Behavioral Health Workforce Shortage

Written Testimony

House Mental Health & Addiction Committee
Senate Behavioral Health Committee

January 25, 2024

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Subject matter: Behavioral Health Workforce Shortage

Agenda

1. **Opening Remarks**: 5 min.
2. **Panel #1: Behavioral Health Workforce Center Briefing**: 30 min.
    a. Dr. Kari Wolf, Illinois Behavioral Health Workforce Center/SIU Medicine
    b. Sonya Leathers, PhD, Illinois Behavioral Health Workforce Center/UIC
3. **Panel #2: Provider Impacts**: 60 min.
    a. Jamal Malone, Ada McKinley Community Services
    b. Jodi Mahoney, North Central Behavioral Health Systems
    c. Kelly Epperson, Rosecrance
    d. Susan Doig, Trilogy Mental Wellbeing
    e. Lindsay Doyle, Chicago Therapy Collective
4. **Closing Remarks**: 5 min.

Testimony Submitted to Joint Committee Hearing
House Mental Health and Addiction and the Senate Behavioral and Mental Health
Submitted by Dr. Kari Wolf, CEO of the BHWC and Chair of the Department of Psychiatry at SIU School of Medicine, and Sonya Leathers, PhD, Director of the BHWC at UIC and Professor at Jane Addams College at UIC

History
On March 8, 2023, Governor JB Pritzker along with state and local officials celebrated the launch of the Behavioral Health Workforce Center (BHWC). The BHWC is funded by the Division of Mental Health at the Department of Human Services (DHS) and administered by the Illinois Board of Higher Education (IBHE). Using a hub and spoke model, the BHWC is physically structured with Southern Illinois University School of Medicine (SIU SOM) contracted as the primary hub and the University of Illinois Chicago (UIC) contracted as the secondary hub. While each hub provides specific functions for the BHWC, the lead hubs work closely and collaboratively together.

Our goal is to make Illinois a leader in creating a behavioral health infrastructure with expanded access points for both practitioners and patients through the following initiatives:

1) Policy recommendations that address structural and policy barriers to recruitment, training, and retention.
2) Statewide and program specific data collection to understand behavioral health workforce shortages, training and retention needs, and initiative outcomes.
3) Professional development and training initiatives to increase retention of behavioral health providers and quality of care.
4) Diversity and equity initiatives to increase the number and diversity of behavioral health workers across the state.

Statistics on Level of Need and Workforce Shortage
Investments to support Illinois' behavioral health workforce and strengthen our system of behavioral health care are particularly critical at this point in time. Illinois has experienced an alarming increase in behavioral health needs both over the past decade and, more recently, as the result of the Covid-19 pandemic.

- Over a quarter of adults in Illinois reported significant symptoms of anxiety or depressive disorder in 2023, compared with just 11% in 2019.
- In 2019, 15% of youth age 12-17 in Illinois experienced a major depressive episode in past year and 11% reported serious thoughts of suicide in 2019, more than double the percentage as compared to 2016.
- Persistent feelings of sadness or hopelessness rose to 57% among teen girls in 2021, twice the rate reported in 2011, while rates among boys rose to 29% from 21% in 2011.
- Hispanic, mixed race, and LGBQ+ youth are at particularly high risk for these difficulties, with nearly 7 in 10 LGBQ+ youth reporting persistent feelings of depression in 2021.
- 13% of youth reported a suicide attempt and 3% reported that they had been injured in an attempt to take their own lives in 2021.

Substance abuse, and in particular opioid abuse, has continued to devastate too many Illinois families:

- In 2022, 3,261 people lost their lives in fatal overdoses in Illinois, an 8% increase from 2021.
- These heartbreaking outcomes often begin with difficulties in adolescence: 16% aged 18- 25 report a substance use disorder.

Unfortunately, too many people never receive the services to treat their behavioral health needs:

- From 2017-2019, 53.6% of the 1.8 million Illinois adults who experienced a mental illness did not receive treatment.
- Only 43% of the 145,000 Illinois youth aged 12-17 who experienced a major depressive episode received any behavioral health care.

The workforce shortage is a critical factor limiting access to behavioral health services:

- In 2021, The American Association of Medical Colleges reported that Illinois has the capacity to meet just 24% of the mental health needs of the state with its current workforce.
- Illinois has 9.8 million people who live in one of Illinois' 221 designated mental health care health professional shortage areas. Rural counties have an average of 1.2 psychiatrists per 100,000 residents compared to 10.5 in the state overall (the need is 25.9 psychiatrists per 100,000 residents).

The Center's analysis of existing data, collection of data from 555 community mental health providers, and ongoing input from advisory groups in 5 practice areas has informed the development and launch of new initiatives to support entry into the workforce and retention of existing providers, including the following:

- An Interactive Map to identify regions with greatest shortage of specific behavioral health providers.
- Expand credentialing and licensing for behavioral health learners at every level through educational pipelines (e.g., a behavioral health career awareness and high school preparation program).
- Job board specifically to connect behavioral health job seekers and employers across Illinois.
- The creation of an employer training program to support the integration of Certified Recovery Support Specialist (CRSS) completers into the workplace.
- Supervision groups for providers without access to a licensed provider in their agency.
- Supervision training to support effective training and ongoing professional development.
- Psychiatry residencies in highest need regions of the state.
- Training in evidence-based practices for use in in non-traditional behavioral health settings such as doctors' offices, schools, and community centers.
- Intervention training in high-need areas identified by providers, such as motivational interviewing.

The Impact of Workforce Shortage

The primary impact of the behavioral health workforce shortage is its impact on the wellbeing of Illinois' residents at times when they are most vulnerable. Individuals and families too often search for behavioral health care for themselves or a loved one and give up on their search due to long wait times, high costs, and travel distances.

The shortage also impacts how services are provided due to their scarcity in a range of complex ways.

- The shortage has resulted in a system of care in which a large percentage of the behavioral healthcare workforce operates on cash-pay basis, meaning that the provider only accepts cash rather than processing insurance payments and then billing a patient. A Harvard 2020 publication found 45% of psychiatrists (compared to 10% in other medical specialties) only accept cash for the care they provide, and a larger percentage accept only a limited number of insurances.
- Psychiatrists who work in cash-pay practices see fewer patients per week, see mostly white patients, see patients more frequently, and for fewer visits. This results in a two-tiered system of mental health care.
- Every behavioral health provider (psychologists, social workers, etc.) needs a clinical internship while in school, and many need clinical training upon degree completion before they can be licensed to practice . The shortage of licensed behavioral health providers to provide this training, lack of qualifying training programs, and lack of billing capacity for training and supervision results in inadequate training and attrition.

