"During the spring 2018 legislative session, a bipartisan group of 10 legislators … sponsored a resolution, HR 711, which declared that Illinois is suffering from a Behavioral Healthcare Workforce Emergency. … House lawmakers are correct and the emergency has escalated to a crisis. In fact, the statistics are blinking red." - ***Behavioral Health Workforce Education Center Task Force Report***

Behavioral Health Workforce Education Center Task Force Report

to the Illinois General Assembly

A Report on the Illinois Behavioral Health Workforce Crisis and ***Recommended Solutions*** *to Grow, Recruit & Retain a Qualified, Modern, Diverse, and Evolving Behavioral Health Workforce: Response to House Bill 5111 (PA 100-0767)*

December 27, 2019

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EXECUTIVE SUMMARY

We have had no applicants for clinical positions who have possessed a master's degree or license since 2018. In 2019 we have only been able to hire individuals with bachelor's degrees and no experience or minimal experience to fill clinical positions. ***Georgianne Broughton, Executive Director, Community Resource Center***

Since the budget impasse we have seen turnover numbers or vacancies that we are unable to fill at records rates. Some behavioral healthcare positions have a 60% turnover and some positions have been vacant for over 1 year. ***Sherrie L. Crabb, MS, QMH, Chief Executive Officer, Family Counseling Center, Inc***

We currently have over 50 full and part-time clinical positions open with very few applicants causing waitlists in many of our programs. **Joan Hartman, Vice President of Strategy & Innovation, Chestnut Health Systems**

Without workforce development initiatives, access to treatment will remain elusive for millions because there are simply not enough workers. **Heather O'Donnell, Vice President of Public Policy and Advocacy, Thresholds**

The quotes listed above are from community behavioral health providers and stakeholders across the state of Illinois. Behavioral health workforce shortages, which have been a major concern in Illinois for decades, have gained a greater sense of urgency as demand for behavioral health services grows. The Illinois behavioral health workforce situation is at a crisis state and the lack of a behavioral health strategy is exacerbating the problem.

During the spring 2018 legislative session, a bipartisan group of 10 legislators, led by Representatives Lou Lang and Tom Demmer, sponsored a resolution, HR 711, which declared that Illinois is suffering from a Behavioral Healthcare Workforce Emergency. The resolution declaring a workforce emergency was unanimously adopted by House lawmakers. House lawmakers are correct, and the emergency has escalated to a crisis. In fact, the statistics are blinking red.

That legislation was followed by SB 1165 (Public Act 101-0202) which received unanimous support in both chambers and was signed into law by Governor Pritzker on August 2, 2019. The law called for the creation of a Behavioral Health Workforce Education Center Task Force (Task Force). The law mandated the Task Force:

- to study the concepts presented in House Bill 5111, as introduced, of the 100th General Assembly,

- to gather data, receive stakeholder input,
- to consider the fiscal means by which the General Assembly might most effectively fund implementation of the concepts presented in House Bill 5111, and
- to submit its findings and recommendations to the Illinois General Assembly on or before December 31, 2019.

From November 16, 2018 to December 12, 2019, the Task Force held monthly video conference and teleconference calls to receive input from stakeholders, examine data collected and discuss strategies and recommendations which this report will cover in the following pages. Appendix E compiles the written stakeholder feedback that was shared with the Task Force.

Mental Health America ranks Illinois 29thth in the country in mental health workforce availability based on its 480-to-1 ratio of population to mental health professionals, and the Kaiser Family Foundation estimates that only 23.3% of Illinoisans' mental health needs can be met with its current workforce. Long wait times for appointments with psychiatrists—4 to 6 months in some cases— high turnover, and unfilled vacancies for social workers and other behavioral health professionals have eroded the gains in insurance coverage for mental illness and substance use disorder (SUD) under the Affordable Care Act (ACA) and parity laws. Illinois faces a statewide crisis in behavioral health access due to its inadequate workforce capacity.

Fueled by the growing opioid epidemic, drug overdoses have now become the leading cause of death nationwide for people under the age of 50. According to the Illinois Department of Public Health, opioid overdoses have killed nearly 11,000 people in Illinois since 2008. Just last year, nearly 2,000 people died of overdoses—almost twice the number of fatal car accidents. Beyond these deaths are thousands of emergency department visits, hospital stays, as well as the pain suffered by individuals, families, and communities. The Department also notes that the opioid epidemic is the most significant public health and public safety crisis facing Illinois.

Shortages are especially acute in rural areas and among low-income and under-insured individuals and families. 30.3% of Illinois' rural hospitals are in designated primary care shortage areas and 93.7% are in designated mental health shortage areas. Nationally, 40% of psychiatrists work in cash-only practices, limiting access for those who cannot afford high out-of-pocket costs. Community mental health centers have long argued that low Medicaid reimbursement rates limit capacity and do not allow for expanding access to services or cover the costs of recruiting and retaining teams for evidence-based behavioral health practices like Assertive Community Treatment.

Insufficient numbers of behavioral health professionals, the absence of an action plan on behavioral health workforce development, inadequate training in evidence-based practices,

and the resulting restrictions on access to high-quality, community-based behavioral health services, were the key motivating factor for creating the Illinois Behavioral Health Workforce Education Center Task Force.

Inspired by the experience of Nebraska, which created the Behavioral Health Education Center of Nebraska (BHECN) in 2009 to build a pipeline for behavioral health professionals and to anchor research and education for behavioral health workforce development, the Illinois General Assembly charged the Task Force with studying the following concepts, which are described in more detail in the legislative language attached as Appendix A1 and A2.

- increasing the number of medical residents in psychiatry training in rural or other underserved areas,
- increasing the number of internships in rural or underserved areas for psychology, social work, and clinical professional counseling students,
- improving training of behavioral health professionals in telehealth techniques,
- improving geographic and demographic analysis of the Illinois behavioral health workforce, and
- developing tools to prioritize behavioral workforce development needs by type and location.

The Task Force identified models that an Illinois Behavioral Health Workforce Education Center could replicate to meet the needs described in each concept, which are summarized in the table in Appendix B.

In addition to these concepts for behavioral health workforce development, the Task Force explored the need to grow capacity in all the behavioral health disciplines, including in peer recovery and other non-traditional behavioral health roles. In addition to increasing the number of certified peer recovery specialists, the Task Force investigated barriers to optimal integration of peers into care teams and to career advancement within the peer workforce. BHECN includes peer support specialists in its interdisciplinary training sites and sponsors an annual peer support conference, both of which Illinois could consider replicating.

An Illinois Behavioral Health Workforce Education Center, organized as a consortium of universities in partnerships with providers, school districts, law enforcement, consumers and their families, state agencies, and other stakeholders could begin laying the foundations to implement these concepts in every region of the state. However, the Task Force notes two challenges to confronting the workforce crisis in Illinois:

- Workforce data collection is not equipped for dynamic workforce planning and development. Filling-in crucial missing values in existing datasets and better utilizing

data analytics is key to accurately assessing behavioral health needs in different regions of the state and to guiding workforce development decisions;
- Responsibility for the behavioral health workforce is dissipated among many different agencies, with no one entity responsible for the workforce planning that is essential for other behavioral health reforms to succeed.

This report describes these challenges in more detail. Both could be overcome by a dedicated Workforce Center that would leverage the research and education strengths of Illinois public university systems along with the commitment and experience of health care service providers throughout the state. The Task Force therefore recommends that Illinois establish an Illinois Behavioral Health Workforce Education Center that would fulfill the following vision and responsibilities:

An Illinois Behavioral Health Workforce Education Center will improve the ability of all state residents to achieve their human potential and to live healthy, productive lives by reducing the misery and suffering of unmet behavioral health needs. It will be responsible for developing and implementing a strategic plan for the recruitment, education, and retention of a qualified, diverse, and evolving behavioral health workforce in the State of Illinois.
Its planning and activity will include,

1. convening and organizing that brings together vested stakeholders spanning government agencies, clinics, behavioral health facilities, hospitals, schools, jails, prisons and juvenile justice, and police and emergency medical services,
2. collecting and analyzing data on the behavioral health workforce in Illinois with detailed information on specialties, credentials, and additional qualifications (such as training or experience in particular models of care), location of practice, demographic characteristics (including age, gender, race and ethnicity, and languages spoken),
3. building partnerships with school districts, institutions of higher education, and workforce investment agencies to create pipelines to behavioral health careers from high schools and colleges; pathways to behavioral health specialization among health professional students; and expanded behavioral health residency and internship opportunities for graduates,
4. evaluating and disseminating information about evidence-based practice emerging from research regarding promising modalities of treatment, care coordination models and medications;
5. developing systems for tracking utilization of evidence-based practices that most effectively meet behavioral health needs, and
6. providing technical assistance to support professional training and continuing education programs that provide effective training in evidence-based behavioral health practices.

Early in the process, the Task Force fully understood that in order to begin to solve the behavioral health workforce crisis in Illinois, there would have to be a variety of inter-related solutions. While this report recommends and makes the case for the creation of an Illinois Behavioral Health Workforce Education Center as one component of an Illinois Behavioral Health Workforce Strategy, the Task Force also recommends:

1. **Establishing resources to develop an infrastructure** available to support and coordinate behavioral health workforce development efforts,
2. **Establishing new financing systems** that considers the cost of providing services and enables employee compensation commensurate with required education and levels of responsibility.
3. **Funding the Community Behavioral Health Care Professional Loan Repayment Program Act (HB 5109- 100-0882) and The Psychiatric Access Incentive Act.**
4. **Broadening the Concept of "Workforce" –** The state should expand the capacity in peer recovery and other non-traditional behavioral health roles and should authorize community-based agencies with certified peer specialists to bill for certain Medicaid substance use and mental health services.
5. **Expanding programs, like telehealth and crisis intervention**, that can extend the reach of the existing workforce.
6. **Leveraging the requirements of consent decrees and settlement agreements** for specific populations in need of behavioral health care to accelerate workforce development and collect more actionable data.

There are many organizations and institutions that are affected by behavioral health workforce shortages but no one entity is responsible for monitoring the workforce supply and intervening to ensure it can effectively meet behavioral health needs throughout the state. Beginning with the proposed Illinois Behavioral Health Workforce Education Center, Illinois has the chance to develop a blueprint to be a national leader in behavioral health workforce development.

The Task Force would like to thank Optum Health for underwriting this report and we thank the members of the Illinois General Assembly for your support and consideration that a Behavioral Health Workforce Strategy is needed in order to thwart the escalating behavioral health workforce crisis that Illinois is experiencing.

I. INTRODUCTION

The behavioral health community in Illinois has been raising the alarm on a workforce crisis for years. Estimates of unmet need consistently highlight the dire situation in Illinois. Over 4.8 million Illinoisans (38%) live in a designated mental health shortage area[1]; community behavioral health centers spend months to fill vacancies for psychologists and social workers; and waitlists for services at understaffed agencies stymie attempts to divert individuals from criminal justice involvement or prevent manageable behavioral health symptoms from becoming disabling conditions. Research from the University of Southern California's Leonard Schaeffer Center for Health Policy and Economics showed a 23% decrease in the number of behavioral health care professionals per 10,000 Illinois residents between 2016 and 2018.[2] Mental Health America ranks Illinois 29th[th] in the country in mental health workforce availability based on its 480-to-1 ratio of population to mental health professionals,[3] and the Kaiser Family Foundation estimates that only 23.3% of Illinoisans' mental health needs can be met with its current workforce.[4]

Counts and growth trends of licensed workers point toward the severity of the problem, but the *distribution* of the behavioral health workforce drives the crisis as well. "Behavioral health services" is an expansive category that includes a broad array of services across a continuum of prevention, crisis intervention, treatment, and recovery support, provided in diverse settings located in urban, suburban, and rural geographies to patients of every possible combination of race, ethnicity, wealth, and insurance status. Understanding the workforce needs of such a complex system is itself a daunting task. To demonstrate the inadequacy of simply comparing workforce supply to estimated demand for services consider that, nationally, 40% of psychiatrists work in exclusively cash-only practices,[5] making counts of licensed psychiatrists a poor indicator of access for low- and middle-income people.

Although we may speak in terms of supply and demand, there is no market mechanism to deploy the available workforce to efficiently meet the demand of the people and places with urgent unmet behavioral healthcare needs. Stubborn imbalances in supply and demand in the behavioral health workforce produces the intransigent shortages for rural and low-income

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[1] Kaiser Family Foundation (2019, September 30). State Health Facts: Provider & Service Use Indicators: Health Professional Shortage Areas. Retrieved on December 5, 2019 from https://www.kff.org/state-category/providers-service-use/health-professional-shortage-areas/

[2] "Seabury, S. (2019). *The Cost of Mental Illness: Illinois Facts and Figures, 2019 Update.* PowerPoint presented to the Illinois Behavioral Health Workforce Education Center Task Force. Chartbook available at http://healthpolicy.usc.edu/Keck_Schaeffer_Initiative.aspx

[3] Mental Health America (2019). *Mental Health in America--Access to Care Data, Mental Health Workforce Availability 2020.* https://www.mhanational.org/issues/mental-health-america-access-care-data

[4] Kaiser Family Foundation (2019, September 30). State Health Facts: Provider & Service Use Indicators: Health Professional Shortage Areas.

[5] National Council for Behavioral Health Medical Directors Institute (2017). The Psychiatric Shortage: Causes and Solutions. Retrieved July 1, 2019 from https://www.thenationalcouncil.org/wp-content/uploads/2017/03/Psychiatric-Shortage_National-Council-.pdf

populations. Healthcare employers in rural areas desperately need behavioral health staff but cannot offer incentives necessary to attract new hires. The Medicaid population's growing *need* for behavioral health services does not translate into *demand* that can generate a supply of providers entering the Medicaid market. Workforce shortages persist and even worsen as the need for services grows.

Providers, consumers, and advocates have offered anecdotal evidence of other particularly urgent workforce shortages. Spanish speaking therapists in suburban Cook County, as well as in immigrant new growth communities throughout the state, for example, and masters-prepared social workers in rural communities, are especially difficult to recruit and retain. Experts in evidence-based practice raise another worrisome problem, the barriers to uptake of those practices in behavioral health settings which include the cost of retraining in the latest evidence-based practices, the cost of using proprietary programs that require additional fees, and gaps in reimbursement policy for evidence-based practice models. One indicator of this problem, reported by the USC Schaeffer Center, is the high and increasing hospital average length of stay for schizophrenia—longer than the ALOS for kidney transplants, heart attacks, and hip replacement, all of which have decreased by at least 18% from 2000 to 2014. The barriers to access to effective treatments for behavioral health conditions at a time when evidence-based practices produce tangible results for medical-surgical patients highlights the gap in investment training and implementation of innovative behavioral health treatment delivery. This is a national problem, but Illinois approaches it from a weak starting position—our rate of hospitalization for adults with serious mental illness is 1.5 times higher than the rest of the U.S.[6] and long stays in psychiatric hospitals for Illinois children on Medicaid have made national news.[7]

Shortages of qualified staff result in long waiting lists for behavioral health services. Reforms aimed at improving the quality and cost-efficiency of behavioral health care cannot be successful without addressing Illinois' behavioral health workforce crisis. But Illinois lacks systematic tracking of the behavioral health workforce, and what datasets do exist were created for purposes other than supporting workforce planning for an accessible, high-quality behavioral health system. Examples of gaps in available workforce datasets include:

- Datasets for licensed behavioral health professionals, such as social workers and counselors, rarely include breakdowns by specialty or setting, and almost never include information on languages spoken and racial/ethnic identity, both crucial factors in serving Illinois' diverse population, nor do they indicate whether the licensed professional is currently practicing.
- Medicaid provider directories are notorious for being incomplete and inaccurate, eliminating another potential source of workforce supply data.

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[6] Seabury, 19

[7] Eldeib, Duaa (2018, June 5). Hundreds of Illinois Children Languish in Psychiatric Hospitals After They're Cleared for Release. *ProPublica Illinois*. Co-published with *The Atlantic*. Retrieved September 24, 2019 from https://features.propublica.org/stuck-kids/illinois-dcfs-children-psychiatric-hospitals-beyond-medical-necessity/

- National workforce databases compiled by the Bureau of Labor Statistics categorize the labor force by professional classification but cannot reveal shortages or surpluses for specific groups such as Medicaid beneficiaries, or people with limited English proficiency.

Given the complexity of the workforce and the limited information available, both individual decision-making to seek behavioral health services and systemic plans to improve quality and coordination of health care too often end in frustration. Yet it cannot be said that the behavioral health workforce has been ignored. Dozens of public agencies are involved in behavioral health financing and service delivery and have been committed to transforming Illinois' behavioral health system to become more community-based, recovery-oriented, and accountable to quality and cost outcomes. Similarly, state and local workforce investment programs have prioritized health care careers, recognizing the need for a coordinated workforce response to changes in health care delivery. But there is no single entity that is responsible for the workforce planning, training, and deployment that is necessary to support a high-performing behavioral health system.

Another challenge we face is the siloed system for behavioral health care which produces resources that are uncoordinated and inefficient. The goal of integrated physical and behavioral health that Illinois has embraced requires team-based care in which each professional is working at the top of their specific license. Inter-professional teams whose members can recognize when a referral is necessary and make a warm handoff will improve access to care. But building those teams across the silos of behavioral health, physical health, child-serving agencies, and many other parts of a holistic health care system is complex. Even within behavioral health professions, individuals train and practice in very different areas. Counts of 'social workers,' for example, will include advocates, case managers, and therapists in the same category. Similarly, the category of 'psychiatrists' in workforce analysis includes practitioners who spend most of their working hours doing therapy along with those who exclusively perform medication management. Poorly coordinated behavioral health services deploy these different professionals inefficiently, contributing to wasted time and resources, and delaying access to the best possible care from the most appropriately qualified professional for each individual with a behavioral health condition.

Team-based models of care thus carry with them many logistical challenges: disaggregating the distinct skill sets within the behavioral health workforce, measuring Illinois' current capacity to staff teams with the ideal mix of skills, and building pipelines and training programs to optimize the current and future workforce. As we will see, there are many pieces of this puzzle that have been worked out already and can be combined to set Illinois on course to meet the demands for behavioral health care today and in the future.

While these are solvable problems, they require the focused attention of academic, clinical, and governmental partners with a clear accountability for specific behavioral health workforce goals. In 2018, the Illinois General Assembly created the Behavioral Health Workforce Education Center Task Force to study strategies for enhancing the state's behavioral health workforce. The Task Force initially took inspiration from the Behavioral Health Education Center

of Nebraska (BHECN) and its expansion of psychiatry residency positions, doctoral-level psychology, and master's level social work and counseling internships, as well as its interdisciplinary training hubs.

Like Illinois, Nebraska faced workforce shortages and gaps in workforce planning capacity that impeded its vision for behavioral health reform. Nebraska's leadership recognized that while shortages were the most visible problem affecting the behavioral health workforce, their effect rippled throughout the delivery system. Behavioral health providers struggling with unfilled vacancies and high turnover cannot devote crucial time and energy to training and implementing evidence-based practices and innovative integrated care models, for example. Their solution, BHECN, is designed to support

(1) **Education** to appropriately train an adequate supply of behavioral health professionals
    - expanding psychiatry residencies, master's and doctoral-level internships in social work, counseling, and psychology, and post-graduate training
(2) **Service** to ensure access to a high-quality, evidence-based continuum of care
    - developing a network of behavioral health interdisciplinary training sites that disseminate best practices in evidence-based, recovery-oriented, team-based services
(3) **Research** to support evaluation, resource allocation, business development, and quality improvement in the behavioral health workforce
    - analyzing workforce availability and prioritizing workforce development need by type and location

From this starting point, the Task Force consulted subject matter experts and compiled stakeholder feedback to develop recommendations for behavioral health workforce development in Illinois. As described in detail below, the Task Force distilled its findings into three categories of behavioral health workforce needs, each of which could be addressed by programs similar to those implemented by BHECN. Those categories are:

- gaps in workforce data,
- shortages of behavioral health professionals and uneven distribution and access across the state, and
- barriers to training and consistent use of evidence-based practices.

These problems affect every Illinois county, every group of people with behavioral health needs--including children and adolescents, justice-involved populations, working adults, people experiencing homelessness, veterans, and older adults—and every health care and social service settings from residential facilities and hospitals to community-based organizations and primary care clinics. These issues resemble the workforce concerns that motivated Nebraska to create BHECN, but the scale of these needs is vastly greater in Illinois, whose largest city has more residents than the entire state of Nebraska. Therefore, the Task Force considered the potential for replicating the conceptual framework of BHECN but also examined methods to phase-in similar activities for Illinois' markedly different demographics. Based on its work, the Task Force proposes the vision statement and articulation of goals below. This report summarizes the Task Force's findings and presents their recommendations for a Behavioral

Health Workforce Education Center in Illinois that can accomplish these goals and contribute to improvements in behavioral health for all Illinois residents.

