Illinois Behavioral Health Workforce Center

Biennial Legislative Report

November 2025

IDHS

IBHE
Illinois Board of Higher Education

BHWC
BEHAVIORAL HEALTH WORKFORCE CENTER

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December 1, 2025

Kari M. Wolf, MD
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Illinois Behavioral Health Workforce Center
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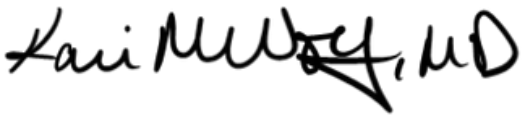
To: Governor JB Pritzker
President of the Senate, Don Harmon
House Speaker, Emanuel "Chris" Welch
Senate Minority Leader John Curran
House Minority Leader Tony McCombie
Members of the General Assembly

As Chief Executive Officer of the Illinois Behavioral Health Workforce Center (BHWC), I have had the pleasure of leading the work for the BHWC over the past two years. Together with state and local partners, the BHWC has collected and assessed behavioral health workforce data and have developed a strategic plan to address the many challenges facing the residents and behavioral health professionals in Illinois.

This report details the issues raised by local, regional, and state leaders in behavioral health services as well as the challenges and opportunities that exist to grow and expand the behavioral health workforce for the future. The following pages also serve as a status report on the development of behavioral health education, training, recruitment and retention of the workforce in Illinois, which you may find helpful in future legislative sessions.

The Behavioral Health Workforce Center is committed to developing and implementing action strategies for the growth of our behavioral health professions, especially in rural and underserved regions of the state. The information included in this report provides a foundation for coordinated efforts and public-private partnerships. I hope you will join with me and our partners as we work to strengthen our behavioral professions, provide needed services, and improve access to behavioral health services through a strong, highly trained workforce for the future.

Sincerely,



Kari M. Wolf, MD

Executive Summary

Key Areas of Impact FY23-FY25: Statewide and Regional

Over the past two years, the Illinois Behavioral Health Workforce Center (BHWC) has advanced statewide efforts to strengthen the behavioral health workforce through coordinated recruitment, education, retention, and policy initiatives. Established through the Behavioral Health Workforce Act, the Center uses data-driven strategies to expand workforce capacity, improve training quality, and support providers across all regions, particularly in Central and Southern Illinois where shortages are most severe.

Key Findings

Illinois continues to face major shortages among behavioral health professionals, including LPCs, LSWs, LMFTs, and psychologists. Providers frequently report limited access to high-quality supervision, uneven training opportunities, high caseloads, burnout, and low compensation – factors that disproportionately impact early-career professionals, those with lower credentials, and underrepresented staff. Surveys also highlight major gaps in skill preparedness, particularly for services involving children and families, serious mental illness, and complex clinical needs.

Through assessments, advisory groups, and ongoing monitoring, the Center identified six core areas of focus: data collection, recruitment, education, retention, quality of care, and policy engagement.

1 *Data Collection and Assessment*

Data Mapping Project: Analysis of IDFPR data shows Regions 4 and 5 hold the lowest provider-to-population ratios across key behavioral health roles, signaling acute access gaps.

Workforce Needs Assessments: Over 2,200 providers, supervisors, and program directors serving community mental health and outpatient mental health, and integrated care settings have contributed data identifying:

- Strong interest in training on trauma-informed care, Cognitive Behavioral Therapy (CBT), Motivational Interviewing (MI), stress management, and supervision
- Barriers including cost, time, and productivity expectations
- Retention risks tied to low pay, workload, organizational climate, and limited advancement
- Skill gaps among early-career staff, especially in child/family work, serious mental illness, and co-occurring substance use and mental health disorders

Provider Engagement and Partnership: 217 agency staff across behavioral health settings – including supervisors, program directors, and executive leadership – participated in advisory groups and listening sessions, shaping statewide priorities around early-career preparation, supervision, workplace culture, training needs, and financial barriers.

Ongoing Data Monitoring to Support Entry into Behavioral Health Positions and Quality of Care: Ongoing monitoring and evaluation informs the Certified Recovery Support Specialist Success Program, Chicago Parent Program, Solution-Focused Brief Therapy, and BHWC training initiatives.

