana	During Post Doc Year	1600	Yes
Iowa	After degree is granted	1500	Yes
Kansas	During Post Doc Year	3600	Yes
Kentucky	After completion of MA degree	3600	No (Accepted)
Louisiana	During Post Doc Year	4000	Yes
Maine			
Maryland	After degree is granted	3250	No (Accepted)
Massachusetts	Upon completion of all supervised experience	3200	No (Accepted)
Michigan	After degree is granted	2000	Yes
Minnesota	After degree is granted	3600	Yes
Mississippi	After degree is granted	1800	No
Missouri	After degree is granted	1500 for post doc, 3500 for pre doc	No (Accepted)

Montana	Upon completion of all supervised experience	3200	Yes
Nebraska	During Post Doc Year	1500 in not less than 1 year	Yes
Nevada	During Grad school or internship/before degree is granted	3750	Yes
New Hampshire	Upon completion of all supervised experience	3000	Yes
New Jersey	Upon completion of all supervised experience	3500	No (Accepted)
New Mexico			
New York	After degree is granted	3500	Yes
North Carolina	After degree is granted	3000	Yes
North Dakota	After degree is granted	3000	Yes
Ohio	After degree is granted	3600	No (Accepted)
Oklahoma	After degree is granted	4000	Yes
Oregon	After degree is granted	1500	Yes
Pennsylvania	After degree is granted	1750	No (Accepted)
Rhode Island			
South Dakota	During Post Doc Year	1800	Yes
South Carolina	During Post Doc Year	3000	Yes
Tennessee	After authorized by the Board to sit for exam	1900	Yes
Texas	After degree is granted	3500	Yes
Utah	Upon completion of all supervised experience	4000	No (Accepted)
Vermont	After degree is granted	4000	Yes
Virginia	After degree is granted	1500	No (Accepted)
Washington	After degree is granted	3300	No (Accepted)
West Virginia	After acceptable MA degree	0 - 192	No
Wisconsin	WI allows exams to be taken at any time	3000	No (Accepted)
Wyoming	After degree is granted	3000	No (Accepted)

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Appendix C

Association of State and Provincial Psychology Boards (ASPPB): Frequently Asked Questions about the EPPP link:

https://cdn.ymaws.com/www.asppb.net/resource/resmgr/eppp_2/faq_revisedeppp_feb2023.pdf

Written Statement for Subject Matter hearing:

This witness statement is being submitted by Cornerstone Services Inc. to highlight the current needs of behavioral health services at not-for-profit service providers like Cornerstone, and to highlight how our BH workforce shortages impact our ability to provide services to those in need.

Cornerstone Services provides an array of behavioral health services to over 700 individuals in Will and Kankakee Counties. The Outpatient Therapy program in the agency's Joliet community mental health center has five master's level therapist positions. Since July 2021 it has seen 11 staff turnovers in these five positions. Three of these staff left Cornerstone for private practice positions where they had already been working part-time to supplement their income. Essentially these staff built up their private practice caseload in order to leave Cornerstone as soon as they obtained their clinical license. Five more left for higher paying therapist positions at other employers, including higher education, the State of Illinois, hospitals, and grant-funded governmental positions. Three of those five staff also had second jobs while working at Cornerstone to supplement their income.

Therapist turnover negatively impacts client care, increases waitlist times, and results in stress and burnout in the staff who remain, including the clinically licensed coordinator. This is an overwhelming number of staff to hire, train, supervise, and then lose--even for a seasoned supervisor. Developing new staff into outstanding clinicians requires a significant amount of personal energy and commitment to onboarding, training, and providing ongoing clinical supervision. At this point, Cornerstone is hiring people just to train them and see them leave for better-paying, less-stressful opportunities. The ongoing turnover has also had a significant impact on our waitlist for therapy services. It was nearly eliminated before the pandemic but has now grown from a three-month wait to ten months. The agency adds approximately ten people to the wait list each month, with a total of 105 individuals currently waiting for therapy.