Vision Statement for an Illinois Behavioral Health Workforce Education Center

An Illinois Behavioral Health Workforce Education Center will improve the ability of all state residents to achieve their human potential and to live healthy, productive lives by reducing the misery and suffering of unmet behavioral health needs. It will be responsible for developing and implementing a strategic plan for the recruitment, education, and retention of a qualified, diverse, and evolving behavioral health workforce in the State of Illinois.

Its planning and activity will include,

1. convening and organizing that brings together vested stakeholders spanning government agencies, clinics, behavioral health facilities, hospitals, schools, jails, prisons and juvenile justice, and police and emergency medical services,
2. collecting and analyzing data on the behavioral health workforce in Illinois with detailed information on specialties, credentials, and additional qualifications (such as training or experience in particular models of care), location of practice, demographic characteristics (including age, gender, race and ethnicity, and languages spoken),
3. building partnerships with school districts, institutions of higher education, and workforce investment agencies to create pipelines to behavioral health careers from high schools and colleges; pathways to behavioral health specialization among health professional students; and expanded behavioral health residency and internship opportunities for graduates,
4. evaluating and disseminating information about evidence-based practice emerging from research regarding promising modalities of treatment, care coordination models and medications;
5. developing systems for tracking utilization of evidence-based practices that most effectively meet behavioral health needs, and
6. providing technical assistance to support professional training and continuing education programs that provide effective training in evidence-based behavioral health practices.

II. BEHAVIORAL HEALTH WORKFORCE DATA—PROBLEMS AND OPPORTUNITIES

To effectively respond to the immediate workforce crisis and lay a foundation to anticipate and prepare for future changes in behavioral health care needs and service delivery, Illinois must have timely and usable data on the behavioral health workforce. This section summarizes the Task Force's findings with respect to data *policy*. Specific data points on behavioral health workforce shortages are discussed in the next section. Here we focus on a way forward to develop data collection and analysis that can support behavioral health workforce planning in Illinois. The Task Force strongly recommends that these data and planning functions be housed in an Illinois Behavioral Health Workforce Education Center that can coordinate research, planning, and education efforts across the state.

Key Takeaways

- State-level data tend to be collected for purposes other than workforce planning, such as licensure oversight, and therefore do not capture critical factors about the actual practice of health care professionals in Illinois.
- National workforce data sources that are designed to support workforce development are also missing important information, like what proportion of the workforce that accepts insurance, and assessments of national data sources raise concerns about the reliability of the occupational classifications they use in behavioral health workforce projections.
- Workforce data dashboards developed by other states, including Nebraska and Indiana, can serve as models for Illinois to create accurate, actionable data that support strategic behavioral health workforce planning.

The Annapolis Coalition on the Behavioral Health Workforce's 2007 Action Plan for Behavioral Health Workforce Development decried the lack of uniform collection methods and absence of benchmarks in workforce data.[8] In 2019 Illinois still shows signs of those fundamental data weaknesses. We know that provider shortages and barriers to access are at crisis levels because indicators are flashing red from other sources—hospital utilization data, where emergency department visits, hospital admissions and readmissions, and length of stay all remain stubbornly high for behavioral health conditions, and law enforcement data showing a disproportionate number of those arrested and incarcerated have a behavioral health condition[9], to give two examples.

[8] Annapolis Coalition on the Behavioral Health Workforce (2007), *An Action Plan for Behavioral Health Workforce Development*. Prepared for the Substance Abuse and Mental Health Services Administration (Contract Number 280-02-0302). http://annapoliscoalition.org/wp-content/uploads/2013/11/action-plan-full-report.pdf

[9] Seabury, 23-24

We also know that Illinois lags behind the U.S. average for availability of behavioral health professionals.[10] But as the University of Southern California Schaeffer Center for Health Care Policy & Economics is careful to point out in its analysis of the Illinois behavioral health workforce, the U.S. average is merely an arithmetic mean, not a validated benchmark for adequate workforce supply.[11] Other statistical models that attempt to estimate workforce supply shortfalls by comparing supply and demand produce vastly different results, which "reflects the difficulties in collecting and projecting accurate supply data to address workforce capacity issues."[12] More than a decade since the Annapolis Coalition's call to action on workforce data, the existing datasets for the behavioral health workforce are still woefully inadequate to guide policy- and practice-level responses to improve access to services.

Other states that the Task Force has looked to for lessons in workforce development have also identified improving data collection and analysis as "foundational"[13] to their work and have prioritized diverse areas for data-improvement:

- **Nebraska**: Building a Statewide Behavioral Health Workforce Dashboard, a tool to analyze and map behavioral health professionals by license and prescriber status, age, gender, race, urban/rural geography, patient age, and language interpretation capacity.[14]
- **Indiana**: Leveraging new "data-dedicated" state agency, the Management Performance Hub, to build an Education and Workforce Development database that links data across state education, workforce development, and health care agencies to facilitate education-to-workforce pipelines and pathways.[15]
- **Wisconsin and Indiana**: Reducing licensing fees and streamlining license renewal process to collect more actionable information while reducing the administrative burden on practicing professionals.[16, 17]

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[10] Mental Health America (2019). *Mental Health in America--Access to Care Data, Mental Health Workforce Availability 2020.*

[11] Seabury, 12

[12] Beck, A.J., Singer, P.M., Buche, J., Manderscheid, R.W., & Buerhaus, P. (2018). Improving Data for Behavioral Health Workforce Planning: Development of a Minimum Data Set. *American Journal of Preventive Medicine.* 54, S192-S198. https://www.ajpmonline.org/article/S0749-3797(18)30067-9/fulltext

[13] Donlon, R. & Williams, N. (2018). Case Study: How Alaska Addresses Its Health Care Workforce Challenges. National Academy for State Health Policy. https://nashp.org/wp-content/uploads/2018/11/AK-Workforce-Case-Study.pdf

[14] Behavioral Health Education Center of Nebraska (2019). Nebraska Behavioral Health Workforce Dashboard. https://app1.unmc.edu/publichealth/bhecn/

[15] State of Indiana (2019). Education and Workforce Development Database. https://www.in.gov/mph/917.htm

[16] Purington, K. & Williams, N. (2018). Case Study: How Alaska Addresses Its Health Care Workforce Challenges. National Academy for State Health Policy. https://nashp.org/wp-content/uploads/2018/11/IN-Workforce-Case-Study.pdf

[17] Fanin, C. (2019, August 29). Wisconsin Reduces Licensing Fees for Nearly 75% of Licensed Occupations [Blog post]. The Council of State Governments. Retrieved September 9, 2019 from https://knowledgecenter.csg.org/kc/content/wisconsin-reduces-licensing-fees-nearly-75-licensed-occupations

- **North Carolina** Child Treatment Program: developing a provider roster with detailed information on competencies in specialized models for children's behavioral health[18]
- **Michigan**: The Behavioral Health Workforce Research Center at the University of Michigan, sponsored by the Health Resources and Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration (SAMHSA), developed standardized Minimum Data Sets and Standard Operating Procedures Reports for specific segments of the behavioral health workforce to track their size, composition, function, and location, but notes the need for personnel dedicated to workforce planning activities, including systematic monitoring of the workforce supply and practice characteristics.[19]

Illinois State Workforce Data

The Task Force collected Illinois-specific workforce data and invited subject matter experts to present their behavioral health workforce research and their perspectives on the state of workforce data.

State data on behavioral health workforce supply

The Task Force requested and received counts of behavioral health professionals by county from the Illinois Department of Financial and Professional Regulation (IDFPR). While these data give a rough indication of where licensed professionals may practice, there are major weaknesses in this dataset as a workforce planning tool.

- Licensed physicians are not reported by specialty, so specific counts of psychiatrists by county are not possible, nor are counts of crucial sub-specialists such as child/adolescent psychiatrists and geriatric psychiatrists
- A professional with a license is not necessarily a practicing clinician, and the licensure database records active licenses but cannot report whether a licensee is practicing, nor can it show whether an active practitioner accepts public or private insurance or whether they are accepting new patients, all important factors for measuring access to care
- Licensure databases also do not collect information on demographic characteristic that are important to people seeking services, such as languages spoken, race and ethnicity, and sex and gender

A table of IDFPR data analyzed by the Task Force is in Appendix C.

The Task Force also requested and received data on credentials of Illinois behavioral health professionals, such as certifications for peer recovery support and drug counseling, from the Illinois Certification Board of the Illinois Alcohol and Other Drug Abuse Professional Certification Association (see Appendix D). The counts of credentialed professionals share many of the same problems as the licensure database, though breakdowns by age, race, and sex are available. A

[18] North Carolina Child Treatment Program (2019). Provider Roster. https://www.ncchildtreatmentprogram.org/program-roster/

[19] Beck, S196

subject matter expert from the Department of Human Services, Division of Substance Use Prevention and Recovery (SUPR) pointed out that counts of credentialed providers in this dataset were not for unique individuals, and the many professionals who hold multiple credentials are included, and counted, under multiple categories. This means that the total figures may overestimate the available workforce but, like the licensure data, the Certification Board data do not account for credentialed individuals who are no longer actively practicing. While the Certification Board's data highlight the SUD workforce crisis--new certifications are declining while the current workforce is aging--the number of credentials issued in Illinois is a poor predictor of access to care.

In addition to licensure and credentialing databases, the Illinois Department of Healthcare and Family Services collects data on Medicaid-enrolled providers, and Medicaid managed care organizations are required to maintain provider directories. Commercial insurers and Medicare Advantage plans also compile provider directories. However, all of these insurer provider directories have received criticism (and sometimes threats of fines) nationally and in Illinois for errors and outdated information regarding provider location and availability for new clients.[20]

One notable weakness in these state datasets on behavioral health workforce supply is that none of them were built for the purpose of workforce planning. The IDFPR and Certification Board databases are maintained to enforce licensure and certification rules, and Medicaid provider data are designed more for oversight of state contractors than for monitoring trends and needs in the overall health workforce. There is progress in SUD workforce data collection that Illinois can build on to create up-to-date, actionable data tools. SUPR and the Illinois Department of Public Health (IDPH) Opioid Data Dashboard, for example, tracks prescribers who are trained to deliver Medication-Assisted Therapy for opioid use disorders and provides an interactive map of MAT sites.[21] A more deliberate and comprehensive approach is necessary, however, to support a strategic workforce plan that can reverse the current crisis in the entire behavioral health system.

The gaps noted above do not reflect a failure of any particular dataset as much as a shortcoming in the overall workforce data landscape. Since "no combination of data sources provides adequate data across the field of behavioral health,"[22] filling those gaps will require a concerted effort to build a consistent, standardized data collection and workforce monitoring system for Illinois.

[20] Availity (2016). The Provider Directory Dilemma: Why fixing bad provider data is more difficult and more important than ever. https://www.ahip.org/wp-content/uploads/2016/09/The-Provider-Directory-Dilemma-Availity.pdf

[21] Illinois Department of Public Health (2019). Opioid Data Dashboard. https://idph.illinois.gov/OpioidDataDashboard/ Accessed December 12, 2019

[22] Beck, S196

State data on behavioral health workforce demand

Measures of demand are necessary to understand the adequacy of workforce supply. Illinois collects data on behavioral healthcare utilization, including hospitalizations and Federally Qualified Health Center (FQHC) encounters, which serve as indicators of both demand for services and unmet need for additional community-based alternatives to emergency departments. The Illinois Department of Public Health and Illinois' not-for-profit hospitals also regularly conduct surveys and assessments of community need that consistently highlight unmet needs for mental health, substance use disorder, and child and adolescent behavioral health services.[23, 24]

Inconsistencies in mental health diagnosis (which could be addressed in workforce education) and reliance on self-reported survey data may limit the usefulness projections of demand, and therefore of conclusions about workforce shortages or surpluses.[25,26] Discipline-specific benchmarks of workforce adequacy and workforce analysis that considers distinct skills, like competency in specific evidence-based practices, are also largely missing for behavioral health. Like measures of workforce supply, estimates of demand for behavioral health services are hampered by the lack of a dedicated workforce-planning purpose guiding data collection and analysis.

National Workforce Data

National Data on Behavioral Health Workforce Supply

Nationally, HRSA exercises leadership in health care workforce development. Direct support through training grants, scholarships and loan repayment programs provides resources for a diverse and well-prepared workforce and HRSA research contributes essential statistics to guide public and private planning.

The HRSA Area Health Resource File combines several datasets to report important characteristics of the behavioral health workforce on national and state levels. A notable strength of HRSA's data collection is the detailed breakdowns of the behavioral health workforce that are not always available from other sources. Using American Community Survey data, HRSA can present breakdowns by age, sex, race and ethnicity—all important for

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[23] Chronicle Media (2015). IDPH assessment shows need for expanded mental health services. Retrieved September 24, 2019 from https://chronicleillinois.com/state-news/idph-assessment-shows-need-for-expanded-mental-health-services/

[24] Healthy Illinois 2021(2016). State Health Assessment. Retrieved September 24, 2019 from http://www.healthycommunities.illinois.gov/documents/State-Health-Assessment-Final-091316.pdf

[25] Seabury, 6-8

[26] See "Strengths and Limitations" in Health Resources and Services Administration (2018). State-Level Projections of Supply and Demand for Behavioral Occupations: 2016-2030. Page 50. https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/hwsm-technical-report-to-dea.pdf

measuring access and diversity—in its U.S. Health Workforce Chartbook. Unfortunately, data on languages spoken remain elusive even in HRSA's research portfolio.

By compiling data from professional associations, like the American Medical Association and the American Association of Nurse Practitioners, HRSA's State-Level Projections of Supply and Demand for Behavioral Health Occupations can show the estimated supply of psychiatrists by specialization in children/adolescents or adults, and can also estimate the supply of nurse practitioners specializing in psychiatry—both common missing pieces in workforce datasets from licensure and credentialing authorities. HRSA's Area Resource File also includes information on practice setting (office or hospital) and practice type (clinical care, administration, teaching, or research). In addition, HRSA collects data on the educational pipeline to behavioral health occupations by analyzing data from the U.S. Department of Education's Integrated Post-Secondary Education System.

HRSA's datasets do have some limitations that an Illinois Behavioral Health Education Workforce Center could work with them to address:

- Like other datasets, HRSA's data does not account for the impact on effective supply of behavioral health professionals who do not accept any insurance, do not accept Medicaid, or are not accepting new patients.
- Standard occupational classifications from the Bureau of Labor Statistics may not be consistent with provider qualifications that are used for insurer credentialing, employer qualifications, or evidence-based integrated health care teams.[27]
    - This points to an important workforce data improvement task: tracking not only the skills and qualifications that are necessary to practice legally but also the special competencies required to implement evidence-based practices for a range of behavioral health conditions and populations. Not every licensed or self-reported social worker, counselor, or psychiatric nurse, for example, has the competencies necessary to participate in an integrated interdisciplinary team, to provide trauma-informed and recovery-oriented services, to serve as care managers for members of managed care organizations,[28] or to provide specific treatment models, such as prolonged exposure therapy for PTSD[29] and medication assisted treatment (MAT) for opioid use disorders.[30] More granular monitoring of the level of training and competency in evidence-based models

[27] Beck, S193

[28] On specific skills needed in interdisciplinary teams and difficulties staffing integrated care teams, see Interprofessional Education Collaborative (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel.* Washington, D.C.; Patel, M.S., Arron, M.J., Sinsky, T.A., Green, E.H., BAker, D.W., Bowen, J.L., Day, S. (2013). *Estimating the Staffing Infrastructure for a Patient-Centered Medical Home. The American Journal of Managed Care.* 19(6), 509-516. https://www.ajmc.com/journals/issue/2013/2013-1-vol19-n6/estimating-the-staffing-infrastructure-for-a-patient-centered-medical-home. On shortages of care managers in managed care, see Government Accountability Office (2019). Medicaid: Efforts to Identify, Predict, or Manage High-Expenditure Beneficiaries. Report number GAO-19-569. https://www.gao.gov/products/GAO-19-569

[29] Watkins, L. Sprang, k, Rathbaum, B. (2018). "Treating PTSD: A Review of Evidence-Based Psychotherapy Interventions". Frontiers in Behavioral Neuroscience. 12: 258.

[30] See https://www.thenationalcouncil.org/mat/ for a review of empirical support for MAT.

within the diverse professionals included in 'the behavioral health workforce' will aid in connecting people to the right kind of services to meet their needs. A systematic analysis of such data can also help push behavioral health workforce development beyond a 'one-size-fits-all' approach and guide allocation of education and training resources toward specific needs for distinct kinds of practice and services.

    - Provider rosters, such as those created by the North Carolina Child Treatment Program, can begin to accomplish this data goal by rigorously assessing skills and informing the public and planners alike of the availability of providers with skills needed to meet particular needs.[31]

- The National Council for Behavioral Health submitted public comments to HRSA expressing concerns about the 2018 behavioral health workforce projections in which they declared, "There are no credible data sources nor national consensus for estimating the supply and demand of behavioral health professionals available to care for children, adolescents, and young adults." The National Council's comments, which were signed by 65 provider, advocacy, and academic organizations, called on HRSA to develop new methods to produce workforce projections for child and adolescent behavioral health.[32]

National Data Behavioral Health Workforce Demand

Accurate measures of both workforce supply and demand for the services provided by the diverse range of behavioral health professionals are necessary to create benchmarks for workforce adequacy. Workforce development depends on reliable forecasts of the optimal number and mix of behavioral health professionals to meet current needs for services and to prepare for changes in need and shifts in modes of service delivery. But missing values on the supply- and demand-side of workforce data turn this optimization problem into guesswork.

Demand estimates for behavioral health services for children, adolescents, and adults are complicated by the absence of an integrated database for behavioral health diagnoses.[33] HRSA's own demand estimates are based largely on survey data—the Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey and the Substance Abuse and Mental Health Services Administration's National Survey on Drug Use and Health.[34] SAMHSA itself releases estimates of unmet need for behavioral health care, and the Kaiser Family Foundation, the Robert Wood Johnson Foundation, and Mental Health America all release rankings of

[31] North Carolina Child Treatment Program (2019). Provider Roster. https://www.ncchildtreatmentprogram.org/program-roster/

[32] Comments on 2018 Behavioral Health Workforce Projections submitted to Health Resources and Services Administration Administrator George Sigounas (2019, April 22). Retrieved September 24, 2019 from https://www.thenationalalliance.org/publications/comments-on-2018-behavioral-health-workforce-projections

[33] Seabury, 6-8

[34] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis (2017). Technical Documentation for HRSA's Health Workforce Simulation Model. https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/hwsm-technical-report-to-dea.pdf

mental health workforce shortages. One common factor that is especially notable from a data-quality perspective is the impact of errors and omissions in estimates of supply and demand on the calculation of benchmarks for workforce adequacy. Improving estimates of demand for behavioral health services is a prerequisite to producing meaningful benchmarks for workforce adequacy. Without such benchmarks, it is difficult to assess the scope of workforce shortages and disparities in distribution or to measure the impact of workforce policy.

Next Steps for Behavioral Health Workforce Data Collection

Despite the limitations and gaps, Illinois has access to many resources for understanding the behavioral health workforce. Yet, we do not have a complete dataset that can guide long-term planning and workforce development. HRSA's workforce programs and research are invaluable to State governments and behavioral health care employers. However, given the complexity of the behavioral health care sector and the variance of local workforce conditions, a strong State partner is crucial to combine, expand, improve, and effectively utilize the data and tools available for workforce development in every Illinois community. An Illinois Behavioral Health Workforce Education Center can be that partner to build on the national leadership of HRSA and the energy of Illinois state agencies to transform the behavioral health system.

In the medium- to long-term a Center could develop Illinois behavioral workforce data capacity by:

- filling gaps in workforce data by collecting information on specialty, training and qualifications for specific models of care, demographic characteristics (gender, race, ethnicity, languages spoken), and participation on public and private insurance networks,[35]
- identifying the highest priority geographies, populations, and occupations for recruitment and training,
- monitoring the incidence of behavioral health conditions to improve estimates of unmet need,
- compiling up-to-date evidence-based practices, monitoring utilization, and aligning training resources to improve uptake of the most effective practices.