2 Recruitment

Statewide Outreach and Marketing: The Center launched a statewide job board to connect employers and job seekers, featuring over 168 vacancies posted by employers and more than 80 job seeker profiles. The Center expanded outreach through conferences, career fairs, a newsletter of 600+ subscribers, and a LinkedIn presence that generated over 11,000 impressions.

3 Education

Education and Career Pathways: The Center identified regions with critical gaps in behavioral health degree programs and prioritized expanding educational pathways, particularly in the southern half of the state. It developed a high school career awareness curriculum for grades 9–12 to spark early interest in behavioral health professions.

Peer Support Development and the Certified Recovery Support Specialist (CRSS) Success Program: BHWC staff partnered with the Division of Behavioral Health and Recovery (DBHR) and the Illinois Certification Board (ICB) to support the CRSS Success Program and statewide recovery/peer support events with 250+ participants.

Expanding Postsecondary and Professional Training: The Center partnered with community colleges to pilot an associate-level Child & Family Behavioral Health Specialist curriculum, adapted from a Maine model, expanding accessible training opportunities.

Enhancing Curriculum and Clinical Skills Training: To address statewide skill gaps, a 15-member ad hoc committee consisting of university and agency partners developed an action plan that includes development of an online skills-training repository for faculty and supervisors that includes curriculum modules for use across disciplines.

4 Retention

Retention remains one of Illinois's most pressing workforce challenges. The Center has responded with training, tools, and partnerships designed to strengthen organizational stability.

Retention Support: The Center hosted three statewide retention events – two in person and one virtual – engaging 281 providers, largely those in leadership roles. An online employee retention toolkit is currently in development to highlight practical tools, best practices, and organizational strategies that agencies can adopt to strengthen workplace culture and reduce turnover.

Dissemination of Retention Support: Provider surveys confirm that improving supervision, workplace culture, and compensation transparency are central to long-term retention. The BHWC continues to share tools and findings through partnerships with organizations such as Chicago Department of Public Health (CDPH), Illinois Association of Rehabilitation Facilities (IARF), Community Behavioral Healthcare Association (CBHA), Illinois Health and Hospital Association (IHA), and others.

5 Quality of Care

BHWC advanced its commitment to quality care through supervision training, continuing education and evidence-based practice dissemination.

Supervision Training: In response to BHWC provider advisory groups and survey data, the Center created three asynchronous supervisor training modules that focus on effective supervision strategies, with 561 providers completing the trainings and 983 more in progress. Supervision Learning Collaboratives were created and the Center matched 16 Licensed Social Workers with Licensed Clinical Social Worker supervisors, created a supervision request tracking system, and launched ECHO programs to support supervisor training.

Statewide Training and Continuing Education: The Center has launched 12 asynchronous CEU-bearing courses that have generated 804 course completions and 1,170 hours of learning. Additionally, the Center delivered 20 CEU-bearing ECHO sessions on trauma-informed care, crisis intervention, integrated care, and telehealth, engaging more than 100 participants.

Evidence-based Practices Training and Implementation Support: The Center provided training and implementation support for Solution-Focused Brief Therapy to 319 providers, strengthened statewide capacity for implementation of PracticeWise MATCH (a treatment manual for mental health needs of children and early teens), and supported training in the Chicago Parent Program for 109 providers across 22 agencies.

> *"I really appreciate the structured breakout rooms in the training! It is a great way to discuss personal experiences and practice skills that we learned about in the lecture portion."*
> -Supervision Learning Collaborative Participant

6 Policy Engagement and Legislative Support

Legislative Impact: The Center contributed to policy briefs and legislative proposals focused on licensure reform, supervision access, and workforce data transparency, as well as providing testimony to the Medicaid Advisory Committee, the joint hearing of the Senate and House Mental Health and Addiction Committees, and participated in the Administrative Burden Reduction Task Force.

Policy Project Team: The Center launched a policy project team to examine accreditation requirements, identify barriers to entering the field, and develop recommendations to support stackable credentials and clearer licensing pathways.

BHWC-Wide Policy Engagement: Center staff advocated for legislative changes tied to regional workforce needs, particularly the collection of more detailed geographic licensing data and played an active role in support of HB3487, legislation that requires the Illinois Department of Financial and Professional Regulation (IDFPR) to collect expanded workforce data.