Cornerstone's behavioral health team in Joliet had recently embarked on training two experienced therapists in trauma therapy, a significant need for many community mental health clients. Unfortunately, the training did not occur because both therapists left for other opportunities where they are making more money while working fewer hours. Turnover occurs in all workplaces, but

a pattern of experienced therapists continuing to leave means we cannot get our team to the point where we can offer advanced treatment for complex problems. This prevents us from supporting the adult serious mentally ill Medicaid population in the best way possible. Additionally, losing independently licensed therapists to private practice has gutted our workforce, including future leaders within the department. Further, independently licensed therapists (LPHAs) are required to be employed by CMHCs to be eligible to bill Medicaid mental health services, but it is also critical to have these staff to provide clinical supervision required to move therapists to clinical license themselves.

The reality is that the cost of living continues to increase, and salary expectations rise. Prior to the pandemic and explosion in private practice groups, new therapists were often obligated to take community mental health positions to gain experience and the supervision required private practice credentials. Now these new graduates can start working in a private practice group right away at a better pay rate. Further, private practices are beginning to offer benefits like clinical supervision, health insurance to full-time (usually 25+ hours a week) and covering continuing education expenses.

This workforce crisis has no end in sight, unfortunately. While Cornerstone is committed to serving individuals with very specific needs, it is imperative that we receive funding to remain competitive with private practice employers.

IARF Testimony to House Mental Health and Senate Behavioral Health Committees on the Ongoing Behavioral Health Workforce Crisis

Tuesday, February 20, 2024

Chairpersons LaPointe and Fine, Vice-Chairs West and Simmons, and all members of the committee, my name is Emily Miller and I am the Vice President of Behavioral Health Policy and Advocacy for the Illinois Association of Rehabilitation Facilities (IARF). We are a statewide association that represents community providers of supports and services for persons with intellectual and developmental disabilities, as well as persons with serious mental illnesses. It is a privilege to submit this testimony on behalf of our member organizations from all across the state, all of whom continue to be severely impacted by the ongoing behavioral health workforce crisis.

In the fall of 2023, IARF applied for and was chosen to participate in a nationwide learning collaborative that focuses directly on the ongoing workforce crisis impacting the behavioral health, and broader human services, sector for a nine-month period. Every month, IARF staff and several member organizations, participate in 90-minute focus group sessions that includes participation from over 30 organizations and entities from across the nation, to learn from one another, share best practices, brainstorm ideas, and work together to progressively chip away at the years-long issue. Through the work of the collaborative, IARF has had the opportunity to hear success stories, both big and small, from other states across the country that could potentially be used here in Illinois as well.

Big Picture Solutions – Continued Increased System Investments/Funding

As much of the focus falls on potential regulatory and policy related changes that the state and individual organizations can make to help alleviate the crisis, the one recurring theme that remains consistent amongst most, if not all, of the states in the program, is the continued need for further budgetary investments in the field, through rate increases and other funding sources. According to representatives of the National Association of State Health Plans (NASHP), North Carolina has recently made a commitment to invest one billion dollars into their behavioral health system to ensure that Medicaid rates match those of Medicare and Idaho has launched a study to create sustainable long-term rates in the state. While funding mechanisms for behavioral health care is inconsistent across the United States, it is the number one theme from states.

Big Picture Solution – Non-Traditional Partnerships

A presentation from Health Management Associates (HMA) during one of the first few meetings of the collaborative highlighted several successful concepts from different areas of the country, including the development of non-traditional partnerships.

- Mecklenburg County, North Carolina: Several provider organizations have developed on-site childcare built directly inside of their facilities for both staff and clients. Individuals do not have to cancel appointments and staff do not have to struggle to find care for their children, resulting in fewer missed appointments and more work productivity. This model has been so successful in the area that there are currently two additional county-funded expansions in the works.
- Rural Minnesota: A behavioral health provider in rural Minnesota has begun offering pet insurance to its employees as part of their benefits package. Statistics show that 33% of millennials own pets, along with 66% of U.S. households. Pet ownership spiked during the pandemic, more than doubling from 2018 to 2021.
- Olmsted County, Minnesota: In Olmsted County, Minnesota, several provider organizations joined together to jointly fund psychiatry services for individuals in the area to establish ACT and Crisis Stabilization services.
- Rural Oregon: An Oregon Health Plan purchased an old hotel building in rural Oregon to develop housing for employees who are hired to provide homelessness services. Lack of quality, affordable housing in the area prohibited the hiring of qualified individuals to provide these needed services.