[35] For recommendations on improving data collection during licensure and re-licensure processes, see Health Workforce Technical Assistance Center (2016). Collaborating with Licensing Bodies in Support of Health Workforce Data Collection: Issues and Strategies. https://www.chwsny.org/wp-content/uploads/2016/06/HWTAC_TA-to-States_Brief.pdf

III. BEHAVIORAL HEALTH WORKFORCE SHORTAGES—EVIDENCE AND PATHS FORWARD

In addition to identifying shortcomings and solutions for Illinois workforce data collection, the Task Force drew on available research and subject matter expertise to illuminate the state of workforce shortages and maldistribution. Throughout this work, the Task Force compiled examples of replicable models for correcting these shortages and imbalances. This section presents those findings, with special attention to specific sub-sectors and populations in the behavioral health ecosystem—children and adolescents, older adults, justice-involved populations, people with co-occurring substance use and mental health disorders, and rural communities.

Key Takeaways

- Across the lifespan, a significant proportion of people with mental illness and substance use disorders go untreated, and long delays in diagnosis are common.
- Workforce shortages are evident in all behavioral health professions, including psychiatry, psychiatric nursing, social work, counseling, psychology, and peer support.
- Providers in Illinois have implemented practice-level initiatives to address workforce shortages and replicable models in other states exist to extend the current workforce and expand pipelines for future behavioral health professionals.
- Workforce shortages are more complex than simple numerical shortfalls. Identifying the optimal number, type, and location of behavioral health professionals to meet the differing needs of Illinois diverse regions and populations across the lifespan is a difficult logistical problem at the system- and practice-level that requires coordinated efforts in research, education, service delivery, and policy.

The significance of behavioral health workforce shortages is in the unmet need for services that they represent—a shortage exists when the amount of need exceeds the capacity of the workforce to provide effective services. Workforce shortages also create especially strong disincentives to seek care for people in the early stages of mental illness or substance use disorder. People experiencing psychological distress must overcome pervasive and powerful stigmas in order to even ask for help, and if a provider is not readily accessible, these individuals may forego care until a crisis compels an emergency response. But such high acuity in persons with behavioral health conditions drives both costs and provider burnout, which add pressure to an already over-burdened behavioral health system. The shortfall in the behavioral health workforce, therefore, is not only a problem in its own right but also creates cumulative damage to the performance of the entire behavioral health system.

As is the case with behavioral health workforce data issues, there are many organizations and institutions that are affected by workforce shortages but no one entity is responsible for monitoring the workforce supply and intervening to ensure it can effectively meet behavioral health needs throughout the state. Prioritizing the workforce needs outlined below will require

additional data analysis and collaborative planning on the part of providers, educational institutions, and other stakeholders. This coordinating role could be filled by an Illinois Behavioral Health Workforce Education Center that can convene cross-sector partners from education, behavioral health delivery and financing, and workforce development.

We begin by briefly describing the unmet need for behavioral health services in Illinois and the forces expected to affect demand for services. We then summarize the Task Force's findings on workforce supply and describe strategies to support recruitment and retention. The next section will address the qualitative side of workforce shortages by detailing problems and potential solutions related to the uptake of evidence-based practice in Illinois' behavioral health system.

Unmet Need for Behavioral Health Services

Approaches to measuring the need for behavioral health services differ based on the perspectives and goals of the research. Some studies focus on the prevalence of those mental illness diagnoses that generate the highest costs while others consider a broad range of self-reported psychological distress, serious mental illness, and substance use. But while methodologies differ, what data we have indicates serious unmet need throughout Illinois and within specific populations.

Estimates of unmet behavioral health care needs:

- In a 2017 survey 29% of Illinois adults who had experienced serious psychological distress in the past year reported unmet need and 33% of those respondents cited unaffordable costs as the reason for not receiving care.[36]
    - 45.8% of the 1.6 million Illinois adults who have experienced a mental illness did not receive treatment.[37]
- An annual average of 799,000 people in Illinois aged 12 and older need but do not receive substance use disorder treatment at specialty facilities.[38]
- National research indicates that only 9.1% of adults with co-occurring mental health and substance use disorders receive care for both and 52.5% received neither mental health care nor substance use treatment.[39]
- Unmet need among youth:

[36] Substance Use and Mental Health Services Administration (2019). Behavioral Health Barometer: Illinois, Volume 5: Indicators as measured through the 2017 National Survey on Drug Use and Health and the National Survey of Substance Abuse Treatment Services. HHS Publication No. SMA-19-Baro-17-IL. Retrieved September 30, 2019 from https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/Illinois-BH-BarometerVolume5.pdf

[37] Substance Use and Mental Health Services Administration (2019).

[38] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality (2019). National Surveys on Drug Use and Health: Model-Based Estimated Totals (in Thousands) (50 States and the District of Columbia) (Excel). Table 26. Retrieved July 11, 2019 from https://www.samhsa.gov/data/report/2016-2017-nsduh-state-specific-tables

[39] Han, Beth, Wilson M. Compton, Carlos Blanco, Lisa J. Colpe. (2017, October). Prevalence, Treatment, and Unmet Treatment Needs of US Adults with Mental Health and Substance Use Disorders. *Health Affairs, 36(10)*. https://doi.org/10.1377/hlthaff.2017.0584

- Only 38.9% of the 121,000 Illinois youth aged 12-17 who experienced a major depressive episode received care.[40, 41]
- 7.7% of people in Illinois over the age of 12 and 15.8% of young adults aged 18-25 have a substance use disorder.[42]
- Mental Health America estimates that over half of Illinois youth with depression receive no services and that three quarters of youth with severe depression do not receive consistent treatment.[43]
- 90% of youth attend a public school that fails to meet minimum recommended ratios for counselors, social workers, psychologists, or nurses.[44]

- Unmet need in the criminal justice system:
  - People who report experiencing serious psychological distress are more likely to be arrested, to be on probation, and to be incarcerated.[45]
  - Less than half of jail inmates with a diagnosed serious mental illness receive medication and less than a quarter receive counseling.[46]
  - A federal court monitor overseeing the *Rasho v Baldwin* settlement found delays in treatment and backlogs in psychiatric evaluations driven largely by shortages of psychiatrists and other behavioral health staff.[47, 48]
- Unmet need among older adults:
  - Nearly 1 in 5 adults age 65 and over have one or more mental health or substance use disorder.[49]
  - Between 2013 and 2019, depression in adults aged 65 and older increased from 13.4% to 14.5% in Illinois.[50]

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[40] Substance Use and Mental Health Services Administration (2019). Behavioral Health Barometer.

[41] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality (2019). National Surveys on Drug Use and Health: Model-Based Estimated Totals (in Thousands) (50 States and the District of Columbia) (Excel). Table 31.

[42] Substance Use and Mental Health Services Administration (2019). Behavioral Health Barometer.

[43] Illinois Children's Mental Health Partnership (2019). FY2019 Annual Report to the Governor. Page 6. Retrieved October 4, 2019 from http://icmhp.org/wordpress/wp-content/uploads/2019/10/FY2019-ICMHP-Annual-Report-Electronic.pdf

[44] Illinois Children's Mental Health Partnership (2019), Page 41.

[45] Seabury, 23

[46] Seabury, 24

[47] Uptown People's Law Center (nd). Rasho V. Baldwin. Retrieved September 24, 2019 from https://www.uplcchicago.org/what-we-do/prison/rasho-v-baldwin.html

[48] Brady-Lunny, Edith (2019, May 31). Monitor: Low staffing hinders progress for mentally ill inmates. *The Pantagraph.* Retrieved September 24, 2019 from https://www.pantagraph.com/news/state-and-regional/crime-and-courts/monitor-low-staffing-hinders-progress-for-mentally-ill-inmates/article_86a86d90-c389-59e4-8403-aff692882c76.html

[49] The Institute of Medicine of The National Academies (2012). The Mental Health and SUD Workforce for Older Adults: In Whose Hands? Report Brief. Retrieved November 7, 2019 from www.nationalacademies.org/hmd/~/media/Files/Report Files/2012/The-Mental-Health-and-Substance-Use-Workforce-for-Older-Adults/MHSU_olderadults_RB_FINAL.pdf

[50] United Health Foundation (2019). America's Health Rankings: Senior Report. Page 57 Retrieved November 7, 2019 from https://assets.americashealthrankings.org/app/uploads/ahr-senior-report_2019_final.pdf

    - While most health care workers, including behavioral health specialists, encounter older adults in their practice, few are trained in geriatric mental health and SUD prevention and treatment:
        - Only 4.2% of psychologists surveyed by the American Psychological Association reported geropsychology as their primary focus, but 39% reported delivering services to older adults.[51]
    - Most older adults are insured through Medicare, but its reimbursement rules deter access to psychiatric consultation during primary care visits.[52]
- Unmet need in rural areas:
    - Rural counties in Illinois have an average of 1.6 psychiatrists per 100,000 residents compared to 12.6 in large urban counties and 10.5 in the state overall.[53]
    - Rural counties have an average of 45.5 primary care physicians per 100,000 residents compared to a state average of 80.7.[54]
    - 30.3% of rural hospitals are in designated primary care shortage areas and 93.7% are in designated mental health shortage areas.[55]
    - One rural community mental health center reported that they have not been able to hire master's level or licensed staff for clinical positions at all since 2018.
        - Hiring bachelor's level staff imposes extra supervisory duties on existing master's level clinicians, further depleting staff time for patient services. Lacking license-holders on staff also reduces service capacity and prevents the center from billing Medicare and commercial insurance.[56]
    - The Illinois State Budget impasse from 2015 to 2017 exacerbated existing rural workforce shortages:
        - Since the budget impasse, rural behavioral health providers have reported turnover as high as 60% and one-year delays in hiring for vacant positions.[57, 58]
        - Rural providers report being less able to absorb the cost of the state minimum wage increase, given current reimbursement rates from state

[51] Terri Huh, J.W., Rodriguez, R., Gould, C.E., Brunskill, S.R., Melendez, L., & Josea Kramer, B. (2018). Developing a program to increase geropsychology competencies of Veterans Health Administration psychologists. *Gerontology and Geriatrics Education.* https://doi.org/10.1080/02701960.2018.1491402

[52] The Institute of Medicine of the National Academy (2012), 2

[53] Illinois Rural Health Summit Planning Committee (2018). The State of Rural Health in Illinois: Great challenges and a path forward.

[54] Illinois Rural Health Summit Planning Committee, 3

[55] Illinois Rural Health Summit Planning Committee, 2

[56] Email from Georgianne Broughton of Community Resource Center to Marvin Lindsey of the Community Behavioral Healthcare Association of Illinois, December 2, 2019

[57] Email from Sherrie Crabb, Family Counseling Center, Vienna to Marvin Lindsey, November 26, 2019

[58] Illinois Partners for Human Services (2019). The Relationship Between Low Wages, Employee Turnover and Community Well-Being. Retrieved November 26, 2019 from http://www.illinoispartners.org/wp-content/uploads/2019/10/ILP_FullReport.pdf.

programs and the lasting impact of the budget impasse on their finances.[59, 60]

Unmet Need for Prevention in Behavioral Health

It is important to emphasize the unmet needs for health promotion, prevention, and early intervention in the Illinois behavioral health system. There is tremendous lost opportunity in delayed treatment after onset of symptoms of mental illness in youth and young adulthood. Other risks of shortfalls in prevention and early intervention include failure to promote healthy development of infants and young children and to prevent substance use disorders in youth, adults, and older adults. Gaps in access to prevention and early intervention across the behavioral health system demand a broad, systemic response in Illinois.

- Nationally, over 15% of children age 2 to 5 have a mental health diagnosis, but there is a "limited number of personnel who are skilled in effective intervention approaches that are uniquely suited to this age group."[61]
- 20% of new mothers in Illinois experience postpartum depression, but only 3 in 10 are diagnosed and only 2 in 10 receive treatment.[62]
- Half of all lifetime cases of mental illness begin by age 14, but the average delay in receiving diagnosis and treatment is 8 to 10 years.[63, 64]

Prevention in early childhood

Infant and early childhood mental health care requires clinical staff with backgrounds and training in developmentally appropriate skills, relationship development, and assessment of primary caregiver-child relationships. Evidence-based interventions based on these specialized competencies are ideally available for both mothers and young children throughout early childhood: during pregnancy, post-delivery, when a special need is identified, at times of loss, crisis, or trauma in the family, or in cases of abuse and neglect.

Shortages of behavioral health professionals with these specific skills interfere with access to effective infant and early childhood mental health care. In one survey conducted by the Illinois Division of Mental Health fewer than 27 community mental health agencies reported that they

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[59] Email from Sherrie Crabb, Family Counseling Center, Vienna to Marvin Lindsey, November 26, 2019

[60] Illinois Partners for Human Service (2019). Minimum Wage Infographic. Retrieved November 26, 2019 from http://www.illinoispartners.org/wp-content/uploads/2019/08/Infographic.pdf

[61] National Scientific Council on the Developing Child (2012). Establishing a Level Foundation for Life: Mental Health Begins in Early Childhood: Working Paper 6. Retrieved September 24, 2019 from https://46y5eh11fhgw3ve3ytpwxt9r-wpengine.netdna-ssl.com/wp-content/uploads/2008/05/Establishing-a-Level-Foundation-for-Life-Mental-Health-Begins-in-Early-Childhood.pdf

[62] Illinois Department of Public Health (nd). Postpartum Depression in Illinois. http://www.dph.illinois.gov/sites/default/files/publications/publicationsowhfspostpartum-depression-factsheet_1.pdf

[63] National Alliance on Mental Illness (nd). Mental Health Facts: Children and Teens. Retrieved September 24, 2019 from https://www.nami.org/NAMI/media/NAMI-Media/Infographics/Children-MH-Facts-NAMI.pdf

[64] Kersting, K. (2005). Study indicates mental illness toll on youth, delays in treatment. American Psychological Association Monitor on Psychology. Retrieved September 24, 2019 from https://www.apa.org/monitor/sep05/treatment

felt they had the level of expertise necessary to provide services to children under 5 years of age. Furthermore, Illinois' capacity to assess and diagnose young children lags behind assessments of parents in its early intervention programs--in state fiscal year 2019, over six parent assessments were completed for every one child assessment.[65]

Early identification and treatment of emergent behavioral health concerns in infancy and early childhood has the potential to intercept preventable lifelong psychiatric disability.[66] To maximize both the cost-effectiveness of public programs and the quality of life for children and families, therefore, it is imperative that Illinois eliminate shortages of behavioral health professionals trained to prevent, assess, and treat children in infancy and early childhood.

Prevention in young adults experiencing first episode psychosis

Evidence-based Coordinated Specialty Care (CSC) for young adults who experience first episode psychosis (FEP) can prevent the derailment of social, academic, and career trajectory that often occurs when psychotic symptoms are left undiagnosed and untreated.[67] While Illinois did develop a Coordinated Specialty Care Program for FEP called FIRST.IL, its reach is restricted by limitations on insurance coverage by both public sector and commercial plans.[68] Without reliable coverage of evidence-based CSC services, providers will be unable to fully integrate treatment for FEP with other medical and behavioral health services delivered through an individual's insurance plan.[69]

Implementing CSC with fidelity to evidence-based models requires specialized teams that can fulfill critical roles, including case management, supported employment and education, psychotherapy, family education and support, medication management, and primary care coordination.[70, 71] Recruiting and training team members for specific CSC roles depends on both an adequate supply of psychologists, social workers, professional counselors, and peer support specialists and a workforce development infrastructure that can train and deploy qualified staff where they are most needed. An Illinois Behavioral Health Workforce Education Center would anchor the work of academic, governmental, and provider partners to build pipelines that

[65] Email correspondence from Department of Human Services, Division of Mental Health to Task Force, November 21, 2019

[66] National Scientific Council on the Developing Child, 6

[67] Heinssen, R.K., Goldestein, A.B., & Azrin, S.T. (2014). Evidence-Based Treatment for First Episode Psychosis Components of Coordinated Specialty Care. Retrieved November 7, 2019 from https://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf

[68] Illinois Department of Human Services, Division of Mental Health (2019). First Episode Psychosis. Retrieved November 7, 2019 from https://www.dhs.state.il.us/OneNetLibrary/27896/documents/By_Division/MentalHealth/Child%20and%20Adolescents/2019/08152019-FirstEpisodePsychosis.pdf

[69] Healthy Minds Healthy Lives Coalition (2017). Fair Insurance Coverage for Families for Early Treatment of Serious Mental Health Conditions. Retrieved November 7, 2019 from https://www.thresholds.org/wp-content/uploads/2017/08/Fair-Insurance-Coverage-for-Families-for-Early-Treatment-of-Serious-Mental-Health-Conditions-SB3213-HB4844.pdf

[70] Heinssen, R.K., Goldestein, A.B., & Azrin, S.T. (2014), 5-7

[71] Illinois Catalog of State Financial Assistance (nd). First Episode Presentation Program (510-FEPP). CFSA Number: 444-22-1294. https://govappsqa.illinois.gov/gata/csfa/Program.aspx?csfa=1294

ensure future workforce adequacy, create training platforms to update skills of the currently practicing workforce, and conduct research to continue planning and policy making to support CSC and other FEP treatments.

Prevention of substance use disorders

Illinois' State Addiction Prevention System is designed to implement evidence-based programs to prevent substance use disorders, but funding is fragmented, uncoordinated, and has been declining over the last 10 years. Between 2008 and 2015, state funding for substance use prevention decreased by 87% and has remained flat since then.[72] The prevention workforce has withered as well—the number of practicing full-time prevention specialists dropped nearly 35% between 2002 and 2012.[73] Low wages and a lack of pathways for career advancement within the prevention field has held back the growth of certified prevention specialists and the patchwork of grant-funding has resulted in gaps in services, incomplete data collection, and inadequate system-wide planning for prevention across the lifespan.

The Illinois Association for Behavioral Health (formerly the Illinois Alcoholism and Drug Dependence Association) proposed an ideal prevention system that would include improved data collection and analysis, training and technical assistance for prevention workers and community stakeholders, and policy and research centers to study and disseminate evidence-based practices that are responsive to specific community needs across the state.[74] These are precisely the tasks that an Illinois Behavioral Health Workforce Education Center would coordinate to strengthen and expand the behavioral health prevention workforce.

Pressures increasing Demand for Behavioral Health Services

While demand is already exceeding capacity to provide behavioral health services, the situation is at risk of worsening as pressures from policy and cultural changes increase demand across the care continuum and lifespan. Without a coordinated workforce-planning response, these changes are simply dangers to a fragile system. From a strategic workforce development perspective, they represent opportunities to push the system forward and address unmet needs before they multiply to affect even more individuals and families across Illinois.

- New programs and mandates for implementing Systems of Care, expanding SUD services to fight the opioid epidemic, shifting from institutional to community-based services, and increasing utilization of peer support all add to competition for already scarce qualified staff
- Mandatory screening for social-emotional health in schools requires more staff to conduct screenings and is likely to create demand for more providers to respond to newly detected behavioral health needs among school-aged children

[72] Howe, S.M. (2019). Illinois' Prevention Workforce. PowerPoint presented to the Illinois Behavioral Health Workforce Education Center Task Force, October 4, 2019.

[73] Illinois Alcoholism and Drug Dependence Association (nd). Blueprint for the Illinois Addiction Prevention System. Page 4.

[74] Illinois Alcoholism and Drug Dependence Association, 1

- Prohibition on expulsion in pre-school means behaviors that had led to expulsion must now be addressed with mental health consultation, which requires new competencies from social workers and additional staff to support consultants
- Stigma reduction, a crucial step toward improving access to behavioral health services, may produce unintended access barriers if it generates demand that the system is not prepared to meet

Behavioral Health Workforce Supply Shortages

As discussed in the previous section, existing workforce datasets have many weaknesses for workforce development decision-making. But there is enough evidence of unmet need to conclude that a more deliberate approach is needed to address shortages and maldistribution of behavioral health professionals. Below we offer a preliminary account of the composition of the behavioral health workforce, the shortages in various types of behavioral health professionals and some actionable solutions to address them. Research that is part of a strategic behavioral health workforce plan, drawing on the resources of the State university system, would produce more comprehensive and actionable analyses of shortages.

Who is in the behavioral health workforce?