Insurance Parity Issues

While Illinois has arguably the most stringent parity law in the country, the current laws still open up ample opportunities for unfair practices and discrimination against treatment for mental illness. These include:

- Arbitrary medical necessity standards whereby someone must present an imminent threat to their own life or others, which is not a standard required in the rest of medicine. For example, people are admitted for hip replacement surgery or IV antibiotics—neither of which pose an imminent threat of death but are still both important reasons for hospital admission.
- Inadequate networks of providers largely due to the low reimbursement rates and high administrative burden placed on mental health professionals. Studies have found that non-psychiatric doctors get 13-20% higher in-network reimbursement from insurance companies compared to the same care provided by a psychiatrist.
- In addition, insurers often have "ghost" panels of mental health professionals where practitioners are listed but when patients attempt to contact those providers, there is not an actual practice at that address or the provider is not accepting new patients.
- Insurance companies often employ a fail-first mentality when approving mental health care. Patients who have failed a particular medication or treatment are often forced to fail that treatment again before the insurance company will pay for the new medication. Insurers may also deny paying for more expensive medications which stabilized the patient in the hospital once they are discharged, leading to relapse of the original condition that led to hospitalization.
- Insurers often utilize co-pays for medical, surgical, and obstetric care but utilize co-insurance for behavioral health care. For example, a patient may have a co-pay of $100 or $50 per day of admission for a heart problem. But if admitted to a psychiatric unit or a substance use disorder treatment center, the patient may have to pay 10% or 20% of the hospital charges.

Recommendations from the BHWC

To provide data on the severity of the shortage of behavioral health providers of different types across the state and the needs of the behavioral health workforce, an online behavioral health workforce database with an interactive map was created based upon data from the Illinois Certification Board (ICB), Illinois Department of Financial and Professional Regulation (IDFPR) and IBHE. Survey data was also collected from 555 community mental health providers from randomly selected sites across the state. Insight from collected data and partner surveys as well as the BHWC's collaborative work with leadership across the state and through conversations with advisory groups, which include members from state agencies, higher education institutions, consumers, parents and behavioral health providers, specific recommendations have emerged and include the following:

- Licensing process needs to be less burdensome.
- Expand pathway and mentorship programs to increase the number of people interested in careers in behavioral health and facilitate their progression through the educational and certification process.
- Expanding clinical training for the behavioral health workforce by creating new training programs and training sites across the state.
- Increase Medicaid reimbursement rates for behavioral health services.
- Improve parity laws to ensure insurance companies are unable to circumvent the system and ensure reimbursement to behavioral health providers commensurate with rates for comparable medical-surgical care.
- Continue to focus on behavioral health workforce retention strategies.
- Expand programs to improve the knowledge and skills of existing behavioral health workforce and primary care providers in evidence-based treatments.

HONORING THE LEGACY
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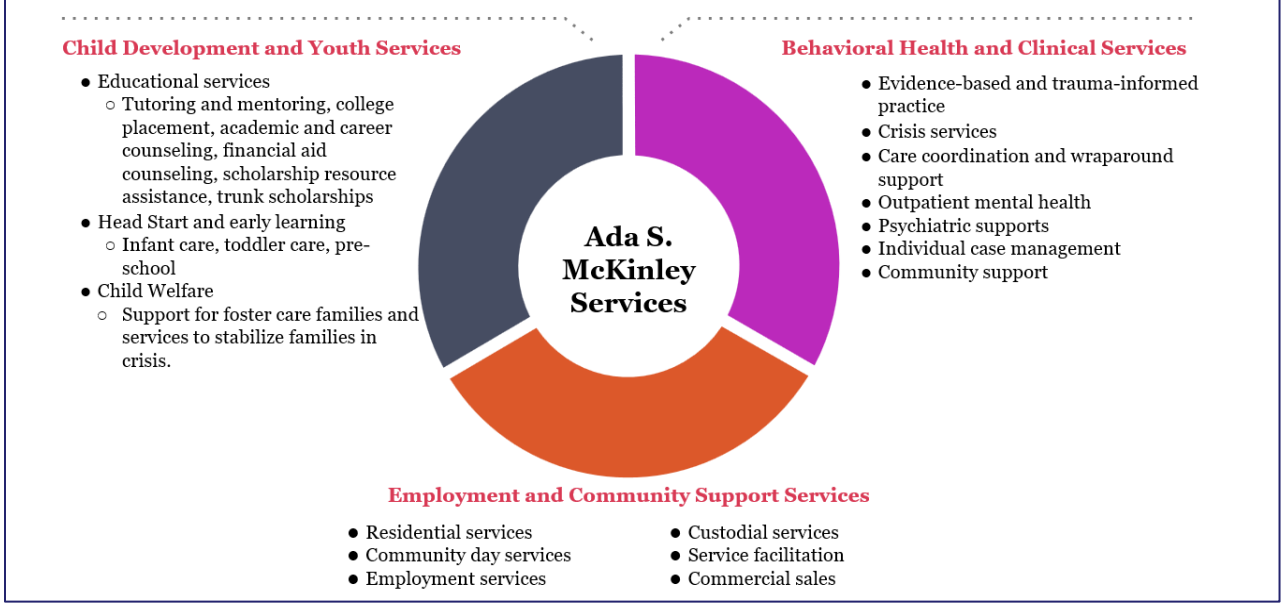
Ada S. McKinley Community Services, Inc. Written Testimony
for the Mental Health & Addiction Committee
Joint with Senate Behavioral Mental Health Committee
Submitted by Jamal Malone, CEO of Ada S. McKinley Community Services, Inc.
January 25, 2024