Big Picture Solution – Optimizing the Current Workforce

As part of their 50-state scan of behavioral health, NASHP highlighted the importance of optimizing the existing workforce and ensuring individuals are working to the "top of their license." This includes ensuring the highest credentialed practitioners are seeing the individuals with the highest needs and ensuring training programs are providing the most appropriate, in-depth, real-world situational training to individuals coming out of institutions of higher education. Individuals are entering the workforce unprepared to immediately begin "doing the job" and require a good deal of additional training and supervision before providing the services in need. An in-depth data project conducted by the Utah Department of Labor focused on the licensed professionals in the state in comparison to the individual needs of the state to assess the actual gaps and determine the requisite number of new professionals needed to make an impact on the crisis. Through that research, they were able to determine that an increase of 40% of the provider pool (8,000 specialists) was needed to address the state's behavioral health needs.

Small Picture Solution – Painting the Full Picture for Providers

While states like Utah were able to focus on larger scale data collection projects to help identify gaps and needs, others have focused on smaller scale projects that aim to provide transparency and paint fuller pictures of the overall state system for providers. A Georgia state agency created a tracking document that is easily accessible for all behavioral health providers that highlights all professional practitioner types, both licensed and unlicensed, graduate and non-graduate, along with all of the services that are able to be provided by each individual practitioner level, each organizational type, and what billing codes can be used and billed for. In Montana, a similar type of document is maintained that highlights behavioral health practitioner levels that don't require graduate education, and includes the

requisites for the credential, what trainings are required, how much the trainings cost, where they are available and what work settings they cover.

Small Picture Solution – Organizational and Bureaucratic Changes

On a smaller scale, but with the potential for more immediate impactful changes that can be made on both an organizational and bureaucratic level, the following are examples of best practices and solutions that have been tested and well-received by individual organizations and through state regulatory and policy actions.

- Hiring bonuses that include initial sign-on bonuses, retention bonuses after specific amounts of time (6 months, one year, five years), and referral bonuses for helping find other qualified individuals who stay on the job for specific amounts of time.
- Increases in paid time off sooner than the traditional three to five years of time.
- Increased employer health insurance premium contributions.
- Increased flexibility for staff through piecework staff and the hiring of floaters who can fill various roles within an organization.
- Production bonuses that are offered more than once a year.
- Flexible hiring practices for retirees – allowing individuals who retire the opportunity to come back to work without losing retirement benefits.
- Offering annual trainings for licensure and paying for the licensure requirements.
- Reducing the traditional work week hours down to 30-35 hours a week with the same benefits package.
- Flexible holidays – allowing employees to swap specific holidays for others; for example, if an individual chooses to work on Christmas Day, they can swap that holiday for a different paid day off.
- Rotation of staff, where feasible; allowing employees to swap between for-profit and not-for-profit work within the organization, if applicable.
- Pooled resources with other organizations for back-office staffing.

While there is no one-size-fits-all solution to the ongoing workforce crisis, through continued investments, shared experiences, non-traditional partnerships and collaborations, further transparency, and allowing organizations to optimize their current workforces through less burdensome requirements and further organizational and bureaucratic changes, we can continue to better serve the individuals in need in our state. IARF appreciates the opportunity to submit this testimony and looks forward to continued partnerships with the General Assembly, state agencies, and all of our partners.

Contact Information:
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inseparable

409 7th St Northwest, Suite 305
Washington, D.C. 20004
February 6, 2024

Joint Committee Hearing
House Mental Health & Addiction Committee and Senate Behavioral Mental Health Committee

Via electronic submission

RE: Bolstering the Illinois Mental Health Workforce

Dear Chair LaPointe and Members of the Committee:

Illinois is simultaneously experiencing escalating rates of mental health conditions and a shortage of mental health care professionals, a challenge mirrored across the country that leaves many individuals unable to find affordable and accessible care. Even where providers do exist, the limited number of mental health professionals available in-network through Medicaid and commercial insurance leaves a significant portion of the population with no choice but to grapple with higher out-of-pocket costs or forgo essential care altogether.

The statistics are alarming: more than two million Illinoisans live with a diagnosed mental health condition, and yet only 23.4% with commercial insurance received specialty care. What's more, among people visiting the ER or hospital for a mental health condition or substance use disorder, only 30.7% receive follow up care within 30 days, putting them at greater risk of relapse or readmission.[1]

While the barriers to accessing mental health care are numerous, Illinois has the opportunity to enact meaningful policy changes that leverage the existing mental health workforce while also strengthening the pipeline of new mental health providers. Chief among these changes are lowering barriers to entering the workforce and addressing low reimbursement rates, administrative red tape, and other health plan practices that discourage providers from joining or staying in plan networks.