Measuring workforce supply is no more straightforward than assessing demand, as both reflect the underlying complexity of behavioral health conditions and behavioral health care delivery. The category of 'behavioral health care professionals' that includes psychiatrists, psychologists, social workers, counselors, therapists, peer support workers and psychiatric advanced practice nurses is expansive but fails to capture the significant role of primary care providers in behavioral health care. Two-thirds of patients with depression receive treatment in a primary care setting,[75] and, according to one study, primary care providers prescribe 59% of psychotropic medications.[76]

While primary care has an important role to play in behavioral health care delivery, the predominance of non-psychiatrists in psychotropic prescribing raises important concerns about how well medical education prepares primary care physicians for this role. For children and adolescents in particular experts warn of the risks of relying on pediatricians as prescribers, emphasizing the "need for specialists trained in psychopharmacological treatment of youth."[77]

From a workforce analysis perspective, this pattern of utilization also highlights the need to monitor the supply of primary care providers as well as behavioral health specialists. It is, therefore, important for access to behavioral health care that, in addition to having the sixth largest number of designated mental health shortage areas in the nation, 3.2 million people live

[75] American Academy of Family Physicians (2018). Mental Health Care Services by Family Physicians (Position Paper). Retrieved September 30, 2019 from https://www.aafp.org/about/policies/all/mental-services.html
[76] Mark, T.L., Levit, K.R., & Buck, J.A. (2009). Datapoints: psychotropic drug prescriptions by medical specialty. *Psychiatric Services.* 60 (9): 1167. https://doi.org/10.1176/ps.2009.60.9.1167
[77]Thomas, C.R., & Holzer, C.E., 8

in one of Illinois' 249 designated primary care health professional shortage areas.[78] We will discuss the need to better prepare primary care providers for integrated behavioral health models in the next section on Evidence-based Practices. Here we look closer at the workforce of specialized behavioral health professionals.

Broad measures of the behavioral health workforce include a wide variety of occupations. HRSA's State-level workforce projections include the following types of professionals:

- Addiction Counselors
- Clinical, Counseling, and School Psychologists
- Clinical Social Workers
- Marriage & Family Therapists
- Mental Health Counselors
- Psychiatrists
- Psychiatric Nurse Practitioners
- Psychiatric Physician Assistants
- School Counselors

The same set of occupations are the basis for the University of Southern California Leonard D. Schaeffer Center for Health Policy & Economics' analysis of Illinois' behavioral health workforce availability, which concluded that Illinois' already below-national-average number of behavioral health professionals per 10,000 residents dropped 23% between 2016 to 2018.[79]

The Task Force examined data on a similar array of health professionals licensed by the Illinois Department of Financial and Professional Regulation (IDFPR) and found that for every occupation at least one county in Illinois did not have a single active license holder (see Appendix C for more data on license-holders by county):

- Physicians
- Physicians Assistants
- Advanced Practice Nurses
- Licensed Clinical Social Workers
- Licensed Social Workers
- Licensed Clinical Professional Counselors
- Licensed Professional Counselors
- Licensed Marriage and Family Counselors
- Licensed Clinical Psychologists
- Occupational Therapists

To respond effectively to the alarms sounding from these broad datasets, Illinois will need to prioritize the workforce needs in its behavioral health system by specific type and

[78]Kaiser Family Foundation (2019, September 30). State Health Facts: Provider & Service Use Indicators: Health Professional Shortage Areas.

[79] Seabury, 14

specialization, practice setting and characteristics, and location. Such targeted workforce analysis is a core project of BHECN, which produces Statistical Briefs by profession and region,[80] and of the Washington Health Workforce Council, which supplements statewide data collection with case studies and "data dives" into specific occupation types.[81] These targeted, up-to-date analyses inform state policy making and support employers' recruitment, training, and retention strategies. Illinois has some baseline indicators of where behavioral health workforce shortages are most acute, and an Illinois Behavioral Health Workforce Education Center comprised of academic, provider-employer, and government partners could replicate the data-driven solutions enacted in Nebraska, Washington, and other states. Some of the specific areas of need and potential solutions are described below.

Psychiatry

Like the rest of the U.S., Illinois has a shortage of psychiatrists that is significantly worse in rural and high-poverty areas even as some urban areas have, on paper at least, an abundance of psychiatrists. As discussed in the previous section, gaps in workforce datasets make it difficult to obtain precise measures of access to psychiatry for particular groups, like people on Medicaid and people with limited English proficiency. We do know that psychiatry is unequally distributed, and as Butryn and colleagues concluded in their 2017 article on mental health workforce shortages, "A thorough understanding of both the nature and the reasons for such maldistribution is critical when planning for strategic resource allocation."[82] The BHECN model provides a guide to developing that understanding and translating it into programs to engage, recruit, and retain behavioral health professionals to best meet the needs of all Illinois communities.

BHECN prioritized increasing the number of psychiatry residents in the state, with particular attention to access in rural areas. Illinois also faces a shortage of psychiatrists in rural and high-poverty areas, as well as specific shortages of child and adolescent psychiatrists and gero-psychiatrists. In order to increase the supply of psychiatrists, Illinois will need to expand its capacity to train new psychiatrists and incentivize graduates to remain in the state to practice. Seven of Illinois' eight medical schools offer psychiatric residency programs, but only three are outside of the Chicago area. Only one of the five child and adolescent psychiatry fellowship programs are outside Chicago, at SIU's School of Medicine in Springfield.[83]

Local and national experts cite limited state and federal funding of psychiatric residency programs as a force driving the shortage in psychiatrists nationally and in Illinois. In particular,

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[80] Behavioral Health Education Center of Nebraska (2019). Workforce Reports. https://www.unmc.edu/bhecn/workforce/workforce-reports.html

[81] Gattman, N.E. (2018). Washington Health Workforce Council 2018 Annual Report. Washington State Workforce Training and Education Coordinating Board.

[82] Butryn T., Bryant L., Marchionni C., & Sholevar F. (2017). The shortage of psychiatrists and other mental health providers: Causes, current state, and potential solutions. *International Journal of Academic Medicine.* 3:5-9. http://www.ijam-web.org/text.asp?2017/3/1/5/209851

[83] Illinois Department of Public Health (2016). Psychiatry Practice Incentive Act Annual Report for Calendar Year 2016.

the federal cap on Medicare funding for Graduate Medical Education creates a bottleneck that prevents students interested in pursuing careers in psychiatry from matching into psychiatry residencies. Other pressures on the psychiatric workforce that the Task Force identified are:

- With over 55% of practicing psychiatrists over the age of 55, more psychiatrists are retiring each year than are graduating from psychiatry residency programs[84]
- Low reimbursement from Illinois Medicaid and commercial insurance are disincentives for psychiatrists to accept insured patients without significant additional funding from consumer out-of-pocket spending or public grant programs
    - Illinois has one of the lowest Medicaid-to-Medicare physician fee schedules in the nation and psychiatry reimbursement rates cover less than 50% of the cost of care[85]
    - Commercial insurers reimburse psychiatrists less than primary care and other specialty physicians for services billed with the same CPT codes[86]
    - Nationally, the number of psychiatrists serving public sector and insured populations declined 10% between 2003 and 2013[87]
- New models, including collaborative care and telehealth, demand new competencies that psychiatric residency programs must build into curricula and training[88]
- Psychiatrists experience high rates of burnout[89]

Illinois' shortage of psychiatrists specializing in serving children and adolescents is especially acute. Eighty-one out of 102 Illinois counties have no child and adolescent psychiatrists, and the remaining 21 counties have only 310 child and adolescent psychiatrists for a population of 2.45 million children.[90] The conclusion Thomas and Holzer reached over ten years ago in their analysis of child and adolescent psychiatry shortages appears to hold true today: "market forces and public mental health policy during the past decade have not directed the limited number of child and adolescent psychiatrists to the areas of greatest need or even provided an equitable distribution."[91]

Nationally, the number of child and adolescent psychiatrists has increased but is still below the number needed to adequately serve current youth behavioral health needs, and demand is expected to grow.[92] Simply growing the supply faster is unlikely to address the disparities in the

[84] Wolf, Kari (2018, December 10). Testimony on possible solutions regarding the shortage of behavioral healthcare workers in Illinois. Written testimony submitted to the Illinois Senate Human Services and Senate Higher Education Committees.
[85] Seabury, 12
[86] Illinois Psychiatric Society (2018). Testimony to Illinois Senate Human Services and Higher Education Committees.
[87] National Council for Behavioral Health Medical Directors Institute (2017). The Psychiatric Shortage: Causes and Solutions, 4
[88] National Council for Behavioral Health Medical Director Institute. 6, 25, & 30
[89] National Council for Behavioral Health Medical Director Institute, 14
[90] Walsh, A.M. (2019, May 17). Collaboration in Action: Improving the Children's Mental Health System in Illinois. PowerPoint presented to the Illinois Behavioral Health Workforce Education Center Task Force.
[91] Thomas, C.R., & Holzer, C.E., 7
[92] Thomas, C.R., & Holzer, C.E., 2

distribution of child and psychiatrists, who are scarcer in rural and high-child-poverty areas, nor will it prepare the future workforce to participate in evidence-based practices.

Large and growing gaps between workforce supply and behavioral health needs also exist in geriatric psychiatry. The geriatric physician workforce in general is insufficient to meet the health care needs of the growing older adult population in the U.S.,[93] and the Institute of Medicine has estimated that by 2030 the country will have only one geriatric psychiatrist for every 27,000 Americans aged 65 or older.[94] As with child and adolescent psychiatry, specialization in geriatric psychiatry requires an additional year of training for medical residents. Without incentives to pursue these specializations, residents face the difficult decision to forego much higher salaries from practicing as a general psychiatrist to spend an additional year in residency.

How can Illinois begin to implement programs to reduce the psychiatric shortage?

Illinois could take steps to meet clear, immediate needs in psychiatry, setting the stage for the Center to do more to expand access to psychiatry in the longer-term:

- Fund the Psychiatry Practice Incentive Act of 2011 (405 ILCS 100), a law that was intended to improve access to psychiatric services through
    - grants to medical schools for expanding psychiatric residencies and child and adolescent psychiatry fellowships,
        - Cost estimate: $160,000 per resident per year to serve a hospital or FQHC in psychiatry
        - Physicians tend to practice within 50 miles of where they complete their residencies, making expansion of residencies and fellowships in the areas with highest need a crucial investment in access to behavioral health care in Illinois
    - scholarships for students in psychiatric specialties who commit to serving designated shortage areas and populations, and
    - loan repayment programs for psychiatrists working in shortage areas or serving high-need populations.
- Fund sign-on bonuses for new hires who commit to at least 3 years of service in rural and underserved areas, where behavioral health employers struggle to compete for scarce qualified staff

Source: Wolf, Kari (2018, December 10). Testimony on possible solutions regarding the shortage of behavioral healthcare workers in Illinois. Written testimony submitted to the Illinois Senate Human Services and Senate Higher Education Committees.

[93] Siouxland News (2019, July 2019). Medical School gets $3.7M to address geriatric care shortage. Retrieved September 16, 2019 from https://siouxlandnews.com/news/local/medical-school-get-37m-to-address-geriatric-care-shortage-07-28-2019

[94] Anderson, C. (2012, July 25). Geriatric mental health workforce faces a growing shortage. *Healthcare Finance.* Retrieved on September 16, 2019 from https://www.healthcarefinancenews.com/news/geriatric-mental-health-workforce-faces-growing-shortage

It is worth recognizing efforts to extend the current psychiatric workforce through the use of, for example, advanced practice psychiatric nurses, or by expanding the scope of practice of psychologists to include prescribing. As part of a systematic workforce development plan, physician extenders, targeted training of primary care professionals to conduct screenings and brief interventions for behavioral health conditions, and scope of practice reform can all play a role in improving access to effective, team-based, person-centered care. However, research has demonstrated that regions that have shortages of psychiatrists also tend to have shortages of other behavioral health professionals, so expansion of prescribing rights does not necessarily improve access. Experiences in Illinois and in Michigan also indicate that expanding prescribing rights to psychologists does not effectively fill gaps left by psychiatrist shortages nor does it create career advancement opportunities for psychologists if the time and resources necessary for training to become a prescriber are not met by adequate reimbursement for providing prescribing services to patients.[95]

Other licensed behavioral health professionals

Similar to psychiatry shortages, Illinois also has a shortage of other master's and doctoral level psychiatric and behavioral health providers such as advanced practice psychiatric-mental health nurses, licensed clinical psychologists, licensed social workers (LSWs), licensed clinical social workers (LCSWs), and licensed clinical professional counselors (LCPCs). According to HRSA's new Health Workforce Connector online tool, in December 2019 there were 46 behavioral health job openings in Federally Qualified Health Care Centers throughout Illinois, mostly for LSWs (30).[96] Using the popular Internet-based job finder, www.Indeed.com, there were 1,115 full-time job openings in Illinois listed under "behavioral health" and 3,051 full-time listings under "mental health," which include bachelor's and graduate level trained professionals. Full-time job listings on Indeed.com by discipline in Illinois included social workers (2213), mental health nurses (1049), LCPC (780), and clinical psychologists (358).[97]

Strengthening the behavioral health workforce requires alignment of resources and enhancement of career pathways that allow us to attract, train, and retain providers in Illinois. A strong behavioral health services infrastructure will include pipeline programs that educate young people about careers in behavioral health such as the Illinois Area Health Education Centers (AHEC) network, incentives such as scholarships and loan repayment programs, and support of Illinois institutions of higher education that offer professional degrees in behavioral health disciplines (e.g., social work, counseling, psychology, psychiatric nursing, psychiatry) and community colleges that prepare paraprofessionals and peer recovery specialists. Adequate compensation and opportunities for on-going training and career advancement are critical for retention.

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[95] Andrilla, C.H.A., Patterson, D.G., Garberson, L.A., Coulthard, C., & Larson, E.H. (2018). Geographic Variation in the Supply of Selected Behavioral Health Providers. *American Journal of Preventive Medicine.* 54(6) S199-S207. https://doi.org/10.1016/j.amepre.2018.01.004

[96] Health Resources and Services Administration (nd). Health Workforce Connector. Accessed December 16, 2019 from https://connector.hrsa.gov/connector/

[97] Indeed.com accessed December 16, 2019.

One of the gaps identified by the Task Force is the two-year post-masters "waiting period" of practice and supervision among social workers and professional counselors that is required to be eligible to take the LCSW or LCPC examinations. During this two-year period, employers have very few options, if any, to bill Medicaid, Medicare, or private insurance for their clinical services, even when provided under supervision of an LCSW, LCPC, or other licensed provider. This is a design flaw in the pipeline, resulting in an untenable situation for employers who wish to fill acute workforce shortages with a combination of LCSWs and LSWs. LSWs need training and supervision in health care employment settings to advance in their careers, but employment of LSWs is not viable because they cannot provide billable services during training. Organizations need a way to pay for LSW services *and* supervision in order to build and sustain a pipeline within their agencies, and to retain workers in the settings in which they are most needed in our state. Some of the larger health systems have developed two-year post-MSW training programs to address this gap, provide excellent team-based training and supervision, and build the workforce they need. Smaller community agencies with budgetary constraints also need similar mechanisms to build and train their workforce. Approaches to clinical supervision policy and standards must be a part of a strategic plan for the Illinois behavioral health workforce. The Task Force identified the Yale Program on Supervision as one resource for this important aspect of workforce development.[98]

Substance Use Disorder Counselors

The rise in opioid use and overdose deaths has directed national attention to shortages of providers capable of assessing and treating people with substance use disorders, especially Medication-Assisted Treatment for opioid use disorder. According to HRSA estimates, Illinois had a shortage of between 320 and 1,030 "addiction counselors" (a broad category used by the Bureau of Labor Statistics that includes a variety of education levels and practice settings) in 2016.[99] Another measure of SUD workforce adequacy, the Provider Availability Index created by Advocates for Human Potential, shows Illinois at the below-national-average rate of 30 SUD providers for every 1,000 adults with a SUD.[100, 101]

The Illinois Department of Human Services Division of Substance Use Prevention and Recovery (SUPR) notes that the SUD workforce is aging while new entrants are declining. 56% of SUD

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[98] Hoge, M.A., Migdole, S., Cannata, E., & Powell, D.J. (2014). Strengthening Supervision in Systems of Care: Exemplary Practices in Empirically Supported Treatments. Clinical Social Work Journal. 42: 171-181. Retrieved December 22, 2019 from https://medicine.yale.edu/psychiatry/supervision/latest/Hoge%202014%20Strengthening%20Supervision%20final_257726_284_14712_v1.pdf

[99] Health Resources and Services Administration (2018). State-Level Projections of Supply and Demand for Behavioral Occupations: 2016-2030. Table 13, Page 31. Retrieved November 14, 2019 from https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/state-level-estimates-report-2018.pdf

[100] Vestal, C. (2015, April 1). How Severe is the Shortage of Substance Abuse Specialists? [blog] *Stateline.* The Pew Charitable Trusts. Retrieved November 7, 2019 from https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/4/01/how-severe-is-the-shortage-of-substance-abuse-specialists

[101] Advocates for Human Potential, Inc. (2014). The Adequacy of the Behavioral Health Workforce to Meet the Need for Services: Overview of Key Findings. Retrieved November 7, 2019 from http://www.ahpnet.com/AHPNet/media/AHPNetMediaLibrary/News/AHP-BH-Workforce-Paper-July-2014.pdf

professionals who are certified by the Illinois Alcohol and Other Drug Abuse Professional Certification Association are over 50 years of age, and new certifications in the most common credential, for Certified Alcohol and other Drug Counselors (CADC), has dropped by one third from 2016 to 2019.[102] SUPR also tracks the education and license levels of certified SUD professionals and reported that the most common license holders were LCPCs and LCSWs—representing 93% of licensed SUD professionals tracked by SUPR--and that 64% of the degreed SUD workforce holds a master's degree. However, national research has concluded that "advanced education may not translate into greater knowledge specific to SUD treatment, as many graduate programs in social work and psychology do not provide specialized training in SUDs."[103] There is a growing need for behavioral health professionals who can provide services for people with mental illness, SUD, and people with co-occurring disorders, but behavioral health education curricula are not typically designed to meet this workforce need.

On the ground, Illinois' universities and behavioral health providers are attempting to fill these gaps in the SUD workforce. Some Illinois academic programs in social work, psychology, and counseling do offer options for pursuing a CADC credential alongside a professional license. Practicing master's level staff can sometimes receive assistance from employers in obtaining CADC credentials. For example, HRSA training grants are supporting Illinois universities and FQHCs to train students and staff in evidence-based SUD treatment.[104, 105] An Illinois Behavioral Health Workforce Education Center could better coordinate pre-service education and professional development with training in SUDs, ensuring that more health care professional students graduate with an understanding of SUDs and that practicing professionals develop competencies in the most current evidence-based practices for SUD prevention and treatment.

A Center devoted to behavioral health workforce education would be a valuable partner in initiatives to enhance Medicaid SUD services, such as Illinois' federal planning grant under the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act,[106] implementation of recommendations from the State

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[102] Frank, Stephanie (2019, March 29). Illinois Department of Human Services, Division of Substance Use Prevention and Recovery Workforce Presentation. PowerPoint presented to Illinois Behavioral Health Workforce Education Center Task Force.

[103] HHS Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy (2018). ASPE Issue Brief: Substance Use Disorder Workforce. Retrieved November 7, 2019 from https://aspe.hhs.gov/system/files/pdf/259346/ExamSUDib.pdf

[104] Health Resources and Services Administration (2018). Fiscal Year 2018 Expanding Access to Quality Substance Use Disorder and Mental Health (SUD-MH) Awards – Illinois. Retrieved December 16, 2019 from https://bphc.hrsa.gov/sud-mh/awards.aspx?state=IL

[105] Health Resources and Services Administration (2018). Behavioral Health Workforce Education and Training (BHWET) and Enhancing Behavioral Health Workforce (EBHW) for Health Centers FY 2018 Grant Awards. Retrieved on December 16, 2019 from https://bphc.hrsa.gov/programopportunities/fundingopportunities/behavioral-health-workforce/awards.html

[106] Illinois Department of Healthcare and Family Services (2019, September 26). Illinois awarded $4.5 million in federal funding to improve Medicaid substance use disorder treatment [Press release]. Retrieved November 7, 2019 from https://www2.illinois.gov/IISNews/20649-Illinois_awarded_$4.5_million_in_federal_funding_to_improve_Medicaid_substance_use_disorder_treatment.pdf

Opioid Withdrawal Management Subcommittee of the Medicaid Advisory Committee, [107] and the expansion of managed care to rural counties that face more acute workforce shortages along with high levels of SUD.