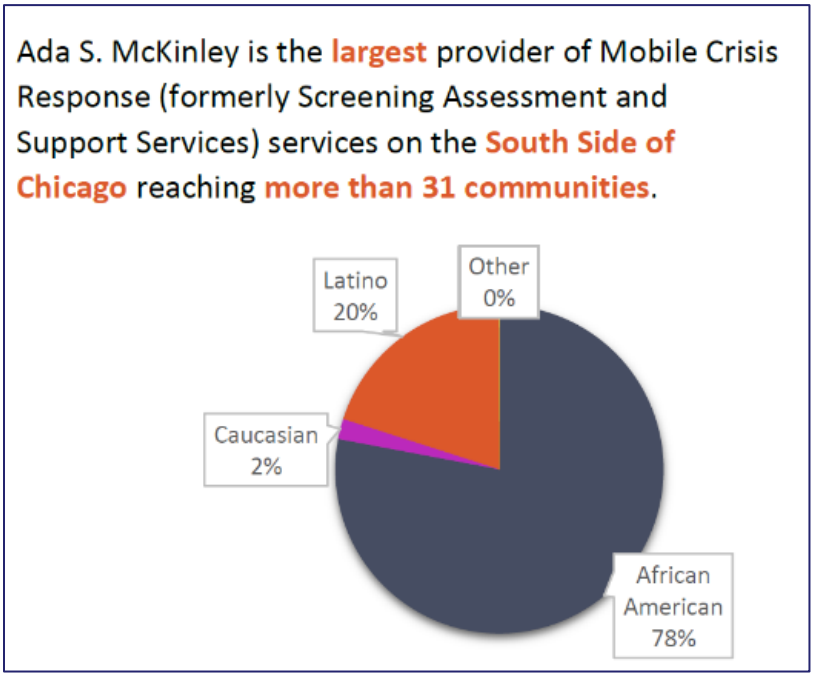
The mission of **Ada S. McKinley Community Services (ASM)**, Inc. is to empower, educate and employ people to change lives and strengthen communities. Celebrating 103 years of continuous service, ASM, through its vision and mission, operates as a human services agency, with over 600 dedicated staff at over 70 program sites that successfully serves over 10,000 children, youth, and families in historically under-funded and under- resourced communities throughout Illinois, Wisconsin, and Indiana.

What We Offer



Within our wide-ranging portfolio of services, Behavioral Health Programs specifically include Mobile Crisis Response, Outpatient Mental Health Clinics, and Pathways to Success. Our Behavioral Health Programs serving adults with intellectual and developmental disabilities provide Community-Based Group Homes, Education and Employment. Ada S. McKinley Community Services is also an AbilityOne Federal Contractor employing people with intellectual and developmental disabilities and veterans.

Teachers, Law Enforcement and Emergency Room Staff depend on us - they rely on us to deflect community-based crisis events to outpatient services or inpatient hospitalization.



In addition to Face-to-face Mobile Crisis Response and Outpatient Clinics we have:

- Coordinated Care Support Organization Designation
- Pathways to Success with Multiple DSAs for Mobile Crisis Response
- Increased Demand, especially post-COVID19
- **Opening new clinics with expanded services. We have hired approximately 30 new staff over the last 12 months.**

ASM continues to grow in these areas and is opening 2 new clinics in Chicago this spring. We have hired over 30 staff in the last 12 months. About 18 months ago, we were approximately 50% understaffed for our Behavioral Health Team; and approximately 25% understaffed for mobile crisis to meet capacity at that time. We have made staffing gains, yet community

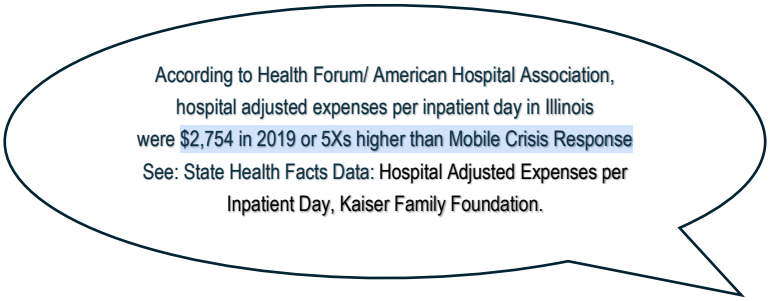
demand for services requires even more staff. It is noted that ASM has historically had a waitlist for appointments prior to the post-pandemic spike in demand.

Staffing Crisis Response –

- Increased average salaries
- Paid Retention Bonuses
- Staff Candidate Referral Programs
- Co-sourced staff with other agencies
- Increase HR – 75% increase in HR Recruiters (or triple the size)
- External staffing agencies to hire locally
- National recruiting campaign
- International recruiting campaign

Mobile Crisis Continues to Need Face-to-Face Response –

Ada S. McKinley's Crisis Event Deflection Rate is historically approximately 65%-70% – including people at risk of hurting themselves or others.



Multiple services options are needed as both in person and virtual are important; It is <u>CRITICAL</u> to keep in-person service; we cannot lose the face-to-face care in lieu of virtual or telephone (988 type) services.

Return on Investment (ROI) – Mobile Crisis Response –

Our Behavioral Health & Clinical Services staff consist of mental health professionals who use **evidence-based**, **trauma-informed** techniques to provide culturally competent therapeutic support in-home and in-community to children, youth, and families. School Suspensions, Emergency Room Admissions and Police Involvement are reduced by our services. Police are already spread thin and asked to be mental health workers in lieu of our programs. We reduce police interventions or involvement through our in-person crisis response services. Mobile Crisis Response and Face-to-face Behavioral Health programs save the state money in many other ways via schools, hospitals, law enforcement and jails.

Other Relevant Information -

- Healthcare, childcare and eldercare rising costs have impacted staff availability:
  - Healthcare, childcare and eldercare rising costs have reduced staffing availability.
  - Many of our staff work second jobs.
  - A large number historically are female and, in many cases, single parents and this reduces their availability for shifts and overtime.
  - In general, industry or market compensation of $40-50K is barely above poverty level.

---- End of Written Testimony ----

rosecrance®

Investing in Our Behavioral Health Workforce
Joint Subject Matter Hearing on Behavioral Health Workforce Shortage
Illinois Senate Behavioral Mental Health Committee
Illinois House Mental Health & Addiction Committee

January 23, 2024

Dear Honored Members of the Committees:

We appreciate the opportunity to provide information on behalf of Rosecrance in advance of the Joint Subject Matter Hearing on the critical issue of the behavioral healthcare workforce shortage. We applaud the Committees' advocacy on this issue, and we look forward to working together to continue advancing this important cause. In advance of the Joint Subject Matter Hearing, we submit the following information:

About Rosecrance – Services Provided and Populations Served:

Since 1916, Rosecrance has been caring for the behavioral health needs of our clients and their families. Our outcomes-based recovery services help accelerate progress and create a roadmap that goes beyond initial treatment. We offer a full continuum of care with comprehensive, individualized treatment for mental health and substance use disorders that includes the following services:

- crisis response services (mobile crisis response and 988 response);
- substance use disorder and mental health residential treatment;
- individual and group outpatient services;
- school-based services for adolescents;
- community-based services provided in the client's natural environment;
- outreach and case management;
- recovery homes and supportive housing;
- psychiatry, medical, and nursing services;
- medication assisted treatment;
- and more.