Promote competitive reimbursement rates

We are encouraged to see that Illinois is currently considering legislation to address several of these components, such as requiring reimbursement rates that reflect market demand and payment parity with other medical professions, and requiring

[1] Inseparable, "Improving Mental Health Care: The Access Report" (2023).

reimbursement transparency. Reimbursement rates for behavioral health services are a critical component of ensuring an adequate workforce.

Reduce barriers to maximizing the current behavioral health workforce

"Ghost networks" of providers that aren't actually available to health plan participants allow insurers to appear to have more robust networks of providers than they actually have. Strong requirements for provider directory accuracy will incentivize insurers to include more providers on their panels. Illinois should also require insurers to ensure timely credentialing of providers and to reimburse for medically necessary out-of-network mental health and substance use services at competitive rates, as well as disallow practices such as more frequent audits and onerous documentation requirements for these services. These actions will help maximize the available workforce and increase access to care.

Cover a full range of professionals and paraprofessionals

Additional policies to maximize the existing workforce and bring more providers in-network include expanding coverage to include paraprofessionals and behavioral health support specialists, which can help improve other providers' capacity to serve more people, and expanding the delivery of primary care services in community-based programs such as Certified Community Behavioral Health Clinics.

Streamline licensing and credentialing

To alleviate burdens on its mental health providers, Illinois should consider creating flexibilities in its licensing regulations and develop credentialing programs for community health providers. Additionally, streamlining processes, ensuring timely approvals for licensure and credentialing applications, and providing funding for required supervision will collectively expedite and support career pathways into mental health professions. We also encourage Illinois to become a signatory of interstate compacts, such as the counseling compact and social worker licensure compact, a simple step that opens the door to more providers.

Build a behavioral health workforce pipeline

In addition to bolstering the existing workforce, building a pipeline of trained mental health care professionals is essential to meet growing demand. Illinois can achieve this by reducing financial barriers through scholarships and incentives for those pursuing mental health careers, especially in underserved areas, and equipping them with the skills they need through training and development. Offering alternative pathways to licensure, such as apprenticeships and credentialing programs, can help broaden access and diversify the mental health workforce. Additionally, providing paid job shadowing and internship opportunities will help attract more students to the field and help support their financial stability.

From a training and skilling perspective, Illinois should incentivize collaboration between higher education institutions and the state mental health agency to integrate training curricula that ensures that health care professionals are better equipped to serve people with mental health conditions and substance use disorders. The state should also establish a mental health workforce education center or training academy to further facilitate the recruitment and development of well-trained providers.

Support retention of the mental health workforce

Recognizing that mental health and substance use treatment providers face high rates of burnout and turnover, Illinois can play a pivotal role in promoting their mental well-being. Initiatives such as creating mental health hotlines for workers and frontline staff, offering trauma-informed care, and waiving certain costs for mental health services can create a supportive environment.

While Illinois has already enacted many effective policies to help address mental health workforce shortages, we strongly urge the state to consider the aforementioned policies designed to build and retain a robust workforce that is sustainable for decades to come. We know that untreated mental health conditions result in both personal and financial impacts on the individual and their family, as well as economic costs to the state. By expanding the mental health workforce and ensuring more in-network providers, Illinois will be better equipped to meet the needs of Illinoisans with mental health conditions and ultimately help save lives.

We thank you for your leadership on this issue and look forward to seeing Illinois transform mental health care access in the state and make a lasting impact on the wellbeing of its residents.

Respectfully,

Caitlin Hochul
VP of Public Policy
Inseparable

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Behavioral Health Workforce Shortage

Testimony before the Illinois State House Mental Health & Addiction Committee

Metropolitan Family Services (MFS) empowers families to learn, earn, heal, and thrive. As a wrap-around human service provider touching more than 120,000 lives in 2023 alone, MFS seeks to nourish families and help them realize their fullest potential through programs in education, emotional wellness, empowerment, and economic stability. Through our emotional wellness programs, we have empowered more than 28,000 individuals and families in 2023 through counseling and mental health services, parenting and family support, and older adult services. MFS also spearheads the Metropolitan Peace Initiative, which coordinates and sustains cross-agency infrastructure of Chicago's community-based and citywide organizations who deliver a comprehensive set of services to communities at the highest risk for violence, including counseling and mental health services.