A strategic plan for the Illinois behavioral health workforce would address the need to attract, train, and retain more psychiatrists, master's and doctoral level psychiatric and behavioral health providers, SUD specialists, and many other licensed professionals. The Task Force's initial findings presented here reflect the breadth and depth of behavioral health workforce needs, but more comprehensive data collection and workforce planning is necessary to ensure the optimal number and mix of behavioral health professionals. The licensed behavioral health professionals described above will be most effective working in teams alongside both primary care providers and a less traditional but vital part of the healthcare workforce, peer support professionals and community health workers.

Non-traditional Behavioral Health Providers

Peer support is a core component of recovery-oriented, team-based behavioral health models. The non-traditional roles of peer support workers are their strength—they bring a unique combination of lived experience and formal training that adds value to behavioral health interventions for individuals and families. Yet the ambiguity of their roles, along with the largely non-standardized training and insecure funding for peer support, also interferes with individual career advancement and system-wide workforce development.[108] Laws barring people with criminal records from working in certain health care facilities or obtaining certain licenses create specific barriers to growth in the important sector of specialized peer support for people leaving jails and prisons.[109]

In a 2010 national survey, 291 certified peer support specialists reported working under 105 different job titles.[110] Since then SAMHSA has developed core competencies to guide training programs, job descriptions, performance evaluation, and career development. However, there is still a great deal of uncertainty about the supply and utilization of the peer support workforce. The Illinois Certification Board tracks peer support credential holders in good standing, and the Board shared their most recent data with the Task Force, shown in the table below. As with Illinois' professional licensure data, we do not know how many of these peer support credential holders are working in the behavioral health field, or in what settings and

[107] Medicaid Advisory Committee Opioid Use Disorder Withdrawal Management Subcommittee (2019). Recommendations. Retrieved November 7, 2019 from https://www.illinois.gov/hfs/About/BoardsandCommisions/MAC/access/Pages/RecommendationsPage.aspx

[108] Nev, J., Teague, G.B., Wolf, J., & Rosen, Cherise (2019). Organizational Climate and Support Among Peer Specialists Working in Peer-Run, Hybrid and Conventional Mental Health Settings. *Administration and Policy in Mental Health and Mental Health Services Research.* https://doi.org/10.1007/s10488-019-00980-9

[109] Communication with Sherie Arriazola, Senior Director, Health Policy & Practice Management, Safer Foundation, November 5 and November 19, 2019.

[110] Gagne, C.G., Finch, W.L., Myrick, K.J., & Davis, L.M. (2018). Peer Workers in the Behavioral and Integrated Health Workforce: Opportunities and Future Directions. *American Journal of Preventive Medicine.* 54(6) S258-S266. https://doi.org/10.1016/j.amepre.2018.03.010

according to what models they are practicing, nor do we have benchmarks to judge the adequacy of the existing supply.

Credentialed Peer Support Professionals in Illinois

	Total State Credential Holders (non-unique)	Total Credential Holders Outside Cook County (outside 9-County Northeastern regions)
Certified Peer Recovery Specialist (primarily serving people with SUD)	277	144 (90)
Certified Recovery Support Specialist (primarily serving people with mental illness)	228	126 (81)
National Certified Recovery Specialist (required for Recovery Homes)	131	30 (14)
Certified Associate Addiction Professional	126	97 (91)
Certified Family Partnership Professional	11	8 (7)

Given the prevalence of mental illness and SUD and the expectations that peer support workers will be incorporated into integrated health homes and other emerging models of team-based care, Illinois should expect demand for peer support to grow. But to the extent that the peer workforce has grown, it has primarily expanded through entry-level, low-wage, part-time positions. Without more attention to workforce advancement, the peer workforce model is not sustainable. Surveys of current peer workers already raise alarms about the perception of peer support work as a 'dead-end' job and experiences of feeling undervalued by co-workers on health teams.[111] National research has also identified low wages, lack of college- and graduate-level peer specialist academic programs, and lack of understanding and valuing of peer roles on interdisciplinary teams as barriers to increasing the supply of peer support and fully integrating them into health teams.[112, 113]

A recent study of barriers to career advancement in the peer support workforce recommended several policy and practice level changes[114] that an Illinois Behavioral Health Workforce Education Center could take leadership of, in coordination with its academic, governmental, and provider/employer partners:

[111] Jones, N., Kosyluk, K., Gius, B., Wolf, J., & Rosen, C. (2019) Investigating the mobility of the peer specialist workforce in the United States: Findings from a National Survey. *Psychiatric Rehabilitation Journal.* doi: 10.1037/prj0000395

[112] Gagne, C. et al, S263

[113] Jones, N. et al (2019). Investigating the mobility of the peer specialist workforce in the United States, 5, 8

[114] Jones, J. et al (2019). Investigating the mobility of the peer specialist workforce in the United States, 7-8

- developing mid- and managerial-level peer support positions for advanced peer support workers,
- expanding supported education to remove barriers, including financial barriers, to obtaining college and graduate degrees necessary for career advancement in clinical settings,
- building higher education pathways that explicitly cultivate the transformation of lived experience into "experiential knowledge through synergistic formal training, education, and mentored practice experience" to advance peer skills and to challenge attitudes that down-play the contribution of formal education to the value of peer support.[115]

Parent Peer Support

Although many peer support workers work directly with individuals with mental illness or substance use disorders, there is a segment of the peer workforce that specifically serves parents and families. Parents and caregivers of children with behavioral health disorders often experience burnout, stigma, and isolation. Navigating the convoluted array of child-serving agencies in order to obtain a diagnosis and access to treatment is itself challenging and stressful. Parent-peer support providers are trained to assist with information and referrals and also to provide emotional support and education. These supports are critical as Illinois builds Systems of Care for children with serious behavioral health conditions.

As with other peer support professionals, attempts to consolidate job descriptions and standardize training for family peer support workforce are complicated by the unique role of peer support—the value of their own lived experience can appear to be at odds with the imperative to elevate the professionalism of the workforce as a whole. However, this need not be a barrier to growing a pool of qualified peer support providers. In fact, the bottlenecks slowing the growth of peer support are not so different from those affecting other segments of the behavioral health workforce and would be addressed by the kinds of recruitment, training, and retention strategies that are needed in other sectors.

Lessons from Behavioral Health Employers

As described above, measures of overall behavioral health workforce shortages include a broad array of professionals. While national and state-level workforce datasets and statistical models may be periodically updated, we have already noted the gaps and weaknesses in those sources. An invaluable resource to supplement formal datasets is the community of providers themselves who are also the employers who hire, deploy, train, and manage the behavioral health workforce across a variety of settings and service arrays. The Task Force consulted several provider-employers and also investigated ways to systematize the collection and utilization of information from behavioral health employers.

[115] Jones, N., et. al. (2019). Investigating the mobility of the peer specialist workforce in the United States, 8

St Louis Psychiatric Rehabilitation Center

The St Louis Psychiatric Rehabilitation Center (SLPRC) shared a case study of their workforce challenges and a corrective action plan they implemented and evaluated between 2017 and 2018.[116] SLPRC reported particular difficulty recruiting and retaining recruiting and retaining Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and paraprofessional Psychiatric Technicians (PTs)—who together comprise 37% of their workforce. Turnover and staff vacancies generated hundreds of thousands of dollars in replacement costs and also interfered with timely access to services, disrupted continuity of care, and heightened stress and burnout for remaining staff.

SLPRC's plan to reduce staff vacancies and turnover directly addressed their workforce's need for competitive salaries, flexible scheduling, and enhanced on-the-job training opportunities. According to their vacancy- and turnover rate-tracking dashboard, those workforce interventions produced dramatic reductions in vacancies and turnover. But SLPRC warned that workforce strategies require constant vigilance to maintain such gains. This echoes a theme from provider experiences with implementing evidence-based treatment models—maintaining fidelity to a proven strategy and continuing training and quality improvement are indispensable for sustainable and enduring results.

Egyptian Health Department

Egyptian Health Department (EHD) is a community mental health and SUD service provider in Southern Illinois that presented its workforce challenges and the "Recruit, Retain, Retrain, Retire" cycle it has used to respond with the Task Force.[117] EHD has experienced great difficulty filling positions for social workers (especially master's level social workers), psychologists, and counselors, as well as high turnover for case managers. While these challenges persist, EHD has implemented a variety of strategies to mitigate the impact of Illinois' workforce crisis on its operations. Loan repayment programs, offered through the National Health Services Corps, and internships to expose students to careers in community behavioral health aid EHD in recruitment. Offering advanced training to bachelor's level staff and fellowship opportunities to master's- and pre-doctoral-level staff, engaging the whole organization in new evidence-based practices, supporting self-care practices to fight burnout, and monitoring and maintaining competitive wage and benefits is helping to retain staff. Rehiring retirees as part-time staff leverages expertise of veteran professionals while training a new generation of clinicians.

Youth and Family Peer Support Alliance

The Youth and Family Peer Support Alliance, a family-run organization that provides peer support to parents and caregivers of youth, presented to the Task Force on the needs of this segment of the behavioral health workforce.

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[116] Vincenz, F.T. (2019, May 31). Recruitment & Retention in State-Operated Behavioral Health Organizations. PowerPoint presented to the Missouri Department of Mental Health Spring Training Institute.

[117] Hampton, A. (2019, May 17). Workforce Challenges. PowerPoint presented to the Illinois Behavioral Health Workforce Education Center Task Force.

Peer support providers face distinct challenges as newer, non-traditional workers, but many of the problems facing the peer workforce are familiar throughout the behavioral health sector: a burdensome credentialing process, low reimbursement rates, difficulty integrating into a medical model, and the need for pipelines and career pathways. For family-run organizations like the Youth and Family Peer Support Alliance, which are governed by family members of children and adolescents with behavioral health conditions, enrollment as a Medicaid provider is especially difficult. Operating in the behavioral health space from outside the Medicaid system intensifies the workforce challenges facing parent peer support providers.

Credentialing: The Family Driven Care Commission has developed a credential for Certified Family Partnership Professionals (CFPP). However, the Youth & Family Peer Support Alliance noted that investing in CFPP credentials is only feasible for organizations that can bill Medicaid for services. Fees for CFPP application and renewal and the requirement for one full year of supervision are also barriers to many parent peer support partners and their potential employers.

Reimbursement: Funding for peer support is fragmented and unreliable. Medicaid-enrolled providers may be able to use some Medicaid revenue to support peer support, but most peer support services themselves are not directly reimbursable in Illinois. Foundation grants and contracts with child-serving agencies tend to be by their nature time-limited.

Career pipelines and pathways: Peer support providers work under many different job titles and career development pathways are unclear. Consolidating job titles and developing stackable credentials and certifications is a key step toward retaining peer support providers in the workforce and creating opportunities for them to both earn and do more within the health system.

The Illinois Health and Hospital Association

Hospitals and health systems provide an enormous amount of behavioral health services in Illinois, and they encounter the same workforce challenges as specialty behavioral health providers. The Task Force consulted with the Illinois Health and Hospital Association on hospitals' specific behavioral health workforce needs, and identified these priority areas:

- Licensed Clinical Social Workers are especially difficult for hospitals to recruit and retain.
- Advanced Practice Nurses are recognized as important members of the primary and specialty care workforce, but they are not able to bill for their services in hospital settings. This is an especially problematic barrier for rural hospitals for which physician shortages are most acute.
- State-based loan forgiveness programs are unavailable for hospitals, despite the need to incentivize clinician retention after training, when private practice often offers higher salaries.
- Long wait times in Illinois licensure and DEA credentialing processes interfere with clinical workforce deployment.

- Hospitals also affected by workforce shortages in community behavioral health agencies. Discharge planners are frequently unable to make timely referrals to community services after discharge, which leads to more unnecessary emergency department utilization.

Washington Workforce Sentinel Network

The Task Force collected information from national and statewide workforce datasets and also sought more granular data from individual provider-employers, described above. This approach has been systematized in Washington State through the State Workforce Sentinel Network. Through this program, volunteers from health care employers provide regular information about their evolving workforce needs through a through a data portal. The 'Sentinels' report on issues such as:

- positions that have exceptionally long vacancies,
- changes in turnover and workforce demand,
- reasons for turnover and retention problems from exit interviews and other sources,
- Skills and competencies that new and incumbent workers need, and
- New roles and occupations that providers are beginning to employ.

Sentinels report changes in onboarding and orientation for new workers and in incumbent worker training programs, which are tracked by setting and occupation type. For example, employers reported adding behavioral health training for medical assistants, trauma-informed care training for SUD professionals, and medication assisted treatment training for community health center staff

The willingness of Illinois providers to share information on their workforce needs and strategies with Task Force indicates the potential for this kind of actionable data sharing between provider-employers and an Illinois Behavioral Health Workforce Education Center that could derive and disseminate lessons and action plans based on a regularly updated workforce dataset.

Replicable Models to Address Behavioral Health Workforce Shortages

The Task Force also considered models for behavioral health workforce development from other states. A comprehensive strategic planning process would be consistently evaluating Illinois' needs and readiness to implement various workforce strategies, but the list below indicates the rich array of resources that could be adapted to support Illinois' behavioral health workforce.

Lessons from the Behavioral Health Education Center of Nebraska

Nebraska's Behavioral Health Education Center was the inspiration for the Task Force's study. A range of recruitment training, and retention programs operated by BHECN are available to be replicated in Illinois. An Illinois Behavioral Health Workforce Education Center could develop into a collaborator and national leader by adapting BHECN programs and developing new

strategies to meet the diverse workforce needs of large metropolitan centers as well as rural areas.

Psychiatry residency program
Although states can advocate for lifting the cap on GME funding for psychiatric residencies, the urgency of the need sounds an alarm for more immediate state-level fixes to the psychiatric pipeline. The Task Force investigated the potential to replicate BHECN's work, in partnership with Creighton University and the University of Nebraska Medical Center (UNMC), to support a psychiatry residency program with a required one-month rural rotation.

The psychiatry residency was part of BHECN's strategic approach to the psychiatry shortage that included a Psychiatry Interest Group and elective course in psychiatry at UNMC, partnerships with community-based education and training sites to provide interprofessional training for psychiatry residents alongside other medical and behavioral health students, pipeline programs in high schools and colleges, as well as continuing education opportunities and job search tools to retain graduates in-state. BHECN also collaborated with academic institutions to enhance psychiatry students' exposure to telehealth.

BHECN reported its achievements of its psychiatric workforce activities from 2013 to 2017:[118]

- The number of UNMC medical students matching in psychiatry residency programs more than doubled.
- With 16 students matching in 2017, UNMC's rate of medical students matching in psychiatry was twice the national average.
- 19 residents completed a psychiatry rural residency from 2015-2017.
- The number of UNMC medical students selecting a psychiatry elective more than tripled.

Doctoral-level psychology internships in rural and underserved practice sites
BHECN partners with the UNMC's Munroe-Meyer Institute Psychology Department to provide five doctoral-level psychology internships in integrated behavioral health-primary care clinics in rural areas of the state. The cohort of interns from 2014-2015 provided over 3,500 dedicated patient visits to children, adolescents, and families in rural areas of Nebraska that would not otherwise have been available. The integrated behavioral health center training sites are supported by a combination of state budget appropriations, AmeriCorp funding, and HRSA Behavioral Health Workforce Education and Training grants.[119, 120]

Ambassador Program
BHECN built on the state's Rural Health Education Network and the University of Nebraska Medical Nebraska's "Grow Your Own" program to create the Ambassador Program to expose

[118] Behavioral Health Education Center of Nebraska (2015). FY 2014 & FY 2015 Legislative Report. Retrieved July 9, 2019 from https://www.unmc.edu/bhecn/_documents/BHECN-Legislative-Report-2015-FINAL.pdf
[119] Behavioral Health Education Center of Nebraska (2017). Legislative Report FY 2016 & 2017.
[120] Behavioral Health Education Center of Nebraska (2015). FY 2014 & FY 2015 Legislative Report.

students in rural and underserved areas to career pathways in behavioral health.[121] The Ambassador Program reaches students as early as high school and follows them through college, professional school, and the start of their careers.[122, 123] High school and college conferences and classes generate interest in behavioral health careers, interest groups and mentorship programs encourage specialization in medical and nursing programs, and ongoing training and resources help retain graduates in the workforce during the critical window after graduation, when support is needed to prevent losing new staff to burnout.[124]

These pipeline programs support BHECN's goals to expand the future workforce in rural and underserved areas and to retain at least 50% behavioral health professional school graduates in state. Events in high schools and colleges also help to reduce mental health stigma—post-event surveys showed 90% of students reporting a change in their perception of mental illness as a result of BHECN presentations.[125]

The online Ambassador Program Toolkit makes resources like templates for conference agendas and behavioral health career pathway brochures available for other states to replicate these pipeline initiatives.[126]

Correctional Sites Internship Program

To address the specific challenge of recruiting behavioral health professionals to serve the needs of individuals in correctional facilities, BHECN created a paid internship for graduate level trainees in psychiatric nursing, social work, psychology, psychiatry, counseling, and physician assistants. BHECN operates the internship program in partnership with the Nebraska Department of Correctional Services and several universities' behavioral health graduate and medical education programs.[127]

Additional Workforce Strategies

The Task Force also investigated other national and state policy initiatives that could address the Illinois behavioral health workforce crisis. A few promising and replicable approaches are described below.

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[121] Boust, S.J. (2015). The Nebraska Behavioral Health Education Center. Prepared for the Academic Support Work Group.

[122] Behavioral Health Education Center of Nebraska (2017). Legislative Report FY 2016 & 2017. Retrieved July 9, 2019 from https://www.unmc.edu/bhecn/_documents/FY16-17-legislative-report.pdf

[123] Behavioral health Education Center of Nebraska (2019). Ambassador Program. https://www.unmc.edu/bhecn/programs/ambassador-program/index.html

[124] Behavioral Health Education Center of Nebraska (2017). Legislative Report FY 2016 & 2017; discussion at February 8, 2019 Illinois Behavioral Health Workforce Education Center Task Force meeting

[125] Behavioral Health Education Center of Nebraska (2017). Legislative Report FY 2016 & 2017, 14

[126] Behavioral health Education Center of Nebraska (2019). Ambassador Program.

[127] Behavioral Health Education Center of Nebraska (2019). Correctional Sites Internship Program. https://www.unmc.edu/bhecn/programs/corrections-internship.html Accessed September 24, 2019.

Preceptor Tax Credits[128]

Growing the future workforce requires increasing the ranks of faculty to teach, mentor, and supervise the clinical training of students pursuing behavioral health careers. A lack of preceptors in particular has presented barriers to training, and several states have implemented programs to incentive participation in preceptor programs that Illinois could replicate for behavioral health professional training.

- Georgia created the first Preceptor Tax Incentive Program in 2014. The original program provides up to $10,000 in tax deductions for an individual preceptor for medical and osteopathic students, and the State Legislature proposed expanding eligibility to physician assistant and advanced practice registered nursing preceptors.
- Colorado targeted rural workforce development with a $1,000 annual tax credit for rural primary care preceptors, including dentists, nurse practitioners, and physician assistants.
- Maryland responded to the need of its Area Health Education Centers by enacting a tax credit for preceptors working in areas with designated workforce shortages.

Streamlining Licensure Processes

A burdensome licensure process is another roadblock to a nimble behavioral health workforce policy. Administrative burdens, long wait times for processing, and high fees can discourage practice, especially for low-income workers, and delay deployment of trained staff. Illinois is a member of the National Occupational Licensing Learning Consortium, whose members have implemented reforms to reduce unnecessary barriers to workforce entry, including streamlining licensing processes.

- In Indiana, the Governor's Health Workforce Council is studying the potential for cross-state credential portability for licensed practical nurses and Certified Nursing Assistants.[129]
- Wisconsin implemented a new licensing fee structure that reduced initial application and renewal fees for 75% of all occupations and professions licensed in the state. The new fees are based on a study that established maximum fees based on the costs associated with administering each license type.[130]

Targeted Programs for Geriatric Behavioral Health Professionals

Older adults are sometimes overlooked in discussions of the behavioral health workforce, and mental health and SUD are often overlooked in geriatric health professional education. An Illinois Behavioral Health Workforce Education Center would convene partners to develop targeted training programs to fill these bi-directional gaps so that geriatric specialists possessed basic competencies in behavioral health and behavioral health specialists are familiar with geriatric-specific needs. Replicable models and strategies the Center could pursue in partnership with providers and state and federal agencies include:

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[128] Liechty, J. (2018). States with Preceptor Tax Credits. Memo prepared for December 21, 2018 Meeting of the Illinois Behavioral Health Workforce Education Center Task Force Meeting.

[129] Purington, Kitty (2018), 4

[130] Fanin, C. (2019, August 29).