Strategic Planning: To guide long-term strategy, the Center facilitated a six-month, multi-stakeholder strategic planning process involving SIU SOM, UIC, and statewide partners to establish priorities for FY26–FY28.

Recommendations for FY26–FY28

To meet the behavioral health needs of Illinois residents and develop an adequate, well-prepared workforce, the Center recommends:

- Development of a statewide career awareness initiative to support awareness of behavioral health professions across educational settings.
- Continued dissemination of high-impact training and agency support to increase quality of care and improve retention rates.
- Expansion of psychiatry residency and fellowship programs in Central and Southern Illinois.
- Expansion of degree and internship opportunities in counseling, social work, occupational therapy, and marriage and family therapy, and doctoral-level psychologists in underserved regions (south and central).
- Increasing funding and support for clinical supervision pathways, particularly for Licensed Clinical Social Workers (LCSW) and Licensed Clinical Professional Counselors (LCPC).
- Strengthening data infrastructure to enable more precise, real-time workforce planning and evaluation.

Through continued partnership with state leaders and provider agencies, the BHWC will sustain momentum toward a stronger, more diverse behavioral health workforce prepared to meet Illinois's evolving behavioral health needs across the entire state.

I. Introduction

History

Established by the 2021 Health Care and Human Services Reform Act, the Center is funded by the DHS Division of Mental Health (now the Division of Behavioral Health and Recovery) and administered by the Illinois Board of Higher Education (IBHE). The legislation tasked the BHWC with a comprehensive charge: to assess workforce gaps, expand training and education opportunities, improve retention, promote diversity, and serve as a statewide hub for data collection and coordination. The BHWC was built with two regional hubs, including a primary hub at the Southern Illinois University School of Medicine (SIU SOM) and a secondary hub at the University of Illinois Chicago (UIC), allowing for broad geographic reach and engagement with urban and rural communities.

The BHWC released its first report to the Illinois General Assembly in December 2023, outlining its foundational year of operations. Initial groundwork included the creation of a multi-year work plan, the launch of the Center's independent website and interactive behavioral health workforce dashboard, and the formation of an Executive Committee and Advisory Council composed of representatives from higher education, provider systems, statewide provider membership organizations, and state government. Provider advisory groups across practice areas (community mental health, integrated care, serious mental illness, etc.) were formed to provide ongoing feedback about behavioral health provider needs and Center initiatives. Five interdisciplinary project teams were subsequently developed to address core workforce development challenges: education and career pathways, access and affordability, career awareness, diversity and equity, and policies impacting the profession. Key accomplishments outlined in that report included the launch of targeted surveys and provider training, the initiation of pilot projects to support parent-peer professionals and non-graduate degree mental health extenders, and the dissemination of evidence-based practices such as the Chicago Parent Program and Solution-Focused Brief Therapy.

Primary Goal

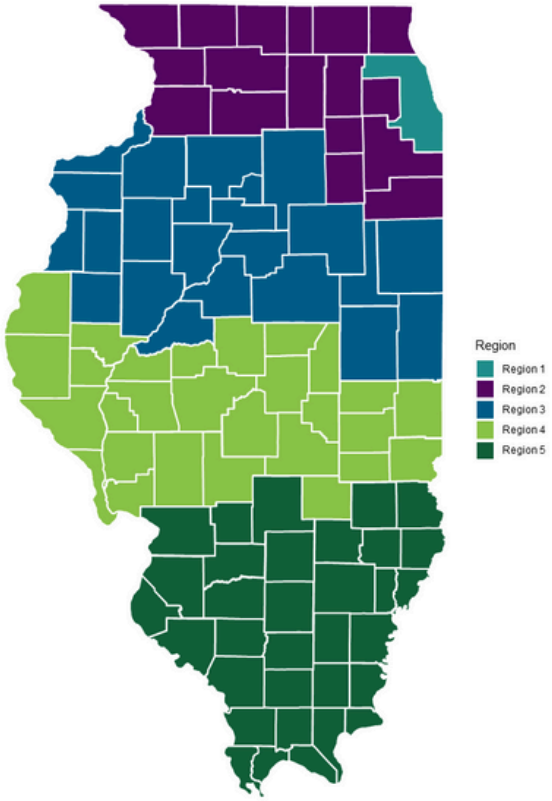
The Behavioral Health Workforce Center's primary purpose is to **strengthen Illinois's behavioral health system by expanding access to effective services** through coordinated workforce recruitment, education, and retention efforts. The Center supports this mission through ongoing data collection, addressing structural and policy barriers, increasing the number and diversity of behavioral health professionals – including those with lived experience – and enhancing provider capacity in accessible community-based and primary care settings.