Currently, MFS employs more than 115 behavioral health (BH) professionals across our programs. As an organization, we strive to be both a provider and employer of choice. Most recently, MFS has actively shifted behavioral wellness services away from a traditional single provider model of care toward a team centered care model. Under this model, BH providers share a caseload, ensuring consumers are less impacted by staff departures and mitigating continuity of care issues. The BH team approach at MFS offers clients a whole service package, including case management, community support, counseling, psychiatric services, skill building, and recovery support services. This modality of care is not often possible in a traditional single provider model, where one clinician is providing all the care, as often used in private practice. Where some services may be considered "outside of their scope," MFS' BH teams are cross trained to deliver all services included in the package and clients at MFS have an entire support network to assist them.

Research has illustrated that BH services are the most impactful when delivered through team care models, as utilized at MFS, because it reduces gaps in care, simultaneously addresses different treatment needs, and is more accessible to clients. Further, team care models have been associated with evidence of less psychiatric hospitalizations, less recidivism, and increased client engagement, as a team can meet clients' needs in a timelier and more comprehensive manner through taking into consideration the social and financial barriers clients may be experiencing that impact their ability to maintain treatment and recovery.

As an agency, MFS strives to support our BH workforce through this model and beyond. BH providers in a team care model share responsibility for providing care, have additional opportunities for consultation and support, and work in an environment that fosters learning and resource sharing. As an agency we conduct monthly BH "Lunch n' Learns" with a clinical focus to provide MFS staff an opportunity to learn from one another across centers and receive

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clinical training as part of their professional development. We bring in external and internal trainers to share resources and present on best practice models such at DBT and CBT and advances in psychotropic medications. Currently, MFS is developing orientation check lists for each BH positions to support new employees that are learning their position and performance expectations, which includes a mix of shadowing, reflective supervision, peer and medical consultation, and other trainings. MFS is currently in the process of rolling out a clinical supervision model with tools to support supervisors and supervisees, improve staff's experience in supervision, and establish consistency in how teams are supervised. Further, we have incorporated team building opportunities on a site level and host quarterly BH Retreats to create more collaboration and cohesion amongst teams.

Beyond building internal structure to improve upon BH outcomes, MFS has historically worked alongside agency partners and the Illinois General Assembly in pursuit of public solutions to enhance clients' lives and support the BH workforce. Most recently, we supported and mobilized for:

- An increase in Medicaid reimbursement for Mobile Crisis Response (MCR) and Crisis Intervention (CI) Services. MCR and CI services are often the first introduction people have with the mental health system and the recent increase in Medicaid reimbursement addresses the historical under-investment in crisis services and its workforce.
- Building a Crisis Continuum of Care that is sustainably funded, with a well-staffed and well- compensated BH workforce, a connected and coordinated provider network, and timely responsive service delivery. We appreciate the Illinois General Assembly's passage of the Strengthening and Transforming Behavioral Health Crisis Care in Illinois Act (P.A 103-0337) last year, which will take a step toward our shared goals of a state-wide crisis response system that can withstand increasing demands.
- Funding and expansion of the Behavioral Health Care Professional Loan Repayment Program. The passage of P.A 103-0056, which funded the Behavioral Health Care Professional Loan Repayment Act at $5 million and added Licensed Marriage and Family Therapists, Certified Recovery Support Specialists (CRSS), and other MA and BA level BH professionals as eligible applicants to the repayment program addresses a persistent issue in the BH workforce. Existing BH providers are often burdened with student loan debt and may be more inclined to work in private practice or a hospital setting as a result, while prospective college students may be dissuaded from entering the BH workforce because of the financial challenges it may bring. Continued direct investment in the BH workforce through student loan relief can change these outcomes and increase BH workforce's capacity state-wide.

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- Creation and Funding of the Human Service Professional Loan Repayment Act. MFS supported the passage of the Human Service Professional Loan Repayment Act to create student loan relief for human service professionals throughout the sector. Though we appreciate the Illinois General Assembly's establishment of the Human Service Professional Loan Repayment Program (P.A 102-1089), this program remains unfunded. Funding for this program would make the sector more attractive for prospective job seekers, address current human service professional workforce shortages, and ensure continuity of program services for clients with diverse needs.
- Mental Health Equity and Prevention Access. We share the Mental Health & Addiction committee's vision to achieving true Mental Health Parity in Illinois. Ensuring that private insurers provide coverage for annual mental health prevention and wellness visits for children, regardless of their previous diagnosis will give additional families in our communities' access to mental health services (P.A 103-0535).