These services are delivered by a staff that includes board-certified psychiatrists, primary care physicians, registered nurses, licensed clinicians (LCPCs, LCSWs, LMFTs), crisis response staff, recreational therapists, nutritionists, teachers, case managers, paraprofessionals, and others.

In fiscal year 2023, Rosecrance served over 54,000 people across our organization, including 43,000 people from Illinois. Rosecrance has more than 40 locations across Illinois that served people from 86% of Illinois counties. (Please see attached fact sheet for additional information on our locations and facilities).

The client population we served included the following characteristics:

Racial Demographics:

White	63%
Black	19%
Hispanic / Latino	9%
Two or more races	5%
American Indian	2%
Asian	1%
Other	1%

Gender:

Male	57%
Female	43%

Age:

Children and Adolescents	37%
Adults	63%

Funding Source:

Managed Medicaid	55%
Private Insurance	29%
Other public funding	10%
Medicaid/Medicare	6%

At Rosecrance, we strive to serve all Illinois residents, regardless of ability to pay. We contract with all Illinois Medicaid managed care companies, and we are in network with all major commercial payers in Illinois. In fiscal year 2023, we provided charity care to 900 patients in the amount of $471,468. In addition to charity care, we provided publicly funded services where reimbursement rates fell below the cost of providing care. These unpaid costs attributed to providing publicly funded services are considered a “community benefit”. In fiscal year 2023, we provided $7 million worth of community benefit, in addition to direct charity care.

Specific Staff Shortages and Changes Over Time:

The vacancy rate at Rosecrance has been dynamic over the last few years:

- Prior to January 1, 2020, Rosecrance averaged a 9% vacancy rate or 110 open positions.
- At the start of January 1, 2022, our vacancy rate had increased to 17%, or 229 openings.
- Today we have an average vacancy rate of 12%, or approximately 160 open positions.

Our success in reducing our vacancy rate can be attributed to a significant investment in wages. Here is a brief overview of our wage investment over the past 3 years:

- June 2021 through January 2022 – We rolled out pay increases totaling approximately $6.5 million. These wage increases were based on salary studies to set compensation at the 50th percentile for each position. The average pay increase was 11%.
- October 2022 – 3% wage increase for all eligible staff, approx. $1.5 million investment.
- September 2023 – 3% wage increase for all eligible staff, approx. $1.5 million investment.
- January 2024 – targeted wage increases for paraprofessionals and nurses, approx. $500,000 investment. This was done in response to data showing that our highest turnover rates were in direct care paraprofessional positions.
- **Total investment in wages since 2021 = $10 million with average increase of 17%.**

At Rosecrance, the rolling 12-month average of open positions, including newly added positions, is 156 open positions across the entire organization. We currently have 158 open positions, however, 27% of these openings are new, after-budget positions related to growth and expanded services. Most open positions are for direct care staff, with the following breakdown:

Clinical Staff	70	49%
Paraprofessionals	49	34.5%
Nursing	15	10.5%
Clinical Leadership	8	6%
Total	142	100%

Items of note regarding the current vacancies:

- We have 10 open positions on our mobile crisis response teams.
- We are looking to hire 8 staff members to expand Assertive Community Treatment (ACT) and Community Support Team (CST) services.
- Our 24/7 programs have a significant number of third shift openings, with 13 overnight positions open.
- Our residential programs are particularly hard hit with a total of 71 open positions. We have had to close units in our residential programs due to staff shortages. We are also relying on staffing agencies, which drastically increases the cost of providing services.

Staffing Needs and Current Strategies:

To address our staffing needs, we have implemented an aggressive and comprehensive recruitment and engagement strategy that includes the following initiatives:

- We launched a company-wide employee engagement campaign focused on culture improvement to ensure staff feel connected to the Rosecrance mission. These efforts improved our already high staff satisfaction rate.
- We implemented new and innovative recruitment strategies, including virtual job fairs, sign-on bonuses, remote work, hybrid schedules, and internal career pathways.

- We expanded our professional development opportunities, including in-house CEU offerings, tuition reimbursement, loan forgiveness assistance, and support to obtain professional certifications and licensures.
- Unfortunately, we have had to rely on contract staff and outside staffing agencies to fill vacancies, at rates 2-3x what an employed staff would make.
- Our most important strategy to address staff vacancies continues to focus on offering a competitive compensation package. As noted above, we have invested at least $10 million in wages to ensure our wages stay at the 50th percentile. Based on our semi-annual staff survey, pay remains the top issue affecting retention. Our goal is a minimum wage of $20/hr. and to then decompress the salary scale from there. A starting wage of $20/hr. is necessary to attract and retain paraprofessional staff when we are competing with many other employers who advertise starting wages at the same level. Achieving this minimum wage will require collaborating with all our funding partners to ensure sustainable funding year-after-year.

Impact on Service Provision:

Unfortunately, the behavioral health workforce shortage has reduced the availability of certain programs and, regrettably, reduced access to care. Our reduced services include the following:

- Residential SUD Treatment – 30 residential beds offline due to staffing shortages;
- Assertive Community Treatment (ACT) program – offline due to staff vacancies;
- Community Support Team (CST) – we only offer one CST program currently, but with additional staffing we would offer 2 more CST programs;
- Office-based mental health outpatient services – vacancies in these programs have led to increased wait times and diminished access; and
- Mobile crisis response programs – we have 10 vacancies in these programs, which can increase burnout as staff and supervisors handle increased volume.

Thank you for your help and support:

The behavioral health workforce shortage is a critical issue that demands urgent attention. On behalf of everyone at Rosecrance, we thank you for your time and commitment to addressing this pressing issue. Please do not hesitate to contact us for any additional information or should you have any questions.

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Illinois Summary of Impact for FY 2023

