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

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

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

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

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

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

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

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

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

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

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

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

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

The Impact of Workforce Shortage

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

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

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

Insurance Parity Issues

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

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

Recommendations from the BHWC

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

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