Illinois has made significant progress, but structural barriers to the maintenance of a well-funded behavioral health workforce remain in place. Community Based Organizations, like MFS, remain understaffed as a sector, impacting our ability to maintain the highest standard of care we aim to provide to our communities. Below is testimony from one of Metropolitan's clinical program supervisors further highlighting some of the issues we face:

My name is Jammie Rubio, I am a Licensed Clinical Professional Counselor (LCPC) at Metropolitan Family Services' North Center, located in the Belmont Cragin community in Chicago. Currently, I am a clinical program supervisor of a behavioral health (BH) team and provide BH treatment to 15+ clients. I have been working for social service agencies since 2013; and have been working in outpatient community mental health field since 2016.

The community and people whom I am privileged to serve are in high need for social services, specifically behavioral health services. In a post Covid-19 world, we have seen destigmatization of mental health which has increased the requests for behavioral health services. However, the BH workforce has not been able to keep up with the demand. BH Workforce has evolved in many facets in an effort to keep up with the demand, such as adding telehealth services and home visits.

As of January 1, 2024, additional licensed practitioners (e.g., LMFTs and Licensed Clinical Professional Counselor) may treat and bill for Medicare and/or Dual Eligible clients. This Centers for Medicare and Medicaid expansion may help to alleviate some organizations and businesses for billing reimbursement; but this alone is not enough to reduce the workforce shortage.

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BH workforce in community mental health continues to be plagued with hiring and retention issues. Community mental health programs are among the few provides that provide care for those who cannot pay or have insurance coverage through Medicaid. Most common: burn out, secondary trauma, long work weeks, difficulty managing high caseloads and demand, and student loan compensation. This is coupled with administrative burdens that make it difficult to compete with other practice settings like private practice, hospitals, or Federally Qualified Health Centers. Community mental health programs are often faced with hiring new staff with little to no experience in behavioral health. It's enticing for recent graduates to work in community mental health, as they can gain work experience and fulfill their supervision hours that are required before they can sit for licensure exam. Too often however, once a person gains their licensure, they leave for better pay and a more manageable case list. Medicaid requires certain administrative paperwork for billing and there are fewer providers that accept Medicaid. This leads to an increased demand for Medicaid providers, like MFS, thereby limiting the pay that community- based organizations can offer to staff and increases current staff's time on administrative work, as opposed to client care, an issue less faced by private providers.

We need to be able to afford to hire more BH workers to meet the demands of clients in the communities we serve and have a balanced case list. This should mean bigger BH teams [more clinicians and case managers, etc.]. A larger staff would mean more regular hours and time for documentation and breaks for self-care. We need higher or competitive salary ranges for licensed/experienced BH workers to improve retention.

We implore the Illinois General Assembly to continue to seek solutions that address:

- Sufficient reimbursement of mental health services rendered to ensure a well-compensated workforce.
- Undue administrative burdens for practicing behavioral health professionals, specifically for community- based providers.
- Barriers to licensing and delays in clearance for prospective behavioral health professionals, with a significant focus on building a behavioral health workforce that reflects the marginalized communities it is serving.
- Sustainable and consistent investment and incentives to expand an imminent behavioral health workforce to meet current and future community needs.
- Making strides toward true mental health parity with provider and insurance coverage equal to that of medical/surgical health.
- Continued student loan relief funding for mental health and human services professionals.

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We appreciate the Illinois House's Mental Health & Addiction's committee consideration of our testimony and for your leadership in building a future behavioral health workforce that is equitable, well-compensated, and equipped to meet the behavioral health needs of constituents across Illinois. We thank you for your time if you have any questions, please feel free to contact Behavioral Health Director, Lauren Finnegan at finneganl@metrofamily.org.

Testimony from Andrea Durbin, Chief Executive Officer

Illinois Collaboration on Youth

Joint Behavioral & Mental Health and Mental Health & Addiction Committee Hearing

February 23, 2024

Good morning, and thank you to Chair Fine, Chair LaPointe, and members of the Senate Behavioral and Mental Health and House Mental Health and Addiction Committees for allowing me to speak to you today. My name is Andrea Durbin and I am the CEO of the Illinois Collaboration on Youth. ICOY represents community-based providers of services to children, youth, and families across the state. Our members provide a range of services, including behavioral health care, to young people involved in the juvenile justice system, the child welfare system, and to youth who are runaway, homeless, or otherwise in crisis.