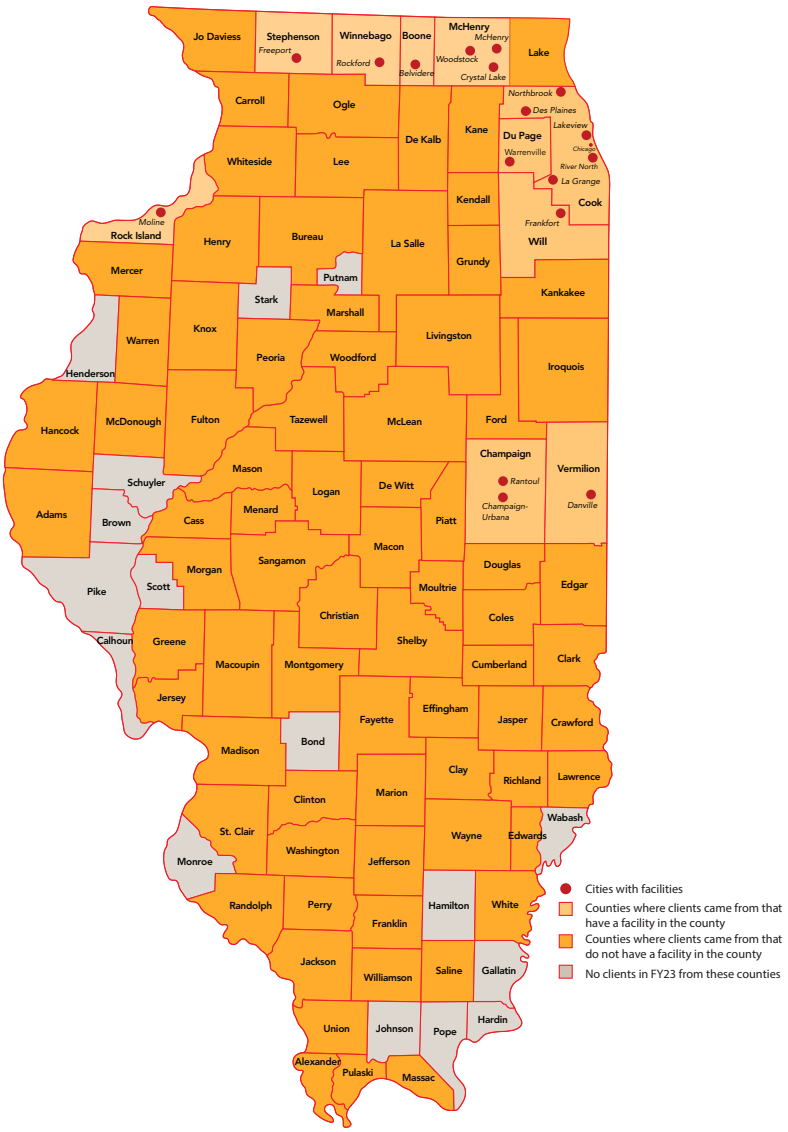
life's waiting®

rosecrance® BEHAVIORAL HEALTH

Founded in 1916, Rosecrance is an integrated network of behavioral health services with a community of 1400 compassionate professionals caring for and supporting more than 50,000 people each year at 60 locations in Illinois, Wisconsin and Iowa.

ROSECRANCE HAS 44 LOCATIONS IN ILLINOIS

SERVING PEOPLE FROM 86% OF ILLINOIS COUNTIES



PEOPLE SERVED IN FY23

42,859
total people

15,739
children & youth served

27,120
adults served

10,161
Average number of clients enrolled in treatment in a day

OUR CARE CONTINUUM

Rosecrance Behavioral Health

- Rosecrance Residential
- Rosecrance Therapies
- Rosecrance Community
- Rosecrance Living
- Rosecrance Learning
- Rosecrance Foundation

217 outpatient groups offered

421 beds

LOCATIONS

59 facilities

ROCKFORD AREA AND ROCK ISLAND (23)

CHICAGOLAND (9)

CHAMPAIGN-URBANA AREA (8)

MCHENRY AREA (4)

SIOUXLAND AND DAVENPORT IA (13)

WISCONSIN (2)

MISSION/VISION

MISSION

To provide help, hope, and lasting recovery to children, youth, adults, and families.

VISION

To embrace and share the power of recovery to help individuals live well, and strengthen families and communities.

David Gomel, Ph.D.
President and CEO
Rosecrance Behavioral Health
312.833.2097

Chicago Therapy Collective
5237 N Clark Street, Floor 2
Chicago, IL 60640

Testimony regarding the Behavioral Health Provider Shortage in Illinois: January 25, 2024

Chicago Therapy Collective (CTC) is nonprofit which serves the behavioral health needs of Chicago's LGBTQ+, and especially Transgender, communities. We provide direct individual therapy services, offer wellness groups, and work to strengthen and improve the mental health care landscape by supporting other organizations in their efforts to provide culturally relevant and efficacious care through clinical training, consultation, and supervision. Our work centers the needs of the most marginalized within the LGBTQ+ community, namely Black Trans Women, Trans Women of Color, LGBTQ+ migrants and asylum seekers, community members with severe or persistent mental illness and complex trauma. Finally, in recognition of the importance of jobs and Housing First initiatives, CTC engages in community based work designed to improve the lives and wellbeing of the clients we serve, such as our most recognizable Hire Trans Now program.

Provider Shortage and CTC: It has become incredibly difficult to hire clinicians, not just because there is a provider shortage, but because there are not enough clinicians who (1) are prepared to treat diverse clients and (2) have experience providing culturally relevant, efficacious therapies to clients with high needs and complex presentations.

Provider Shortage and LGBTQ+ Illinoisans:
As of 2020, there were 506,000 LGBTQ+ Illinoisans, a number which has likely grown (Williams 2020). Meanwhile, ILDHS reports that Illinois only has 13.8 behavioral health care providers for every 10,000 residents, with estimates suggesting that close to 40% of Illinois residents live in Mental Health Professional Shortage Areas. Unfortunately, research shows that far too many mental health providers report a lack of confidence and skill in providing therapy services to LGBTQ+ individuals that is effective and affirming and many LBGTQ+ individuals report difficulty finding mental health providers trained in culturally relevant, affirming, and effective mental health care that aligns with their specific needs (Fish et al., 2022; Fish et al. 2021; Martos et al., 2018; Rees et al., 2021; Rock et al., 2010; Shelton & Delgado-Romero, 2013). **LGBTQ+ Illinois residents are unlikely to be able to access a mental health provider who can provide them with effective, culturally relevant care based on a shortage of providers with the training and competency to meet their needs.** Add to this the additional barriers of access to mental health care that is financially and geographically accessible and we see that LGBTQ+ Illinoisans are up against staggering barriers to effective, culturally relevant mental health services.

These access issues become dire when one also considers that LGBTQ+ individuals face disproportionately high levels of depression, anxiety, trauma, substance abuse disorders, and suicidality when compared with their heterosexual and/or cisgender peers; their need for culturally relevant, effective, and affirming mental health care is

CTC
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simply higher and especially critical as poor mental health in LGBTQ+ populations is widely attribute to experiences of stigma and discrimination. The provider shortage is especially dire for LGBTQ+ Illinoisans.

We believe that many of the problems, and the solutions, to the behavioral health care provider shortage are clinical in nature.