II. Partnerships

A cornerstone of the Behavioral Health Workforce Center's approach is deep and sustained collaboration across sectors. To fulfill its legislative mandate, the Center has partnered with a diverse array of organizations, including higher education institutions, healthcare systems, provider organizations, community mental health agencies and state agencies. These partnerships have been crucial in shaping the Center's strategies and ensuring that its initiatives are informed by real-world workforce needs.

The BHWC has fostered statewide engagement, ensuring representation across all five Illinois Department of Human Services (DHS) regions:

- Region 1: Cook County
- Region 2: Northern Illinois
- Region 3: North Central Illinois
- Region 4: Central Illinois
- Region 5: Southern Illinois



Advisory Council

Broad-based stakeholder body that guides the Center's programmatic work and provides input to address financial and systemic barriers to the behavioral health workforce.

Provider Advisory Groups

A forum for members to share information and resources as it pertains to workforce retention, training and technical assistance and provide recommendations around key practice areas

Project Teams

In FY25, the BHWC launched five new interdisciplinary project teams, each tasked with addressing major priority project areas including: Career Awareness and Development, Education and Career Pathway, Access and Affordability, Building a Diverse and Equitable Workforce, and Policy Changes that Impact the Profession.

Advisory Council

The BHWC Advisory Council serves as a broad-based stakeholder body that guides the Center's programmatic work. The Council provides input to address financial and systemic barriers to the behavioral health workforce. Council members include representatives from:

1. Public and private higher education institutions
2. State agencies (e.g., DHS, IBHE, IDFPR, ISAC)
3. Behavioral health provider organizations
4. Community based providers

The Council met quarterly throughout FY24 and FY25 to provide input on the strategic plan, identify system-level barriers and recommend recruitment and retention strategies. Council members also played a key role in promoting career awareness efforts and distributing educational resources across their networks.

Provider Advisory Groups

In January 2023, the Center launched provider advisory groups to better understand the training and retention needs of behavioral health providers across Illinois. In FY23-FY25, these groups included providers from Community Mental Health; Child, Adolescent, and Parent Services; Integrated Care; Serious Mental Illness; Substance Use and Recovery; Psychiatric Mental Health Nurse Practitioners; and Recovery Support Specialists. Provider groups are comprised of behavioral health professionals from all levels, including agency leadership, program coordinators, chief executive officers & presidents, chief operations officers, chief program officers, human resources officers, clinical supervisors and managers, directors (executive, deputy, senior, clinical, medical), peer support specialists, psychologists, and therapists. The provider advisory groups offer a forum for members to share information and resources as it pertains to workforce retention, training and technical assistance and provide recommendations around key practice areas.

These groups support the development of specific initiatives leading to the creation of ad hoc groups focused on addressing key needs. For example, the Center has convened ad hoc and ongoing workgroups to address targeted topics, including Supervision, Mentoring, Workforce Development in Child and Adolescent Services, and Educational Pathways. Between 2023 and 2025, 217 agency staff from all regions of the state participated in provider meetings, listening sessions, and one-on-one discussions, providing valuable insights that continue to inform statewide strategies for workforce training and retention.

These groups have been instrumental in surfacing provider needs, identifying training gaps, and advising on the design of continuing education content. They also contributed to statewide surveys and helped shape the content of Extension for Community Care Outcomes (ECHO) trainings for both clinical and non-clinical audiences (see Data Collection and Assessment for more details). These groups draw participants from all five Illinois Department of Human Services (DHS) regions, ensuring that perspectives from urban, suburban, and rural areas are represented.

Project Teams

In FY25, the BHWC launched five new interdisciplinary project teams, each tasked with addressing major priority project areas including: Career Awareness and Development, Education and Career Pathway, Access and Affordability, Building a Diverse and Equitable Workforce, and Policy Changes that Impact the Profession.