I would like to address two major challenges that are affecting our ability to recruit and retain a qualified workforce. Let me say up front that the behavioral health workforce exists within the larger human services ecosystem, and that this work is necessarily interconnected.

The first challenge has to do with the recruitment and hiring process.

Prior to the 2018 passage of a federal law known as the Family First Prevention Services Act or FFPSA, community-based organizations were permitted to offer “conditional employment” to candidates. This allowed agencies to make employment offers with a starting date, while a background check clearance was pending. Those hires were allowed to begin the onboarding process, including required training, under the direct supervision of a full-time staff member. FFPSA included a provision that banned conditional employment for congregate care settings. However, Illinois has taken a much more restrictive approach by eliminating conditional employment for a wide range of human service providers including all child welfare programs, DHS-funded youth services, and day care and early childhood providers, among others.

Couple the removal of conditional employment with the barriers in getting required background checks done and it is astonishing that anyone gets hired.

Illinois has a sole source contract for fingerprinting with Accurate Biometrics. A quick check of the Accurate Biometrics website this morning shows that there are no locations available in Aurora, the 2nd largest city in Illinois. Job candidates there must travel to Naperville, Oak Brook, or Joliet. Candidates in Mt. Vernon have one day in the next several weeks – March 5th, between 10 a.m. and 2 p.m. – to get their fingerprints done, while candidates in Belleville have three options – all on Mondays, between 9 a.m. and 1 p.m. And so on.

Remember that people who are interested in our jobs have no other option for fingerprinting. Therefore they must take time off from their current job, travel sometimes several miles to meet a limited time window, and possibly arrange for child care or other concerns, all for a job offer they have not yet received! And then it may take several weeks for the clearance process to be completed.

One of my providers has reported losing 45 prospective hires in the past few months from people who withdrew their applications in the middle of the hiring process.

We should revisit the concept of conditional employment with clearly established guidelines, and establish uniform procedures, timeframes, and accountability for returning background checks. We should also expedite mobile fingerprinting for community providers, and allow the Illinois State Police to provide fingerprinting services as well.

Our second challenge is with retaining employees, and a key part of that is ensuring that employees are compensated appropriately and that they are able to support themselves and their families with the wages they have earned.

In 2022, the Illinois General Assembly passed SB3925 (PA 102-1089) unanimously, to address the human service workforce crisis that directly impacts communities across Illinois. Funding the Human Services Professional Loan Repayment Program will provide loan repayment assistance to qualified human services professionals to recruit and retain them to work in community-based human services organizations.

This legislation prioritizes frontline human service workers with disproportionate amounts of student loan debt. Student loan debt, particularly in our profession, is an equity issue: The average MSW graduate leaves their program with more than $30,000 in student loan debt, with many starting salaries for positions at CBOs starting at less than $60,000 per year. Black women nationally hold a disproportionate amount of debt to their white counterparts.

Based on an upcoming report from Illinois Partners for Human Service, a survey of more than 850 frontline human service workers employed by community-based organizations showed that the most common characteristic among respondents *who did not make a living wage* (outside of household size) was their level of education.

- 67% of frontline human service workers surveyed with a GED/HS Diploma do not earn a living wage.
- 60% of frontline human service workers with some college/vocational/associate's degree do not earn a living wage.

Educational debt plays a huge role in whether employees perceive that they are earning a living wage.

So now it is time to fully fund the Human Service Professionals Loan Repayment Program. Appropriations for the Human Service Professional Loan Repayment Program are included in HB4601/ SB3082. This legislation is being supported by both Illinois Partners and the Illinois Collaboration on Youth. We are asking for $15 million in appropriations, which would provide approximately 1000 repayments at various levels to human service workers, including Master's degrees, Bachelor's degrees, Associate's degrees, and other required licensures.

This week the Governor included $250,000 in his proposed FY25 budget for the Human Service Professionals Loan Repayment program. While we are grateful to be included at all, this amount of funding would only provide relief for a few individuals. We have an industry-wide problem. Let's address it.

Thank you.