To Improve the Therapist Shortage in IL we must:

(1) Fund Therapies that Work! Fund a diversity of Therapies, Training Opportunities, and Specialized Programs with an emphasis on both high efficacy AND cultural & clinical competency
(2) Expand the metrics utilized for Program Evaluation/Outcomes and Funding of Mental Health Services to be more aligned with client care
(3) Pass Legislation to Protect & Advance Voluntary Mental Health Care in IL: Systems that work are voluntary systems.

Fund Therapies that Work! Fund a diversity of Therapies, Training Opportunities, and Specialized Programs with High Efficacy and Cultural & Clinical Competency

1. Therapists need training and supervision in providing a broader, more in-depth and culturally relevant set of therapist. Most are predominantly trained and supervised in short-term / time-limited therapies, which are less efficacious than long-term or interpersonally focused courses of treatment for complex clients, such as those with trauma backgrounds, from marginalized groups, or with severe illness. The same is true for clients receiving non culturally specific care, such as brief manualized treatments. Early career therapists commonly find the lack of efficacy in the treatments they provide to be demoralizing, contributing to feelings of helplessness, burnout, and ultimately, therapists leaving the field and/or being unable or unwilling to work with populations of high need.
2. Supporting therapists in being able to provide more diverse highly efficacious treatment will lead to: (a) more retention of experienced clinicians, (b) fewer existing therapists discouraging students, early career clinicians, and potential therapists from entering the field, (c) more clinicians willing and able to provide services to our most vulnerable, underserved and marginalized community members, and (d) better treatment outcomes.
3. **Specific Types of Therapies & Programs that Work which desperately need funding in IL:**
    a. *Open Dialogue*, a team based family intervention for young adults experiencing a first episode of psychosis: after treatment 82% no residual symptoms, 86% full-time school or employment, and most are medication free (Seikkula & Jaakko, et al. 2006).
    b. *Psychotherapies of depth, insight and intensity:* Long history of success in using these techniques with complex or high need clients, e.g. outpatient clinic in Quebec treating those experiencing psychosis has 30 year record of 64% cure (symptom free for 10+ years). Therapies of all types that

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focus on interpersonal variable have better and longer lasting treatment outcomes for clients with a diversity of diagnoses.

c. *Soteria Houses*: Residential Programs that are medication free for severe mental illness, shown to yield equal or better results than hospital or medication based programs without the harmful side effects and costs of medication (Bola & Mosher, 2003).

d. Hearing Voices Network Programs: peer led groups run by trained facilitators which support those seeking to live well while hearing voices. Early research suggests high efficacy/very positive outcomes (Spanggard, Rhode & Ostergaard, 2023).

e. *Other Programs:* Non-Police Community Response Teams; Peer Respites, Living Room Programs, Healing Homes, Warm Lines, emotional CPR and Housing First Initiatives.

4. **We should consider strengthening and implementing policies that require accredited graduate programs, internship training sites and continuing education opportunities to include LGBTQ + training and competencies, as well as training and competency in a diversity of treatment modalities.**

Updating Metrics utilized for Program Evaluation/Outcomes and Funding of Mental Health Services

1. Funding available for therapy services within IL, as well as metrics commonly used to evaluate program effectiveness, typically treats 'number of clients served' during limited periods of time (ie, a grant cycle) as a positive outcome. This has the unintended effect of promoting short-term/time-limited therapies and undermining access to treatments that are more efficacious for clients with complex presentation and diverse lived experiences, to the detriment of both those seeking care and the therapists forced to provide less individualized, and therefore less efficacious care.
2. We cannot maintain a mental health workforce with enough therapists if we are forcing them to only see a revolving door of patients who (a) through the stipulations of funding streams, are not able to stay in therapy long enough to get better, (b) do not get better because they are not able to access therapies that meet the needs of their complex and our diverse lived experiences.
    a. To give an example framed relative to Parity with Medical Providers: a client, and non-smoker, recently shared that they have been diagnosed with emphysema, likely due to living in an area of Chicago with very high air pollution/low air quality for over 50 years. They will have to meet with a Pulmonologist for ongoing clinical treatment long-term. We would not say that the Pulmonologist is not effectively or efficaciously treating this client's emphysema- a chronic condition tied to the environment- because they treatment will be long-term. Similarly, clients presenting to therapy with distress tied to systemic issues such as racism, homophobia, and transphobia are presenting to therapy while they continue to experience ongoing harm in the present: they are not being failed by therapists when their treatment is long-term, rather, they are being provided with culturally

relevant, trauma informed care that is highly efficacious and optimizes their functioning and quality of life.

3. We need to increase the number and availability of innovative public-private partnerships and programs to meet the needs of diverse clients across the state.

Systems the Work are Voluntary Systems

1. We must take action to advance and protect Voluntary Mental Health Care in IL by limiting mandated treatment. Therapists know deeply that forced care simply does not work and typically relies on forced medication and hospitalization which is more likely to have a detrimental effect than a positive one. Therapists do not want to participate in systems that cause harm and do not help.
2. Over the last few years both California and New York have expanded the reach and scope of Mandatory treatment beyond "imminent risk of harm to self or others" and now force psychiatric and hospitalization based treatments on some of the most vulnerable within the community, specifically those who are unhoused. This expansion is unprecedented, highly opposed by many, and has little to no efficacy. It is also a violation of bodily autonomy and human and client rights. We must act to stop "Care Courts" (such as those now in California) and other forced 'treatment' initiatives that violate client and human rights (such as those in New York) from expanding the use of court ordered or mandated treatment in IL next if we want to retain therapists in the field and continue to advance efficacious, ethical care.

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1. **What behavioral health services does your organization provide? What populations do you serve?**

   Chicago Therapy Collective (CTC) is a North-side nonprofit which serves the behavioral health needs of Chicago's LGBTQ+, and especially Transgender, communities. We provide direct individual therapy services, offer wellness groups, and support other organizations in their efforts to provide culturally relevant and efficacious care through clinical training, consultation, and supervision. Our work centers the needs of the most marginalized within the LGBTQ+ community, namely Black Trans Women, Trans Women of Color, LGBTQ+ migrants and asylum seekers, as well as community members with severe or persistent mental illness and complex trauma. Finally, CTC engages in community based work designed to improve the lives and wellbeing of the clients we serve, such as our most recognizable Hire Trans Now program.