Each team included 10–20 members representing public universities, community colleges, behavioral health providers, provider membership organizations, and governmental partners. Teams met monthly for 5 months and operated with a clearly defined scope of work tied to BHWC priorities.

Key accomplishments of these teams include: Recommendations to expand supervision pathways for social workers, identification of entry-point barriers for adult learners, drafting of high school and college-level career awareness toolkits, development of a statewide diversity data collection tool, draft policy guidance for stackable credentials and accreditation reform.

Ongoing system collaboration with key state partners

1. Illinois Transformation of Children's Mental Health Services Initiative
2. Illinois Certification Board (ICB) and Alcohol and Other Drug Abuse Professional Certification Association (IODAPCA)
3. Illinois Division of Behavioral Health & Recovery (Formerly DMH & SUPR now merged as IDBHR)
4. Illinois Department of Human Services (IDHS)
5. Cook County Health (CCH) Behavioral Health Workforce Assessment Steering Committee
6. University of Illinois Urbana Champaign (UIUC) Provider Assistance and Training Hub (PATH)
7. Community Behavioral Healthcare Association of Illinois (CBHA)
8. Cook County Behavioral Health
9. Illinois Board of Higher Education (IBHE)
10. Illinois Community College Board (ICCB)
11. Illinois Association of Rehabilitation Facilities (IARF)
12. Illinois Primary Health Care Association (IPHCA)
13. Cook County Behavioral Health Regional Behavioral Health Collaboratives
14. Madison County 708 Board
15. Illinois Children's Mental Health Partnership
16. National Association of Social Workers, Illinois Chapter (NASW)
17. Illinois Association of Infant Mental Health

Center staff also shared expertise and represented the organization through presentations and panel participation at eleven statewide conferences (see the appendix for full list) and professional gatherings across Illinois. The presentations highlighted the Center's training, recruitment, and retention resources.

These collaborations enhance the Center's reach across the state. For example, leadership from ICB and IDBHR Wellness and Recovery Services were partners in three well-attended events for recovery support professionals. Collaboration ensured content that fit the needs of the recovery support community, facilitated the broad dissemination of the events, and resulted in highly rated events that supported both students working toward certification in behavioral health and established professionals.

The Center also facilitated cross-team communication and regular updates via newsletters, advisory briefings, and joint planning sessions. This model has encouraged shared ownership and innovation across systems of care.

III. Key Areas of Impact FY23-FY25: Statewide and Regional

Since its inception, the Behavioral Health Workforce Center (BHWC) has prioritized workforce development across all of Illinois's regions. From Southern Illinois to inner-city Chicago, the BHWC initiatives have directly supported workforce expansion, community engagement, and education-to-employment pathways. Through FY25, the Center has engaged more than 150 statewide partners spanning education, healthcare, and policy sectors to foster collaboration and alignment.

The breadth of BHWC's impact over the past two years reflects a shift from planning to implementation. By aligning efforts across data, education, policy, and training, the Center is addressing both short-term workforce gaps and long-term transformation of the behavioral health workforce system. In the next section, the following six impact areas are defined for progress:

1. DATA COLLECTION AND ASSESSMENT
2. RECRUITMENT
3. EDUCATION
4. RETENTION
5. QUALITY OF CARE
6. POLICY ENGAGEMENT & LEGISLATIVE SUPPORT

1 DATA COLLECTION AND ASSESSMENT

Data Mapping Project

In 2025, the BHWC completed a data mapping and analysis project (see Illinois Behavioral Health Workforce Data Report regarding statewide and regional data on licensure, professional distribution, degree conferral, and clinical training capacity.

To better understand the state's capacity to develop its behavioral health workforce, the Center collaborated with IBHE to map education-to-licensure gaps. This information highlights areas in which targeted strategies are needed to increase degree conferral in underserved regions. The BHWC analyzed data provided by IBHE in November 2023. This dataset included the number of behavioral health-related degrees conferred statewide from 2019 to 2023.

A comprehensive regional analysis can be found in the appendix.