- **Pikes Peak Model for Training in Professional Geropsychology**: The Pikes Peak Model articulates five geropsychology domains that provide guidance on the knowledge and skills necessary for psychologists specializing in serving older adults. However, a shortage of clinical geropsychology faculty inhibits the capacity to train students in this field. Many older adults with mental health needs will rely on generalist psychologists who have limited exposure to geropsychology training during their education. The Council of Professional Geropsychology Training Programs (CoPGTP) developed recommendations, based on the Pikes Peak domains, for developing training programs in foundational competencies in geropsychology for psychologists who serve older adults but have little or no specialized skills in aging.[131]
- **The Geriatric Scholars Program**: The Veteran's Health Administration (VHA) adapted its evidence-based primary care education model to train licensed psychologists. The GSP uses the Pikes Peak Model for Training in Professional Geropsychology as a foundation for its mixed didactic/interactive curriculum, which includes a 30-hour intensive course in geriatric medicine and a quality improvement project that trainees complete at their home VHA facility, with six months of coaching support.[132]
- **Priming the Geropsychology Pipeline Project**: The American Psychological Association produces resources for recruitment, career placement, and continuing education in geropsychology that could be used to help bring a geropsychology workforce development strategy to scale in Illinois.[133]
- **Improving Mood-Promoting Access to Collaborative Treatment (IMPACT)**: IMPACT is an integrated care approach to treating older adults with depression or dysthymic disorders developed by the University of Washington. IMPACT utilized a collaborative team composed of a primary care provider, a consulting psychiatrist, and a social worker serving as a "depression care manager" to deliver intensive treatment, maintenance support, and relapse prevention.[134]

Growing and Advancing the Peer and Parent-Peer Support Workforce

A Behavioral Health Workforce Education Center could work to fill the gaps in the peer and parent-peer workforce development by:

- assessing the credentialing and reimbursement processes and recommending reforms,
- evaluating available peer-parent training models, choosing a model that meets Illinois' needs, and working with partners to implement it universally in child-serving programs throughout the state,

[131] Hinrichsen, G.A., Emery- Tiburcio, E.E., Gooblar, J., & Molinari, V.A. (2018). Building foundational knowledge competencies in professional geropsychology: Council of Professional Geropsychology Training Programs (CoPGTP) recommendations. Clinical Psychology: Science and Practice. 25(2) https://doi.org/10.1111/cpsp.12236

[132] Terri Huh, J.W. (2018)

[133] American Psychological Association (2019). Priming the Geropsychology Pipeline. https://www.apa.org/pi/aging/programs/pipeline/ Accessed September 16, 2019.

[134] AIMS Center (2017). IMPACT: Improving Mood-Promoting Access to Collaborative Treatment. University of Washington, Psychiatry and Behavioral Sciences Division of Population Health.

- including peer recovery specialists and parent-peer support professionals in interdisciplinary training programs, drawing on lessons from BHECN's partnership with Lasting Hope Recovery Center and Community Alliance which provides interdisciplinary, trauma-informed training to peer support specialists alongside psychiatry and pharmacy residents, nursing, social work and counseling students.[135, 136]

A key lesson for Illinois in BHECN's approach to workforce development activities is the alignment of training and education with state goals for implementing integrated care models that require both psychiatric capacity and cross-sector competencies in coordinated, comprehensive team-based services for at-risk and high-need populations.[137, 138] To replicate BHECN's successes and tailor their programs to Illinois-specific strengths and needs, Illinois must leverage workforce and behavioral health resources—including Federal and foundation grant funding, Workforce Investment Act programs, the National Health Services Corp and other non-GME physician workforce training programs, and existing behavioral health partnerships such as the Illinois Children's Mental Health Partnership—and align with reforms in Illinois, such as 1115 waivers, Integrated Health Homes, Federal SUD treatment and prevention grant programs, and NB settlement implementation.

[135] Behavioral Health Education Center of Nebraska (2019). Lasting Hope Recovery Center. https://www.unmc.edu/bhecn/partnerships/collaboratives-Lasting-Hope.html Accessed December 6, 2019.
[136] Behavioral Health Education Center of Nebraska (2017). Legislative Report FY 2016 & 2017, 19.
[137] Behavioral Health Education Center of Nebraska (2017). Legislative Report FY 2016 & 2017, 28. See also Thomas and Holzer recommendation to coordinate workforce development with creation of systems of care models
[138] Thomas, C.R., & Holzer, C.E. (2006), 8.

IV. Support for Use of Evidence-Based Practices

Increasing access to behavioral health providers across disciplines is an essential first step toward improving behavioral health outcomes. Another critical task in the development of an adequate system of care is increasing provision of behavioral health interventions with the highest likelihood of effectiveness given an individual's specific behavioral health needs. Evidence-based behavioral health interventions, which have empirical support for their effectiveness, have been developed through decades of research trials and implementation studies. These interventions show consistently stronger effects on symptom reduction than behavioral health practices in "usual care." Despite the clear benefits of evidence-based practices, their use across all provider types providing psychosocial services is low, with the majority of behavioral health services estimated to be inconsistent with evidence-based practices.[139]

This gap in treatment quality results in a significant loss of quality of life and productivity for individuals with behavioral health conditions, who potentially fail to make gains in symptom reduction and functioning that would occur if provided with optimal treatment. An essential function of the proposed Illinois Behavioral Health Workforce Education Center will involve the support of providers' use of evidence-based interventions.

Reasons for suboptimal use of empirically supported practices are complex, with factors ranging from the content of providers' initial training, lack of ongoing training and support for use of new practices, variance in organizational support and expectations for use, and broader systemic factors.[140] Fortunately, implementation research has provided at least initial guidelines to support greater uptake and adequate use of evidence-based practices and work within Illinois has already begun addressing some of the key barriers to use. The majority of behavioral health training programs across disciplines provide content in evidence-based interventions and state initiatives have supported greater knowledge and use of these interventions. This section describes the strengths and opportunities for improvement in evidence-based practice uptake in Illinois and identifies model programs to expand workforce training and patient access to the most effective behavioral health care.

[139] Harvey, A. G., & Gumport, N. B. (2015). Evidence-based psychological treatments for mental disorders: modifiable barriers to access and possible solutions. *Behavior research and therapy*, 68, 1–12. doi:10.1016/j.brat.2015.02.004

[140] Aarons, G. A., Hurlburt, M., & Horwitz, S. M. (2011). Advancing a conceptual model of evidence-based practice implementation in public service sectors. *Administration and policy in mental health*, *38*(1), 4–23. doi:10.1007/s10488-010-0327-7; Harvey, A. G., & Gumport, N. B. (2015)

Illinois Strengths and Assets for Evidence-based Practice

Illinois is home to a rich array of training resources and innovative organizations for testing and disseminating on-the-ground implementation of evidence-based practices. However, these initiatives are not coordinated and, crucially, lack a systematic method for assuring that training programs results in practice in fidelity with evidence-based models. BHECN offers a model for establishing a main academic site responsible for developing, coordinating, and evaluating training programs in evidence-based practices with regional hubs to extend its reach to rural areas and underserved areas. To grow its capacity, BHECN also identifies and secures funding for training and sustainable implementation of evidence-based models.

An Illinois Behavioral Health Workforce Education Center could fill a need for guidelines for standardized behavioral health training during and after professional education and move Illinois toward integration of the clinical services, education, research, and outreach functions necessary for ongoing workforce development. For example, behavioral health agencies and providers working in areas without routes for specialized certification (e.g., severe and persistent mental health disorders, child or adult mental health) could be provided with suggested minimum standards for training (didactic and experiential) for specific types of behavioral health needs based on findings from dissemination research. The Center could also bridge the gap between innovative practices being deployed in communities and university researchers who are often unaware of those activities and the opportunities for evaluation and implementation research that they present.

The figure below highlights some of the training programs and innovations in practice that represent strengths for an Illinois Behavioral Health Workforce Education Center to build on. This is not a comprehensive list but is intended to convey the already available resources for training in evidence-based practices in Illinois which, as part of a comprehensive workforce strategy anchored by the proposed Center, could be more systematically tracked and aligned to magnify their impact throughout the state.

Illinois Strengths and Assets in Evidence-Based Practice Training

HRSA-funded Behavioral Health Workforce Education and Training (BHWET) Grants

- Southern Illinois University, University of Illinois at Chicago, Loyola University, Illinois State University, University of Illinois Urbana-Champaign, University of St. Francis, Dominican University, and Governor's State University have received BHWET awards.
- BHWET grants support
    - training for social work, psychology, counseling, psychiatric nurse practitioner, psychiatry, and para-professional students,
    - interprofessional education before and during field placement,
    - internships in rural or underserved areas,
    - longitudinal field placements of 6 months or more,
    - integrated behavioral health and primary care training sites, and
    - evaluation, data tracking and quality improvement.

Jane Addams College of Social Work at the University of Illinois at Chicago's HRSA-funded Integrated Behavioral Health Care Training Program and Integrated SUD Training Program

- provides specialized training in specific evidence-based behavioral health interventions in four tracks--child/ adolescent, young/middle adult, older adult, and individuals with SUDs--to prepare social work students to serve low-income, racially and ethnically diverse Chicago residents in integrated primary care settings,
- provides field instructor and faculty training on topics to support use of evidence-based practices (e.g., supervision of students learning MAT and other evidence-based practices), and
- includes stipends for students to offset lost income from additional time spent in integrated care training.

Southern Illinois University-Illinois Health and Hospital Association (SIU-IHA) Opioid ECHO

- Project ECHO (Extension for Community Healthcare Outcomes) is a model for improving primary care physician's ability to manage complex conditions, including behavioral health conditions.
- IHA and SIU have partnered on an Opioid ECHO to increase access to physicians who have DATA-2000 waivers to prescribe buprenorphine for opioid use disorder by
    - growing the number of providers with waivers in Illinois counties with limited medication-assisted treatment services,
    - training clinicians who currently have waivers, but are not prescribing, to begin using their waivers and treating patients with MAT,

- engaging and activating primary care and behavioral health partners through the Project ECHO Opioid Hub consisting of a multi-disciplinary team working in an FQHC.

Illinois Children's Mental Health Partnership's Mental Health Consultation Initiative

- ICMHP is leading efforts to design a sustainable, accessible, and effective infant and early childhood mental health consultation model that will strengthen the capacity of child serving systems to prevent, identify, treat, and reduce the impact of mental health issues in infants and young children.
  - The Mental Health Consultation Initiative is establishing consistent qualification standards for a mental health consultation model and creating a registry to track mental health consultants, their certifications, and professional development.
  - The mental health consultation model is currently being evaluated by Chapin Hall.

Children's Mental Health Initiative 2.0

- In 2019 the Illinois Children's Healthcare Foundation awarded six-year grants to help build Systems of Care that provide comprehensive, integrated care to families and children.
- Four Illinois regions, each lead by a community provider, received funding to implement plans developed under the Children's Mental Health Initiative 1.0 grants
- Each plan seeks to improve collaboration among mental and physical health. providers, schools, parents and caregivers, juvenile justice and other child-service agencies.

Model Program for Training in Evidence-Based Treatment: The North Carolina Child Treatment Program (NCCTP)

The Task Force considered ways to infuse skills in evidence-based practice across providers and identified a promising model in the North Carolina Child Treatment Program's Learning Collaboratives. The NCCTP uses a competency-based platform to train children's mental health providers to use evidence-based treatment with high model fidelity, which ensures effective delivery that can produce the outcomes predicted by the research backing each model.

Guided by public health and implementation science principles, the NCCTP Learning Collaboratives use master trainers and specially trained extenders to conduct trainings, monitor

model fidelity, and assess competency. North Carolina developed its own master trainers and extenders, who speak with training sites every other week for 30 minutes using a fidelity metric to ensure implementation is adhering to the specific evidence-based model. Alternatives to this intensive competency-based training method produced less fidelity during training and lower success in achieving competency.

Staff from the NCCTP emphasized that developing the infrastructure for their competency-based Learning Collaboratives required a 'long-haul mentality' along with a distinct entity responsible for disseminating evidence-based practices and maintaining provider capacity. North Carolina initially built their training platform for disseminating Trauma-Focused Cognitive Behavioral Therapy and found that it was replicable for any manualized evidence-based children's mental health treatment model. NCCTP now offers training in Parent-Child Interaction Therapy, Child-Parent Psychotherapy, and Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS). Providers who complete the training and fidelity checks for these models are listed in the NCCTP's Provider Roster but must continue training to remain listed. The Provider Roster is searchable by county, insurance accepted, language spoken, training level (in training or graduated), and treatment model. The Provider Roster is another potentially replicable tool that fills an additional workforce need for usable data on provider availability.

Illinois has its own experience with evidence-based training processes for children's mental health providers. The Evidence-based Treatment Initiative (EBTI) that the Department of Human Services' Division of Mental Health launched in 2005 included didactic training in cognitive behavior therapy and behavioral parent training combined with ongoing consultation and technical support, similar to the process used in North Carolina.[141] The EBTI has demonstrated that, with funding to support the participating providers, implementing the 12-month training process in community mental health agencies is feasible and that there is evidence that the training improves outcomes.[142] The EBTI also invested in additional e-learning resources for community children's mental health providers, launched Professional Learning

[141] Illinois Children's Mental Health Partnership (2015). FY 15 Annual Report to the Governor. Retrieved on December 19, 2019 from http://icmhp.org/wordpress/wp-content/uploads/2016/01/FINAL-FY-15-ICMHP-Annual-Report-9-28-15.pdf

[142] Starin, A.C., Atkins, M.S., Wehrmann, K.C., Mehta, T., Hesson-McInnis, M.S., Marinez-Lora, A. & Mehlinger, R. (2013). Moving Science Into State Child and Adolescent Mental Health Systems: Illinois' Evidence-Informed Practice Initiative. *Journal of Clinical Child & Adolescent Psychology,* DOI: 10.1080/15374416.2013.848772. Retrieved December 19, 2019 from https://www.researchgate.net/publication/258212638_Moving_Science_Into_State_Child_and_Adolescent_Mental_Health_Systems_Illinois'_Evidence-Informed_Practice_Initiative

Communities, and developed collaborative partnerships with the State university system to support training in evidence-based practices for the developing workforce.[143]

An Illinois Behavioral Health Workforce Education Center would explore ways to expand these training processes to providers serving adults with behavioral health conditions. The Task Force inquired with leadership from the NCCTP about the potential to use their Learning Collaborative platform for adult services. While they believe the training platform is replicable, attempts to adapt the children's mental health learning collaboratives for adult treatment models was held back by the high rates of un-insurance among adults with behavioral health conditions in North Carolina, which has not expanded Medicaid eligibility to low-income adults.[144] As a Medicaid expansion state, Illinois has an advantage in extending the Learning Collaboratives to evidence-based models for adult behavioral health care.

Training the Future Behavioral Health Workforce in Evidence-based Practices

Illinois also needs to develop and coordinate model programs for ensuring that pipelines for the future workforce are preparing students to understand and implement evidence-based practices. Combining programs already active in Illinois with lessons from BHECN, the proposed Center would develop partnerships with integrated primary care medical practices to serve as training sites for interns in psychology, social work, and other behavioral health professional education programs.

In 2017 BHECN, in partnership with the Munroe-Meyer Institute, trained 47 doctoral-level psychology students in twenty-three rural and nineteen urban integrated behavioral health-primary care clinics.[145] BHECN also partnered with Community Alliance, an Omaha community behavioral health center, to develop model behavioral health interprofessional community-based education and training sites. Two behavioral health hospitals are also participating as interprofessional training sites for psychiatry and family medicine residents, nursing, pharmacy, and social work students, peer support specialists, and other health professionals in training.[146] These BHECN programs demonstrate the kind of interprofessional education for integrated care that is possible with statewide alignment of resources through a dedicated Workforce Center. The size, composition, strengths, and needs of Nebraska's behavioral health system differ from those of Illinois, and a workforce strategy will have to be tailored to those build on strengths and meet the most urgent needs.

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[143] Starin, 8.
[144] October 17 phone conversation with Beverly Glienke, Training Director, North Carolina Child Treatment Program and Dana Marie Hagele, Co-Director, North Carolina Child Treatment Program.
[145] Behavioral Health Education Center of Nebraska (2017). Legislative Report FY 2016 & 2017, 20.
[146] Behavioral Health Education Center of Nebraska (2017). Legislative Report FY 2016 & 2017, 19.

To refine its focus and plan future programs, BHECN regularly collects data to understand workforce challenges and anticipate emerging needs. In addition to its online, interactive Behavioral Health Workforce Dashboard and profession- and region-specific behavioral health workforce reports, BHECN is continually exploring new pathways for training in evidence-based practices. For example, BHECN has partnered with academic institutions to expose more behavioral health students to experiences with telehealth in response to the Tele-Mental Health Utilization and Training Needs Assessment.[147] BHECN's research role, as well as the workforce research conducted by the Washington Workforce Council (described in the previous section), are exemplar programs for an Illinois Behavioral Health Workforce Education Center that can nimbly respond to new workforce needs and developments in scientific discovery of behavioral health prevention and treatment. An Illinois Center would not replace other workforce development programs in the public and private sector but could serve as a repository of best practices and be responsible for improved dissemination of most up-to-date evidence-based models in behavioral health.

[147] Watanabe-Galloway, S. Haakenstad, E., Evans, J., & Liu, H. (2018). Barriers and Best Practices for Using Telehealth Services in Nebraska. University of Michigan, School of Public Health, Behavioral Health Workforce Research Center. Retrieved on December 13, 2019 from http://www.behavioralhealthworkforce.org/wp-content/uploads/2018/04/Y2FA2P4_Telehealth-Full-Report-BHECN.pdf

V. Next Steps and Recommendations for a Workforce Center

The behavioral health workforce in Illinois has many problems, and efforts to resolve them are mostly uncoordinated and not sustainable as long-term solutions. The Task Force recommends establishing an Illinois Behavioral Health Workforce Education Center to lead a cross-agency, cross-sectoral strategy to improve access to a qualified diverse workforce providing evidence-based behavioral health prevention, treatment, and recovery services. The workforce is part of a broader context of behavioral health care in Illinois, and a Behavioral Health Workforce Education Center alone will not repair structural weaknesses caused by uncoordinated, fragmented public sector systems. A coordinating body, similar to the regional behavioral health authorities that operate in partnership with the Behavioral Health Education Center in Nebraska, would magnify the impact of an Illinois Workforce Center and make solutions more universally accessible to all Illinois residents. Although the details of such a coordinating body (or bodies) is beyond the scope of this report, the Task Force highlights the need to address deeper structural issues in order to build a stronger foundation for behavioral health care in Illinois.

Structure of an Illinois Behavioral Health Workforce Education Center

An Illinois Behavioral Health Workforce Education Center would be structured as a hub-and-spoke model linking academic institutions that serve rural and small urban areas and at least one academic institution serving the densely urban Chicago-area. A central location in a Behavioral Health Workforce Institute within one academic institution would be tasked with a convening and coordinating role for workforce research and planning including monitoring progress toward Center goals. This central hub must also coordinate with key state agencies involved in behavioral health, workforce development, and higher education in order to leverage disparate resources from health care, workforce, and economic development programs in Illinois government.

In order to identify and choose the Center's central location and its partners, the Task Force recommends that the Illinois Board of Higher Education issue a Request for Information (RFI) with input and assistance from the Department of Human Services, Division of Mental Health. The RFI would articulate the principles of a Center and the specific tasks required of the central and regional hub locations. These tasks include but are not limited to:

- Convening academic institutions providing behavioral health education to:
    - develop curricula to train future behavioral health professionals in evidence-based practices that meet the most urgent needs of Illinois' residents,
    - build capacity to providing clinical training and supervision, and
    - facilitate telehealth services to every region of the state.