2. **What specific shortages are you facing? Which occupations, in what areas, and how has that shortage changed in the last few years?**

   It has become incredibly difficult in this current moment to hire clinicians, not just because there are not enough, but because there are not enough who are prepared to treat diverse clients and have experience providing culturally relevant, efficacious therapies to clients with high needs and complex presentations. It is even harder when striving to hire LGBTQ+ Clinicians, Black Clinicians, and Clinicians of Color, all of whom remain highly under-represented in the mental health field. This is true for Psychologists, Licensed Professional Counselors, Clinical Social Workers, and Licensed Marriage and Family Therapists. In our modern-day push for efficiency, we have too often sacrificed efficacy and become overly reliant on training student therapists in manualized and/or one-size-fits all approaches to psychotherapy that do not prepare early career clinicians to meet the needs of diverse and/or complex clients. They then either avoid working in settings serving clients with the highest need, or too quickly become demoralized and/or burnt-out and leave the field. This is underscores our belief that not only do we need to fund and support diverse therapies that work, we also need to fund and create avenues for ongoing, in-depth professional training for clinicians so that we can develop and retain seasoned clinicians in the field.

3. **How is your organization meeting its staffing needs currently?**

   In short, we're not. The demand for culturally relevant therapy for LGBTQIA2S clients with complex or high needs far outstrips the availability of providers.

4. **How does this shortage affect your ability to provide services? Has your organization had to turn away patients, cut services, discontinue lines of business, etc?**

   Our organization, which is first and foremost a group of clinicians and direct service providers, continues to hone its offerings in response to the reality that we cannot meet the demand for our specialized services at this time. We do not feel it is ethical or appropriate to leave clients on a long waitlist, so we have pivoted and developed a curated network of providers whose work we have vetted and who can occasionally take a new client. Rather than operate a waitlist, we operate an individualized referral service and strive to ensure potential clients are placed with a service provider who matches their specific needs as quickly as possible- in house with us, or out in the community. In recognition of the systemic issues at play- from the overall provider shortage to the specific shortage of clinicians and treatment programs prepared to meet the unique needs of LGBTQ+ clients, those with complex trauma, and those with severe or persistent mental illness, we have redirected some of our professional focus. We now engage in capacity building work and directly support other organizations through consultation and clinical training and supervision: this is our current effort to at least maintain, and hopefully increase, the availability of providers and behavioral health programming that meets the specific needs of the communities we serve. Additionally, we devote time to advocacy and education in hopes that we can continue to evolve the current behavioral health system to meet the needs of our diverse communities.

1. **What behavioral health services does your organization provide? What populations do you serve?**

Trilogy is a 501(c)(3) behavioral healthcare and mental health organization with 50+ years of experience serving people with serious mental illness in the city of Chicago, as well as Evanston and Skokie. Trilogy's mission is to provide comprehensive integrated care that enables people in mental health recovery to build meaningful, independent lives.

About 70% of what we do is outreach into the community. We are helping individuals maintain their stability in the community and avoid hospitalizations, stabilize after a crisis, receive counseling and therapy, access benefits (including income and permanent housing) and maintain their independence.

Trilogy is uniquely positioned to address the complex and intersecting behavioral and primary care needs of clients through partnership with FQHC's. Last year, we served nearly 4,000 individuals, completed nearly 900 intakes, 250,000 client encounters (session), with over 85,000 via telehealth, and over 162,000 hours of direct clinical service.

While the need for mental health care and behavioral health care is acute across the city, the need is highest on the South side of Chicago, an area that has been called a mental health desert. As a result, Trilogy is currently working to expand services on the South side of Chicago to provide mental health care to communities that have been underserved for decades. Our new location in Chatham will provide a comprehensive array of services for children, teens, families and adults.

2. **What specific shortages are you facing? Which occupations, in what areas, and how has that shortage changed in the last few years?**

a. One of our greatest challenges currently is a shortage of mental health care professionals to serve our clients and help them on their journey to recovery. Frontline clinical staff who directly interface with clients are in highest demand, and there is significant competition to fill these roles. Our starting salary for someone with a Bachelor's degree is 45-50K. Most of these roles require a car. The cost to live in Chicago, pay loans and have a car can be prohibitive.
b. About 15-20% of our staff are peers, many of our front-line clinical jobs are filled by new grads. we find that it really takes 6-9 months for staff to really get up to speed on the job. This combined with burnout and turnover leaves little time for employees to stabilize teams and results in a reduction continuity of care
c. Nursing positions are also difficult to fill and retain.
d. While we do offer incentives up to $7,000 annually (twice yearly payments of $3,500) based on billing, staff have to work at Trilogy a year to get those.
e. Employees report love of mission and find work rewarding, it is often hard, and emotionally taxing. As an outreach worker to see a lot of pain and loss and cannot help people in many ways. This is especially hard for younger employees.
f. Staff with the least experience serve increasingly complex clients. We are not always able to find supports in other areas of care including home nursing and homemaker care, specialty providers.
g. Inadequate hospital care resulting in people getting released before they are stabilized adds to the burden and burnout of staff.

h. Many of the staff we promote into leadership are so focused on filling the gaps on teams that they have little time for teaching and training on becoming good leaders. There is a high expectation on leaders to manage, safety, morale, compliance and ensure quality care across multiple teams and programs.
i. We have a 35-42% annual turnover rate for clinical employees.
j. Growth to meet demand is very difficult due to the churn, cost to train in a FFS world
k. Difficulty retaining Licensed staff or staff who get their licenses while working at Trilogy because they are in demand in private practice, hospital and managed care organizations that pay higher.

3. How is your organization meeting its staffing needs currently?

a. Increased recruiting efforts, streamlining efforts to interview and hire
b. Investment in an internal training department to address compliance, new staff orientation, and best practices.
c. 2 annual increases to bring people closer to market since the rate increase. Merit-based increase annually.
d. Investment in AI to help staff enter notes more efficiently.
e. Adding job progressions for front-line staff in 4 areas to recognize growth, knowledge and higher pay.
f. Highlighting opportunity for loan repayments to employees.
g. Expanding employee resource groups
h. Hired an Employee Experience Manager to better support staff
i. Flexible and hybrid work schedules
j. Expanding student internships

4. How does this shortage affect your ability to provide services? Has your organization had to turn away patients, cut services, discontinue lines of business, etc.?

a. Trilogy maintains a waiting list of clients who need services who we are not able to support immediately for therapy services.
b. **We turn away 20-30 people per week who need services** due to lack of capacity on teams.
c. Our growth is limited because of the turnover, difficulty hiring for replacement positions, while hiring for new positions. Our margins are so tight it's very difficult to add sites, much of what the rate increases brought in is going to increased staff salaries.
d. Impact on residential services, these are the most difficult positions to hire for. The need for housing, particularly with on-site supports is high, yet we cannot grow due to difficulty maintaining physical sites and staffing.
e. Trilogy has not reduced lines of service, however, we really consider the feasibility of applying for new grants, funding and adding services due to difficulties with hiring and retention.
f. Trilogy spent 2.3 million dollars on a new building in Chatham. That building will require about 1.5 million in renovations. These are difficult and risky investments for a non-profit