Statewide Key Findings:

1. Data from the Illinois Board of Higher Education from 2019-2023, conferred 4,935 license-eligible psychology degrees, 617 license-eligible counseling degrees, 9,226 license-eligible social work degrees, 377 license-eligible MFT degrees, 1,274 license-eligible degrees in occupational therapy, and 139 license-eligible psychiatric mental health nursing certifications.
2. That data report demonstrates that of the twelve Psychiatry Residency Programs in Illinois, none exist in Southern Illinois (Region 5). This shortage creates a gap in locally available clinical rotation opportunities. Additionally, more psychiatrists retire than graduate from residencies each year, compounding the shortage in rural and underserved areas.
3. The number of Psychology license-eligible degrees conferred in Central (4) and Southern (5) Illinois is lower than in other regions of the state. Only Psychologists who have completed an internship as part of their doctoral degree can graduate. After graduating with their doctoral degree, Psychologists must complete a post-doctoral program before they can be independently licensed. SIUC offers the only post-doctoral accredited internship program outside of the Cook County Region.
4. The number of Social Work license-eligible degrees conferred in the Central Region (4) is the lowest of all regions.
5. Only Cook County and the North Central Regions (1 and 2) confer degrees in MFT and OT. SIUC has started a new OT program in region 5 and conferred seven license-eligible degrees for its inaugural class in May of 2025.
6. A shortage of MFT programs in downstate Illinois (regions 3, 4, and 5) may reflect an absence of educational offerings but may also be housed in other degree programs not using the MFT degree title. Further exploration is needed.
7. The lack of OT degrees conferred in North Central, Central, and Southern Illinois (3, 4, and 5) demonstrates limited access to educational programs needed to address the regional workforce shortage.
8. In all behavioral health professions assessed for this report, the low number of providers in the North Central, Central and Southern Illinois Regions (3, 4, and 5) may be a result of fewer degrees conferred in these regions.

1 DATA COLLECTION AND ASSESSMENT

The Center also developed plans to collect and integrate Medicaid (HFS) data to enhance the dashboard's predictive capabilities. In collaboration with Health Management Associates (HMA), the Center staff completed a Mental Health and Substance Use Disorder Prevalence & Workforce Study that used Medicaid data to identify counties and regions with a high level of utilization of behavioral health services and low number of providers.

BHWC Needs Assessments

Examining state workforce data was an essential part of the Center's assessment as it highlighted shortage areas and provided baseline information on needs across the state. However, existing data had gaps regarding the specific needs of behavioral health providers across the state. For example, the factors that lead to provider attrition and the unmet needs in educational preparation were unclear. Thus, the Center has performed a series of statewide provider surveys to examine workforce needs in behavioral health settings in Illinois.

The Center completed surveys on Community Mental Health (CMH), Integrated Care (IC), Serious Mental Illness (SMI), and Early-Career Staff.

Additionally, research is underway to assess the status of Recovery Support Specialists and Child & Family Behavioral Health Specialist positions. Data being collected by Prevention First will be analyzed to provide comparable information about providers who work in substance use and recovery programs.

Needs assessment information was collected from community mental health agencies and began with stratified random sampling from the five regions to ensure balanced geographic representation. When recruitment of randomly selected samples did not result in an adequate sample size, convenience sampling was employed, with close monitoring of regional response rates to maintain diversity and accuracy. Details on methodology can be found in the Appendix. Future surveys will assess needs from private practice, hospital and additional workplace settings.

The assessments functioned as a method to collect feedback from providers regarding:

- Demographics of the providers across regions
- Provider education and employment
- Confidence in providing services to specific groups and for specific needs
- Perceived adequacy of the training received
- Use of various interventions
- Attrition probability and contributing factors

A roadblock to understanding the workforce shortage identified in the first year of the Center's operations is the lack of detail in the data collected by the state. Previous data collection was not specific enough to even determine the number of providers currently in practice. **The Center worked closely with IDFPR to support the passage of HB3487, requiring the state to collect more detailed licensing data.**

This is a significant accomplishment as it will provide the Center with more comprehensive information about shortage areas, critically needed provider types, provider demographics, and areas of practice.