- Functioning as a clearinghouse for research, education and training efforts to identify and disseminate evidence-based practices across the state
- Leveraging financial support from grants and social impact loan funds
- Providing infrastructure to organize regional behavioral health education and outreach
    - As budgets allow, this may include conference and training space, research and faculty staff time, tele-health and distance learning equipment
- Regional hubs:
    - Assessing and serving the workforce needs of specific, well-defined regions
    - Specializing in specific research and training areas, such as telehealth or mental health-criminal justice partnerships, for which a regional hub can serve as a statewide leader

Model Budget, BHECN 2016/2017

The model for the Illinois Behavioral Health Workforce Education Center, the Behavioral Health Education Center of Nebraska, operates on an annual budget of about $3 million, half of which is appropriated by the state legislature. (See Appendix F1 for a breakdown of BHECN's FY 2016/2017 budget). However, Illinois has over 6.5 times the population of Nebraska, 11.5 times the number of Medicaid enrollees, and projected behavioral health workforce shortfalls 4 times as great (See Appendix F2 for detailed comparisons). In addition, BHECN shares its coordinating role in the state behavioral health system with, primarily, the Region 6 Behavioral Health Authority in Omaha, and the state's five other regional behavioral health authorities. Although any behavioral health workforce strategy in Illinois can rely on having a strong partner in DMH, which brings the training resources and expertise it has built through the Evidence-based Treatment Initiative, Illinois does not have analogues to Nebraska's regional coordinating bodies to share responsibilities for planning, program development, funding, and evaluation. The larger scale of Illinois behavioral health needs and the broader scope of its coordination needs compel Illinois to anticipate a significantly higher budget for an Illinois Behavioral Health Workforce Education Center. Therefore, the Task Force recommends initial state investment in the estimated amount of $6 million dollars with additional funds to be procured from private and federal sources.

VI. Conclusion

The Task Force has concluded that there is a strong case for establishing an Illinois Behavioral Health Workforce Education Center to anchor a strategic plan for the recruitment, education, and retention of a qualified, diverse, and evolving workforce. This report articulates the nature of the workforce crisis in Illinois and the potential for a multi-faceted workforce strategy to address the crisis and ensure access to high quality behavioral health services for all Illinois residents. With suicide, depression, and substance use at crisis levels, the state must take the necessary steps to increase access and strengthen community capacity to provide lifesaving behavioral health services by bolstering the workforce. There is no question that the barriers to

strengthening behavioral health workforce capacity and improving service delivery will not be easily overcome, but with challenge comes opportunity. Through the Illinois Behavioral Health Workforce Education Center, Illinois can promote innovation and be a national leader in behavioral health workforce development.

Appendix A1 – Task Force Enabling Legislation

Public Act 100-0767

HB5111 Enrolled LRB100 19028 RLC 34282 b

AN ACT concerning health.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act may be cited as the Behavioral Health Workforce Education Center Task Force Act.

Section 5. Behavioral Health Workforce Education Center Task Force.

(a) The Behavioral Health Education Center Task Force is created.

(b) The Task Force shall be composed of the following members:

(1) the Executive Director of the Board of Higher Education, or his or her designee;

(2) a representative of Southern Illinois University at Carbondale, appointed by the chancellor of Southern Illinois University at Carbondale;

(3) a representative of Southern Illinois University at Edwardsville, appointed by the chancellor of Southern Illinois University at Edwardsville;

(4) a representative of Southern Illinois University

School of Medicine, appointed by the President of Southern Illinois University;

a representative of the University of Illinois at Urbana-Champaign, appointed by the chancellor of the University of Illinois at Urbana-Champaign:

(1) a representative of the University of Illinois at Chicago, appointed by the chancellor of the University of Illinois at Chicago;

(2) a representative of the University of Illinois at Springfield, appointed by the chancellor of the University of Illinois at Springfield;

(3) a representative of the University of Illinois School of Medicine, appointed by the President of the University of Illinois;

(4) a representative of the University of Illinois at Chicago Hospital & Health Sciences System (UI Health), appointed by the Vice Chancellor for Health Affairs of the University of Illinois at Chicago;

(5) a representative of the Division of Mental Health of the Department of Human Services, appointed by the Secretary of Human Services;

(6) 2 representatives of a statewide organization representing community behavioral healthcare, appointed by the President of Southern Illinois University from nominations made by the statewide organization; and

(7) one representative from a hospital located in a municipality with more than 1,000,000 inhabitants that principally

provides services to children.

(c) The Task Force shall meet to organize and select chairperson from the non-governmental members of the Task Force upon appointment of a majority of the members. The chairperson shall be elected by a majority vote of the members of the Task Force.

(d) The Task Force may consult with any persons or entities it deems necessary to carry out its purposes.

(e) The members of the Task Force shall receive no compensation for serving as members of the Task Force.

(f) The Task Force shall study the concepts presented in House Bill 5111, as introduced, of the 100th General Assembly. Additionally, the Task Force shall consider the fiscal means by which the General Assembly might most effectively fund implementation of the concepts presented in House Bill 5111, as introduced, of the 100th General Assembly.

(g) The behavioral health workforce comprises a broad range of professions providing prevention, treatment, and rehabilitation services for mental health conditions and substance use disorders. In order to address workforce capacity issues that impact access to care, the Task Force must engage in extensive planning and data collection. Because there is no central data repository that exists for Illinois' behavioral workforce, the Task Force will identify a data set, which is a foundational step to analyzing and providing recommendations to the concepts presented in House Bill 5111.

(h) The Task Force shall submit its findings and recommendations to the General Assembly on or before ~~September 28th, 2018.~~ December 31, 2019.

(i) The report to the General Assembly shall be filed with the Clerk of the House of Representatives and the Secretary of the Senate in electronic form only, in the manner that the Clerk and the Secretary shall direct.

(j) The Board of Higher Education shall provide technical support and administrative assistance and support to the Task Force and shall be responsible for administering its operations and ensuring that the requirements of this Act are met.

Section 99. Effective date. This Act takes effect upon becoming law.

Appendix A2 – HB5111 as Introduced, with Concepts for Study by the Task Force

AN ACT concerning health.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act may be cited as the Behavioral Health Workforce Act.

Section 5. Findings. The General Assembly finds that there are insufficient behavioral health professionals in this State's behavioral health workforce and further that there are insufficient behavioral health professionals trained in evidence-based practices. This workforce shortage leads to inadequate accessibility and response to the behavioral health needs of persons residing in this State of all ages, children, adolescents, and adults. These shortages have led to well-documented problems of consumers waiting for long periods of time because care is not available. As a result, individuals with mental illness or substance use disorders end up in hospital emergency rooms which are the most expensive level of care or are incarcerated and do not receive adequate care, if any. As this State moves individuals from institutions to community care to keep them more closely connected with their families and communities, the behavioral health services workforce shortage is increasingly felt by the inability to hire and retain behavioral health professionals in this State.

The purpose of this Act is to improve community-based behavioral health services for persons residing in this State and to increase the number of behavioral health professionals and train these professionals in evidence-based practices that will improve the quality of care, including utilizing the existing infrastructure and telehealth services which will expand outreach to more rural and underserved areas in this

State.

Section 10. Behavioral Health Education Center; creation; duties.

(a) The Behavioral Health Education Center is created and shall be administered by a teaching or research State university, or both. The Center shall be operational on or before July 1, 2019.

(b) The Center shall:

(1) provide funds for 2 additional medical residents in a State-based psychiatry program each year beginning July 1, 2019 until a total of 8 additional psychiatry residents are added in 2022. The Center shall provide psychiatric residency training experiences that serve rural areas of this State and other underserved areas. As part of his or her residency training experiences, each Center-funded resident shall participate in the rural training for a minimum of one year. A minimum of 2 of the 8 Center-funded residents shall be active in the rural training each year;

(2) provide funds for 5 one-year doctoral-level psychology internships, master social workers, and master level clinical professional counselors in this State within 12 months after the effective date of this Act and every year thereafter and increase the number of interns in the program to 10 within 36 months after the effective date of this Act. The interns shall be placed in communities so as to increase access to behavioral health services for patients residing in rural and underserved areas of this State;

(3) focus on the training of behavioral health professionals in telehealth techniques, including taking advantage of a telehealth network that exists, and other innovative means of care delivery in order to increase access to behavioral health services for all persons within this State;

(4) analyze the geographic and demographic availability of this State's behavioral health professionals, including psychiatrists, social workers, community rehabilitation workers, psychologists, substance abuse counselors, licensed mental health practitioners, behavioral analysts, peer support providers, nurse practitioners, psychiatric-mental health nurses, and physician assistants;

(5) prioritize the need for additional professionals by type and location;

(6) establish learning collaborative partnerships with other higher education institutions in this State, hospitals, law enforcement, community-based agencies, and consumers and their families in order to develop evidence-based, recovery-focused, interdisciplinary curricula and training for behavioral health professionals delivering behavioral health services in community-based agencies, hospitals, and law enforcement. Development and dissemination of the curricula and training shall address the identified priority needs for behavioral health professionals; and

(7) beginning July 1, 2020, develop 5 behavioral health interdisciplinary training sites each year until a total of 20 sites have been developed. Ten of the 20 sites shall be in counties with a population of fewer than 50,000 inhabitants. Each site shall provide annual training opportunities for a minimum of 3 behavioral health professionals.

(c) No later than December 1 of every odd-numbered year, the Center shall prepare a report of its activities under this Act. The report shall be filed electronically with the General Assembly, as provided under Section 3.1 of the General Assembly Organization Act, and shall be provided electronically to any member of the General Assembly upon request.

Appendix B -- HB 5111 Concepts and Findings of the Task Force

HB5111 Concept for Workforce Center	Model Program Identified by Task Force
Add two additional psychiatric residencies per year to reach eight total new positions for residents serving rural and underserved areas	Increasing the number of psychiatry residents, especially for rural areas, was the initial focus of **BHECN**. Through pipeline programs, mentorship and other recruitment and support programs, BHECN has helped to more than double the number of University of Nebraska Medical College's students matching in psychiatry. [https://www.unmc.edu/bhecn/_documents/FY16-17-legislative-report.pdf]
Add ten additional one-year doctoral-level psychology, master's-level social work, and master's level clinical professional counselor internships for rural and underserved areas	Psychology interns at **BHECN**'s interdisciplinary training sites have provided over 3,500 dedicated patient visits in rural areas of Nebraska. BHECN's partnership with UNMC's Munroe-Meyer Institute has allowed 43 psychology, clinical professional counseling, social work and other behavioral health professional students complete supervised training at primary care clinics with integrated care services.
Focus on the training of behavioral health professionals in telehealth techniques, to increase access to behavioral health services for all persons	**BHECN** has developed a telehealth curriculum for the licensed behavioral health workforce that focuses on information technology standards for distance telehealth, security and credentialing. BHECN also funds telehealth training for Psychiatry Residents at Creighton-Nebraska Psychiatry Resident Program and hosts annual Behavioral Health Information Technology Summits to introduce the latest development in telehealth and improve access to rural Nebraska

Analyze the geographic and demographic availability of Illinois' behavioral health professionals, and prioritize the need for additional professionals by type and location;	Several states have created workforce dashboards to guide public and private workforce initiatives. **BHECN** operates such a dashboard, the Nebraska Behavioral Health Workforce Dashboard, and **Indiana's Management Performance Hub** produced a dashboard specifically to guide deployment of resources for opioid use disorder treatment Washington State completed an 18-month Behavioral Health Workforce Assessment to support its goal of integrating behavioral and physical healthcare by 2020. Washington State also operates a **Workforce Sentinel Network** to allow volunteers from health care employers to provider regular information about their evolving workforce needs. A dashboard of these real-world data is used to identify and respond to emerging signals of changes in occupations, skills, and roles required in healthcare systems. [https://app1.unmc.edu/publichealth/bhecn/ https://app.box.com/file/429107939705 https://www.in.gov/mph/files/MPH-2018-Annual-Report.pdf http://wa.sentinelnetwork.org/about/]
Establish learning collaborative partnerships with other higher education institutions, hospitals, law enforcement, community-based agencies, and consumers and their families in order to develop evidence-based, recovery-focused, interdisciplinary curricula and training for behavioral health professionals delivering behavioral health services	**North Carolina Child Treatment Program**'s Competency-based Learning Collaborative platform: The NCCTP uses a competency-based platform to train children's mental health providers to use evidence-based treatment with high model fidelity, which ensures effective delivery that can produce the outcomes predicted by the research backing each model. The founders of the NCCTP model believe it is replicable for adult treatment models, but North Carolina's decision not to expand Medicaid under the ACA has limited its ability to extend the Learning Collaborative approach to a largely uninsured population.

Develop five behavioral health interdisciplinary training sites each year until a total of 20 sites have been developed, each of which will provide annual training opportunities for a minimum of three behavioral health professionals	**BHECN**'s internship programs use the 42 integrated behavioral health-primary care clinics established in partnership with UNMC's Munroe-Meyer Institute to train behavioral health interns in integrated care. BHCEN is also partnering with Community Alliance, a community behavioral health center, to develop a model behavioral health interprofessional community-based education and training site
Consider the fiscal means by which the General Assembly might most effectively fund implementation of these concepts	**BHECN**'s budget offers a template for an Illinois Center, but the scale of behavioral health workforce need, and therefore the required financial resources, will inevitably be much larger in Illinois, which has X times the population of Nebraska. BHECN receives funding through appropriations from the Nebraska legislature but also actively seeks external funding from universities, federal grants through HRSA, SAMHSA, and AmeriCorp, and private foundations.

Appendix C – Select licensure data from the Illinois Department of Financial and Professional Regulation

County	LCSW	LCSW per 1,000 residents	LCPC	LCPC per 1,000 residents	LPC	LPC per 1,000 residents	LSW	LSW per 1,000	Psychologist	Psychologist per 1,000 residents	LMFT	LFMT per 1,000 residents	OT	OT per 1,000 residents
Adams	62	9.44	49	7.46	19	2.89	19	2.89	3	0.46	2	0.30	31	4.72
Alexander	0	-	2	3.30	1	1.65	0	-	0	-	0	-	0	-
Bond	13	7.82	5	3.01	6	3.61	2	1.20	0	-	2	1.20	3	1.80
Boone	34	6.35	12	2.24	6	1.12	10	1.87	2	0.37	2	0.37	13	2.43
Brown	3	4.58	5	7.63	2	3.05	0	-	0	-	0	-	1	1.53
Bureau	15	4.55	13	3.94	4	1.21	8	2.42	0	-	0	-	5	1.52
Calhoun	0	-	2	4.16	0	-	0	-	0	-	0	-	0	-
Carroll	4	2.79	1	0.70	1	0.70	0	-	1	0.70	0	-	2	1.40
Cass	6	4.89	5	4.08	2	1.63	3	2.45	1	0.82	1	0.82	3	2.45
Champaign	333	15.86	102	4.86	62	2.95	93	4.43	78	3.71	6	0.29	68	3.24
Christian	9	2.76	14	4.29	4	1.22	4	1.22	0	-	0	-	5	1.53
Clark	2	1.28	3	1.92	1	0.64	0	-	0	-	1	0.64	4	2.56
Clay	2	1.51	6	4.53	1	0.75	1	0.75	0	-	0	-	4	3.02
Clinton	15	3.99	13	3.45	8	2.13	11	2.92	0	-	0	-	23	6.11
Coles	23	4.52	43	8.45	19	3.73	7	1.38	9	1.77	0	-	12	2.36
Cook	6743	13.02	3392	6.55	2687	5.19	1932	3.73	2629	5.07	323	0.62	2709	5.23
Crawford	4	2.13	4	2.13	0	-	1	0.53	1	0.53	0	-	3	1.60

County	LCSW	LCSW per 1,000 residents	LCPC	LCPC per 1,000 residents	LPC	LPC per 1,000 residents	LSW	LSW per 1,000	Psychologist	Psychologist per 1,000 residents	LMFT	LFMT per 1,000 residents	OT	OT per 1,000 residents
Cumberland	4	3.70	4	3.70	1	0.93	1	0.93	1	0.93	0	-	1	0.93
De Witt	2	1.27	7	4.44	3	1.90	1	0.63	0	-	0	-	2	1.27
Dekalb	65	6.24	72	6.91	50	4.80	22	2.11	18	1.73	11	1.06	25	2.40
Douglas	5	2.57	2	1.03	5	2.57	6	3.08	0	-	0	-	4	2.05
DuPage	1127	12.14	913	9.83	582	6.27	412	4.44	487	5.24	69	0.74	687	7.40
Edgar	7	4.03	5	2.88	3	1.73	3	1.73	2	1.15	0	-	1	0.58
Edwards	3	4.69	0	-	0	-	1	1.56	0	-	0	-	3	4.69
Effingham	15	4.38	27	7.89	14	4.09	3	0.88	0	-	0	-	23	6.72
Fayette	6	2.80	7	3.27	3	1.40	3	1.40	0	-	0	-	3	1.40
Ford	9	6.79	6	4.52	2	1.51	2	1.51	0	-	0	-	4	3.02
Franklin	15	3.88	8	2.07	2	0.52	3	0.78	0	-	0	-	8	2.07
Fulton	15	4.30	9	2.58	7	2.01	6	1.72	2	0.57	0	-	5	1.43
Gallatin	1	1.98	2	3.95	1	1.98	2	3.95	0	-	0	-	1	1.98
Greene	4	3.07	4	3.07	2	1.53	2	1.53	0	-	0	-	1	0.77
Grundy	17	3.34	20	3.92	11	2.16	13	2.55	4	0.78	1	0.20	28	5.49
Hamilton	3	3.68	2	2.45	1	1.23	1	1.23	0	-	0	-	0	-
Hancock	4	2.24	5	2.80	4	2.24	3	1.68	0	-	1	0.56	0	-
Hardin	1	2.56	0	-	0	-	0	-	0	-	0	-	0	-

County	LCSW	LCSW per 1,000 residents	LCPC	LCPC per 1,000 residents	LPC	LPC per 1,000 residents	LSW	LSW per 1,000	Psychologist	Psychologist per 1,000 residents	LMFT	LFMT per 1,000 residents	OT	OT per 1,000 residents
Henderson	0	-	2	2.98	0	-	0	-	0	-	0	-	2	2.98
Henry	22	4.48	9	1.83	15	3.06	14	2.85	3	0.61	2	0.41	20	4.07
Iroquois	12	4.35	12	4.35	6	2.17	9	3.26	1	0.36	0	-	9	3.26
Jackson	56	9.75	65	11.32	19	3.31	18	3.13	27	4.70	1	0.17	10	1.74
Jasper	4	4.16	4	4.16	0	-	1	1.04	1	1.04	0	-	4	4.16
Jefferson	25	6.61	13	3.44	3	0.79	9	2.38	1	0.26	1	0.26	10	2.64
Jersey	7	3.20	12	5.49	4	1.83	3	1.37	0	-	1	0.46	7	3.20
Jo Daviess	10	4.68	6	2.81	3	1.40	2	0.94	2	0.94	1	0.47	2	0.94
Johnson	10	8.03	2	1.61	0	-	3	2.41	1	0.80	0	-	3	2.41
Kane	476	8.91	316	5.92	187	3.50	148	2.77	114	2.13	54	1.01	231	4.32
Kankakee	58	5.27	72	6.54	38	3.45	43	3.91	9	0.82	0	-	33	3.00
Kendall	116	9.07	59	4.61	38	2.97	50	3.91	20	1.56	2	0.16	47	3.67
Knox	14	2.79	21	4.19	3	0.60	11	2.20	4	0.80	1	0.20	6	1.20
La Salle	64	5.85	40	3.66	19	1.74	25	2.28	6	0.55	1	0.09	32	2.92
Lake	806	11.50	463	6.61	307	4.38	226	3.22	374	5.34	37	0.53	381	5.44
Lawrence	2	1.27	1	0.63	2	1.27	3	1.90	0	-	0	-	4	2.54
Lee	22	6.43	14	4.09	6	1.75	9	2.63	9	2.63	2	0.58	5	1.46
Livingston	19	5.31	13	3.64	4	1.12	7	1.96	1	0.28	0	-	8	2.24