Mental Health and Addictions Committee

Chairperson: Lindsey LaPointe

Subject Matter Hearing Testimony - Behavioral Health Workforce Shortage

Submitted by: Jodi Mahoney – President & CEO – North Central Behavioral Health Systems, Inc

January 25, 2024

Esteemed state legislators,

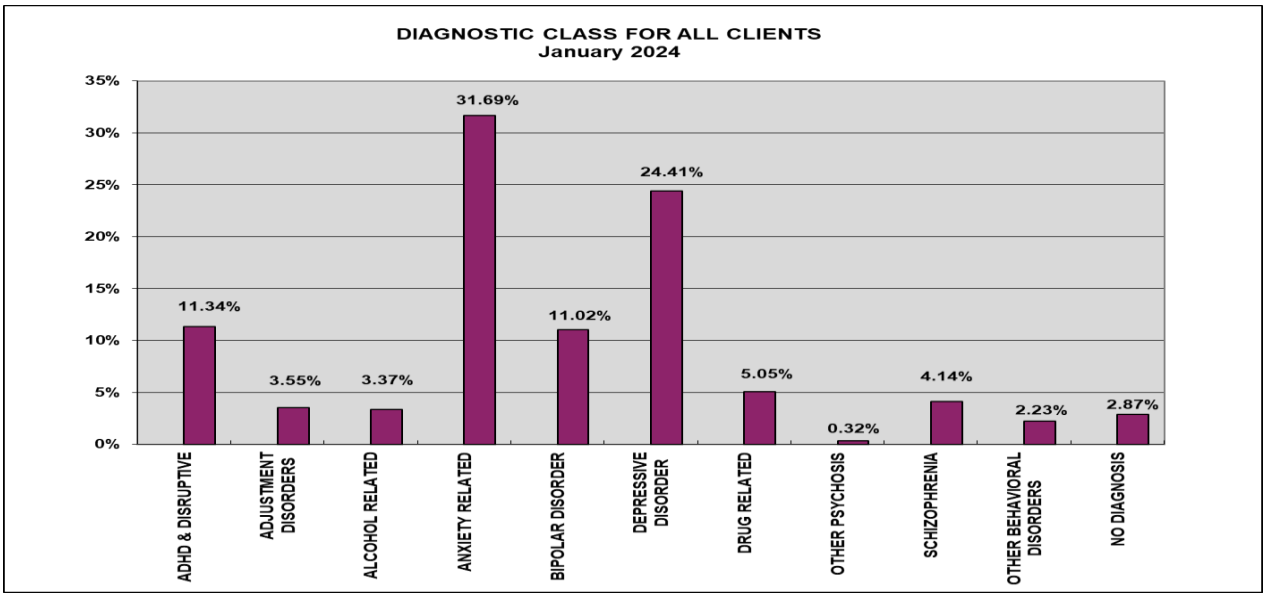
I am honored to be here today to testify on behalf of our organization and share information on the behavioral health services we provide, the population we serve, and the specific staff shortages we are currently experiencing.

North Central Behavioral Health Systems (NCBHS) is dedicated to offering comprehensive mental health and substance use services to individuals in our community. We are a recent Substance Abuse Mental Health Service Agency (SAMHSA) Certified Behavioral Health Clinic (CCBHC) grantee and a designated Illinois Certified Community Behavioral Health (IL-CCBHC) pilot site designee. Our goal is to ensure accessible and high-quality care for all who seek our assistance.

Our organization, NCBHS resides in North Central and Central Illinois, serving eight counties and 110 communities throughout a geographic area of 250,000 square miles with 9 site locations. We have an employee count of 130 staff, an ongoing open caseload of 3,000 clients per month, and we serve 10,000 unduplicated clients annually.

The population we serve is diverse, comprising children, adolescents, adults, and elderly individuals from various socioeconomic backgrounds. Our services are tailored to address a wide spectrum of behavioral health conditions, including depression, anxiety disorders, and substance use disorders. (See Fig. A)

(Figure A)



However, we are currently experiencing significant staff shortages in multiple occupation areas. Over the past few years, the shortage has intensified, making it increasingly challenging for us to fulfill our staffing

needs adequately. The professional labor pool is non-existent. Recruitment to fill positions can take 8-12 months depending on the specific credential and position. Labor costs have significantly accelerated due to the competition and high demand within this shallow labor pool. Retention has decreased to an average of 24 months due to providers competing for the same professionals. At this time, we have twelve (12) vacant positions with an additional twenty (20) new positions to be added to fulfill the service obligations within the two CCBHCs. The open positions are present within all professions:

- Licensed Behavioral Health Therapists
    - Licensed Clinical Social Workers
    - Licensed Professional Counselors
    - Licensed Family and Marital Therapists
- Qualified Mental Health Professional
    - Master's Level Therapists
- Mental Health Professional
    - Bachelor's Level Therapist
- Residential Assistance Aide
    - High-School degreed

An example of the type of service positions these professionals fill within our organization include:

- Behavioral Health Therapists and Counselors (Mental Health and Substance Use)
- Crisis Intervention Specialists
- Case Managers
- Supervised Residential Aides
- Care Coordinators
- Psychosocial Rehabilitation Counselors
- Clinical Management and Leadership
- Peer Engagement Specialists

These positions represent a 21% vacancy rate within the organization.

To counter these staffing challenges, we have implemented various strategies. Efforts include increasing our recruitment endeavors, partnering with academic institutions to provide internships and student loan forgiveness programs, and the use of telehealth services to bridge the gap between clients and providers.

Despite our efforts, the staff shortage significantly impacts our existing workforce requiring them to carry a caseload size 25% higher than targeted, additional administrative paperwork, and inability to see their clients with the frequency and duration prescribed by the Licensed Professional. This extra demand serves to perpetuate the problem of job burnout, job satisfaction, retention, and turnover. Consequently, we have been forced to minimize appointment availability and extend wait times for service access. The staff shortage not only affects our organization but also has detrimental effects on the community we serve, leaving individuals without the vital support they desperately need.

It is crucial for legislators to acknowledge this issue by supporting initiatives that attract and retain behavioral health professionals in our state.

In conclusion, I would like to thank you for the investments that have been made to date by the state to help support developing solutions to the workforce challenges providers face. However, I urge you, esteemed legislators, to consider the impact of the staff shortages our organization and many others face in providing essential behavioral health services.