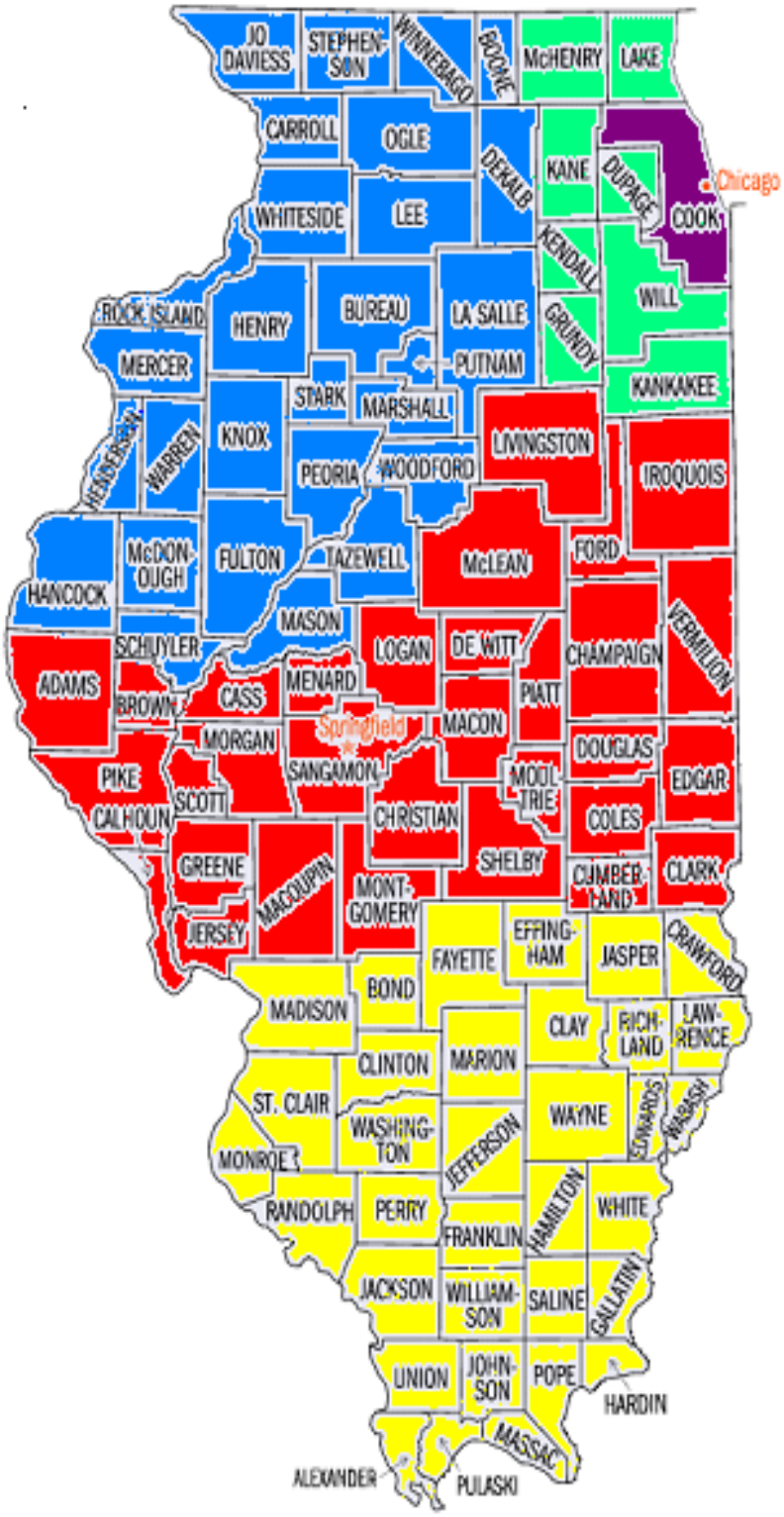
County	LCSW	LCSW per 1,000 residents	LCPC	LCPC per 1,000 residents	LPC	LPC per 1,000 residents	LSW	LSW per 1,000	Psychologist	Psychologist per 1,000 residents	LMFT	LFMT per 1,000 residents	OT	OT per 1,000 residents
Logan	13	4.49	10	3.46	12	4.15	3	1.04	1	0.35	1	0.35	1	0.35
Macon	53	5.06	41	3.92	21	2.01	14	1.34	4	0.38	2	0.19	30	2.87
Macoupin	16	3.53	8	1.77	4	0.88	5	1.10	1	0.22	0	-	7	1.54
Madison	153	5.79	117	4.42	55	2.08	45	1.70	21	0.79	6	0.23	88	3.33
Marion	16	4.25	18	4.78	6	1.59	5	1.33	0	-	0	-	13	3.46
Marshall	6	5.20	4	3.47	0	-	2	1.73	0	-	0	-	2	1.73
Mason	3	2.21	2	1.47	2	1.47	1	0.74	2	1.47	0	-	3	2.21
Massac	4	2.84	4	2.84	0	-	1	0.71	0	-	0	-	1	0.71
McDonough	18	6.01	35	11.68	10	3.34	6	2.00	10	3.34	2	0.67	5	1.67
McHenry	270	8.75	227	7.36	139	4.50	71	2.30	70	2.27	12	0.39	154	4.99
McLean	157	9.08	140	8.10	45	2.60	44	2.55	50	2.89	8	0.46	42	2.43
Menard	3	2.44	11	8.95	2	1.63	2	1.63	2	1.63	0	-	6	4.88
Mercer	3	1.92	3	1.92	3	1.92	3	1.92	0	-	0	-	5	3.20
Monroe	18	5.24	22	6.41	6	1.75	3	0.87	1	0.29	0	-	18	5.24
Montgomery	10	3.50	8	2.80	9	3.15	2	0.70	0	-	0	-	4	1.40
Morgan	27	7.95	17	5.00	10	2.94	10	2.94	3	0.88	1	0.29	4	1.18
Moultrie	1	0.68	6	4.08	2	1.36	1	0.68	0	-	0	-	1	0.68
Ogle	25	4.91	19	3.73	13	2.55	9	1.77	1	0.20	1	0.20	11	2.16

County	LCSW	LCSW per 1,000 residents	LCPC	LCPC per 1,000 residents	LPC	LPC per 1,000 residents	LSW	LSW per 1,000	Psychologist	Psychologist per 1,000 residents	LMFT	LFMT per 1,000 residents	OT	OT per 1,000 residents
Peoria	141	7.81	186	10.30	52	2.88	44	2.44	37	2.05	7	0.39	62	3.43
Perry	10	4.72	8	3.78	4	1.89	3	1.42	0	-	0	-	6	2.83
Piatt	12	7.32	6	3.66	8	4.88	4	2.44	1	0.61	0	-	5	3.05
Pike	5	3.20	2	1.28	5	3.20	1	0.64	0	-	0	-	1	0.64
Pope	1	2.37	1	2.37	0	-	1	2.37	0	-	0	-	0	-
Pulaski	0	-	2	3.66	1	1.83	1	1.83	0	-	0	-	0	-
Putnam	2	3.48	1	1.74	0	-	1	1.74	0	-	0	-	2	3.48
Randolph	18	5.61	8	2.49	7	2.18	2	0.62	0	-	0	-	8	2.49
Richland	10	6.34	8	5.08	2	1.27	3	1.90	2	1.27	0	-	8	5.08
Rock Island	48	3.35	48	3.35	29	2.02	19	1.32	11	0.77	5	0.35	38	2.65
Saline	10	4.18	11	4.60	2	0.84	5	2.09	2	0.84	0	-	9	3.76
Sangamon	175	8.96	168	8.60	80	4.10	75	3.84	49	2.51	8	0.41	101	5.17
Schuyler	5	7.24	1	1.45	1	1.45	1	1.45	5	7.24	0	-	1	1.45
Scott	0	-	0	-	0	-	1	2.03	0	-	0	-	1	2.03
Shelby	5	2.30	7	3.22	2	0.92	4	1.84	0	-	1	0.46	5	2.30
St Clair	136	5.21	102	3.91	81	3.10	45	1.72	14	0.54	14	0.54	84	3.22
Stark	6	11.06	0	-	1	1.84	0	-	0	-	0	-	1	1.84
Stephenson	21	4.69	16	3.58	9	2.01	5	1.12	3	0.67	0	-	12	2.68

County	LCSW	LCSW per 1,000 residents	LCPC	LCPC per 1,000 residents	LPC	LPC per 1,000 residents	LSW	LSW per 1,000	Psychologist	Psychologist per 1,000 residents	LMFT	LFMT per 1,000 residents	OT	OT per 1,000 residents
Tazewell	79	5.97	71	5.37	32	2.42	25	1.89	10	0.76	6	0.45	42	3.17
Union	22	13.06	11	6.53	0	-	2	1.19	2	1.19	0	-	5	2.97
Vermilion	41	5.34	20	2.60	5	0.65	13	1.69	7	0.91	0	-	7	0.91
Wabash	4	3.46	5	4.33	0	-	3	2.60	1	0.87	1	0.87	6	5.20
Warren	5	2.94	5	2.94	2	1.17	4	2.35	0	-	0	-	1	0.59
Washington	7	5.00	6	4.29	4	2.86	4	2.86	2	1.43	0	-	6	4.29
Wayne	5	3.06	4	2.45	1	0.61	2	1.22	0	-	0	-	5	3.06
White	6	4.39	8	5.85	2	1.46	2	1.46	0	-	1	0.73	8	5.85
Whiteside	30	5.39	17	3.06	9	1.62	9	1.62	3	0.54	1	0.18	12	2.16
Will	454	6.56	440	6.36	290	4.19	236	3.41	145	2.09	21	0.30	405	5.85
Williamson	83	12.38	46	6.86	14	2.09	23	3.43	18	2.68	0	-	23	3.43
Winnebago	199	7.01	144	5.07	75	2.64	78	2.75	28	0.99	22	0.77	95	3.34
Woodford	20	5.20	23	5.98	7	1.82	7	1.82	4	1.04	2	0.52	20	5.20
State Total	**12,650**		**7,955**		**5,232**		**4,006**		**4,321**		**644**		**5,870**	
# counties w/ zero	**5**		**4**		**14**		**8**		**42**		**60**		**7**	

Appendix D -- Certification Board Map

Illinois Certification Board, Inc.
July 1, 2019



Region I
813

Region II
2028

Region III
745

Region IV
596

Region V
3961

Outside Illin

Total:
8635

Note:
As of 3/1/ 2017 The Region Map will only include the number of certified professionals in good standing.

This listing does not reflect multiple credentials held by a single person.

Inactive, Emeritus and those in the application phase are

Appendix E – Stakeholder Feedback

THRESHOLDS

HOME | HEALTH | HOPE

Recommended Workforce Development Incentives to Promote Provider Uptake of Evidence-Based Behavioral Health Services Across Illinois

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Below are Thresholds' recommendations to strength Illinois' behavioral health workforce.

1. ***Create and fund Centers of Excellence or Learning Collaboratives with providers with experience in delivering evidence-based treatment models to train other providers in these service models.*** The state must invest in educating and training behavioral health providers on best practices. This kind of environment will also foster new innovation and help providers address challenges and share lessons learned.

2. ***Medicaid payment rates must fully support evidence-based treatment models.*** Illinois ranks 38th compared to other states in payment that supports mental health services.[1] If reimbursement rates do not cover the full cost of delivering a service model, there is naturally not going to be significant provider uptake of such models.

3. ***Develop and fund student loan repayment programs for behavioral health professionals that deliver evidence-based practices (e.g., Assertive Community Treatment) in underserved communities and regions across Illinois.*** To incentivize behavioral health professionals that participate in evidence-based approaches or that locate in areas where there are service shortages, the state should develop incentives such as student loan repayment programs.

4. ***Payment of enhanced reimbursement rates for targeted evidence-based models or for location in underserved regions would grow access to care for those with the most serious mental illnesses and substance use conditions.***

5. ***Illinois should shift from fee-for-service Medicaid reimbursement to a payment model that empowers and enables mental health professionals to deliver evidence-based care that results in the best health outcomes.*** Illinois' antiquated state regulatory system for mental health stymies what mental health professionals are able to do for clients. Modernizing these rules in ways that harness the community-based workforce, allowing for innovation, staffing flexibility, and the integration of mental health and substance use treatment with other medical care, combined with paying for positive health outcomes, would not only improve the quality of care delivered but also would reduce workforce burnout and turnover.

6. ***Develop programs in high schools, universities and medical schools across Illinois that build a stronger pipeline of, and career path for, all mental health professionals.*** A particular focus of these programs should emphasize social justice, as well as career development and opportunities for persons with lived experience. This would include developing mentorship networks, social media campaigns and in-person presentations by people in the field.

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[1] Kaiser Family Foundation, State Health Facts, *State Mental Health Agency Per Capita Mental Health Services Expenditures*.

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EMPOWERING LATINAS AND THEIR FAMILIES
EST. 1973

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North Riverside, IL 60546
708.442.1299

October 30, 2019

Blanca Campos
Community Behavioral Health Association

Jaimee Ray
Illinois Board of Higher Education

Sharon Post

Dear Colleagues:

We greatly appreciate the opportunity to submit comments and recommendations re. SB1165/Public Act 101-0202 creating the Behavioral Health Workforce Center Task Force. We hope that the Task Force can address workforce shortages of counselors, advocates (medical, legal, etc.), therapists and other trained professionals working on domestic violence, sexual assault, stalking, trafficking and other forms of gender-based violence.

Apna Ghar, Inc. and Mujeres Latinas en Acción have several recommendations related to workforce shortages, maldistribution and the uptake of evidence-based practices in the currently practicing workforce and soon to be entering members of the same workforce.

Recommendations

Heightened Inclusion of and Greater Appreciation that Gender-Based Violence supportive services (intervention/prevention) are critical components of the Behavioral Health sector or field.

Increased Awareness and Outreach for the Recruitment of Students in Behavioral Health

- Colleges and Universities should increase efforts to educate students about the wealth of professional opportunities in the field.
- Colleges and Universities should create awareness about how diverse the behavioral health field is.

Development of curricula at participating Colleges/Universities (or at the BHECN) for future providers

- Curriculum development on gender-based violence that highlights its intersectionality with public health and community violence/public safety issues.
- Curriculum development for training on cultural competency with expertise from culturally specific providers and/or experts in the field –
    - *Meet the Participant Where They Are- it's beyond sharing a common language. What are the cultural values that professionals should be aware? What behaviors or nuanced approaches should the professional consider and adopt to serve specific populations?*
- Curriculum development for training on supporting immigrant and refugee populations (particularly types of trauma related to migration and displacement in addition to experience of gender-based violence).

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Increased Resources from state, federal and local agencies to improve the competitiveness of Behavioral health organizations

- Increase employee pay to compete with MCOs, FQHCs and hospitals particularly those that provide trauma informed care.
- Additional employee benefits like loan forgiveness, rental/housing assistance and /or transportation assistance.
- Forming coalitions to negotiate better health/dental/general employee benefits at reduced costs.
- Forming coalitions to ensure financial and operational quality and compliance (example hiring a government grants officer to work across several agencies).
- More formalized partnerships to solidify recruitment and partnership with public and state universities.
- Creation of paid fellowship opportunities (post-Bachelor's and Master's students) to address turnover issues and develop a pipeline of fellows to employees.

Thanks so much for the opportunity to submit. Please feel free to contact me at 773-890-7667 or ltortolero@mujereslat.org or Neha Gill at 773-883-4663 x231 or ngill@apnaghar.org should you have any questions.

Sinceramente,

Linda Xóchitl Tortolero

Linda Xóchitl Tortolero
President and CEO

Cc: Neha Gill, Executive Director, Apna Ghar, Inc. (Our Home)

Illinois Association for Behavioral Health

937 South Second Street · Springfield, IL 62704
217.528.7335 · 217.528.7340 fax
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IABH Programs: cebringoodman teeninstitute, operation snowball

October 17, 2019

The Illinois Association for Behavioral Health (IABH) is pleased to submit these comments and feedback to the Behavioral Health Workforce Education Center Task Force on behalf of our membership. IABH's members include more than 70 direct service agencies and affiliated organizations, 10 corporate members who support behavioral health service agencies, and over 8000 individual members who are practitioners working in the behavioral health field. The Association also manages two direct-service youth addiction prevention and leadership programs that include a workforce development track to attract youth to the behavioral health field.

Our providers face numerous and pervasive challenges that go beyond simple budget solutions. The increasing awareness of, and urgency to prevent and treat mental health (MH) and substance use disorders (SUD) at the onset, and at early stages of the diseases are placing increasing and at times, impossible demands on our system. Providers face challenges in recruiting new staff, retaining current staff and training staff to move into leadership positions. The following recommendations represent input from numerous sources, including service providers, practitioners, state leaders, training and educational professionals and industry experts.

Fiscal Recommendations

- Salaries: advocacy efforts should include activities to ensure that MH and SUD treatment professionals' salaries are on an equal level with other healthcare professionals. Too often MH and SUD professionals leave the field to pursue other areas of healthcare for the simple reason that moving allows them to pay their bills without holding multiple jobs at once.

- Fiscal support should be provided to incentivize a base living wage for entry level addiction prevention specialists. (Addiction prevention services are financed through a grant-based system in the Department of Human Services.)

- Rates for MH and SUD treatment services should be increased to ensure staff are adequately compensated for their work, expertise and education level.

Educational Recommendations

- Promoting the field as a career option: state support for programs should promote the behavioral health field as a career choice for high school and college students. Students should view a career in behavioral healthcare the same they would nursing or allied fields.

- Low-cost training options: policy makers should continue to support programs that provide low- or no-cost training opportunities for professionals currently in the field. This would be a great assistance to provider's ability to retain staff.

- Loan forgiveness programs: the State should fully fund PA 100-0862/HB 5109 – the Community Behavioral Health Care Professional Loan Repayment Program Act. We also ask that similar student loan

forgiveness programs be expanded to include students who pursue graduate level degrees for MH and SUD professions. The fact that salaries lag behind other healthcare professionals make it difficult to attract students to the field when they will face repaying loans almost immediately upon entering the field.

- Collaboration with schools of public health, social work and related fields should be pursued to explore both career pathways and to attract new talent to the field.

- Partner with colleges and universities to increase educational opportunities for the MH and SUD prevention, treatment, and recovery support services workforce.

- Work with colleges and universities towards curriculum integration for MH and SUD prevention, treatment, and recovery support.

- Develop an Illinois core knowledge and skill set that is marketable across different prevention areas such as suicide prevention, teen pregnancy prevention, etc.

Recommendations for Public Sector

- Incentivize agencies to employ certified addiction prevention specialists.

- Create incentives and low-cost opportunities for prevention specialists to achieve certification.

- Provide bonus incentives for continuing MH and SUD training and education.

- Identify if workforce training needs drive turn-over rates. Develop training plan to address gaps and reduce turnover.

- Increase SUD clinical supervision opportunities for the workforce.

- Define SUD prevention, treatment, and recovery support supervision basic and advanced skill set.

- Provide and incentivize training and certification opportunities for existing and potential MH and SUD services supervisors.

- Promote American Society of Addiction Medicine (ASAM) board certification.

- Identify comprehensive core and advanced knowledge/skills needed to work with patients with MH and/or SUDs including concomitant risks such as TB and Hep C, etc.

- Training both for use of EHRs as well as use of tech for treatment – telepsych, apps, training/supervision increasing both service and training/supervision.

From: Hossam Mahmoud <drhouss@yahoo.com>
Sent: Monday, December 16, 2019 7:05 PM
To: Marvin <mlindsey@cbha.net>
Cc: Meryl Sosa <msosa@ilpsych.org>
Subject: Fw: Workforce Report

Dear Mr Lindsey,

My name is Hossam Mahmoud. I am the President of the Illinois Psychiatric Society.

Please, find below the benefits that we, at the Illinois Psychiatric Society, consider when it comes the shortage in psychiatric workforce in IL and the suggested solution of funding medical school debt relief. Psychiatrists need to have the funding for their medical school debts because:

1. More residents will stay in IL after they finish their residency because that is what would be required.
2. In all likelihood, the residents would have to work in rural or underserved areas to get the funding so that would be very helpful for patients.
3. It will also help residency training programs in IL attract residents because they would get part of their medical school cost covered.

Best regards,

Hossam

Hossam Mahmoud, MD MPH DFAPA
Medical Director and SVP Behavioral Health, Regroup
President, Illinois Psychiatric Society

Appendix F1 -- Behavioral Health Center of Nebraska Budget, FY 2016/2017

State Appropriations, LB603	
Personnel	631,707
Operations	1,060,789
Total Annual Appropriation	$1,692,496
Additional State funding for rural psychology internships (LB 901)	$548,000
Additional State funding for training for behavioral health screening in primary care settings (LB 556)	$648,000
Federal and Foundation Funding	$431,208
Total BHECN Budget	**$3,319,704**

Appendix F2 -- Comparison of Scale of Need -- Nebraska vs Illinois

	Nebraska	Illinois
Population	1,929,268	12,741,080
Medicaid enrollment, total	242,317	2,823,612
Medicaid enrollment, children	165,400	1,310,900
Estimated number of residents 18 or older with Serious Mental Illness	54,000	340,000
Estimated number of residents, 12 or older, with Substance Use Disorder	117,000	824,000
Estimated number of residents, 18-25, with Serious Mental Illness	12,000	71,000

Estimated behavioral health workforce shortfall by 2030		
	Nebraska	**Illinois**
Psychiatrists	120	920
Psychologists	90	60
Addiction Counselors	120	770
Mental Health Counselors	360	1540
Total	**790**	**3310**