Findings from the needs assessments informed – and continue to inform – BHWC goals and initiatives. A high-level summary of the findings from the needs assessments are presented below:

1 DATA COLLECTION AND ASSESSMENT

Summary

- **Population**: Across assessments, white females are the majority of providers, indicating a lack of gender and cultural diversity in community mental health settings.
- **Training gaps:** Providers expressed a strong interest in trainings on trauma-informed care, CBT, MI, mindfulness, harm reduction, stress management, and supervision but cited cost, time constraints, and productivity expectations as major barriers for skills-based training.
- **Retention supports needed:** Factors influencing turnover include low pay, workload stress, unsupportive agency culture, and lack of advancement opportunities, especially for less-experienced staff and those with lower educational attainment.
- **Skill preparedness gaps:** Lack of workforce preparedness and confidence, especially for early-career staff. High-need areas include providing services to children and families, treatment of serious mental health issues (e.g., psychosis), and treatment of complex conditions.

Although relatively consistent findings were present across settings, results from each assessment are outlined below:

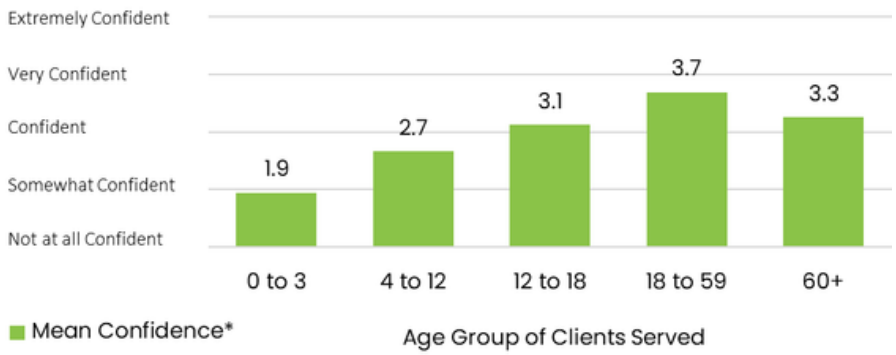
Community Mental Health (CMH) (N = 555)

Sites were eligible to participate if they provided traditional outpatient mental health services and accepted publicly funded health insurance, such as Medicaid and Medicaid managed care. This included Certified Community Behavioral Health Clinics, non-profit organizations, hospital-based clinics, programs within Federally Qualified Health Centers, county health departments, and other municipally funded programs and centers. Providers could be employed as therapists or as staff working in direct practice in other programs at that site. Private practice groups were not included.

Confidence and Training Findings

- Providers felt more confident in addressing adult mental health concerns compared to children and adolescents or working with parents (Figure 1).
- Providers felt less adequately trained to treat psychosis (59.8%) and substance use (63%) compared to treating adult depression (88.6%) and anxiety (89.1%).
- Providers across the state expressed a strong likelihood of attending further training across a range of areas and were particularly interested in training in burnout prevention (81.3%), stress management (79.2%), and effective supervision (74.6%).
- The most significant barriers to attending training included cost (74.4%), time constraints (60.7%), and productivity expectations (35.6%).

Figure 1. CMH Providers Average Confidence Serving Age Groups

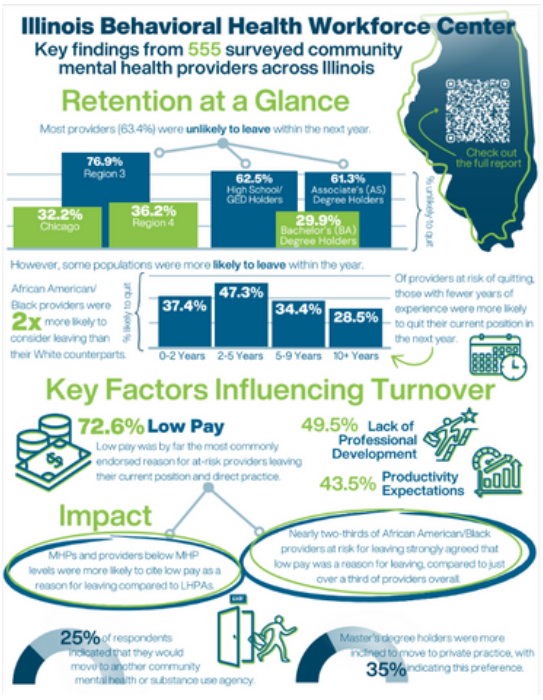


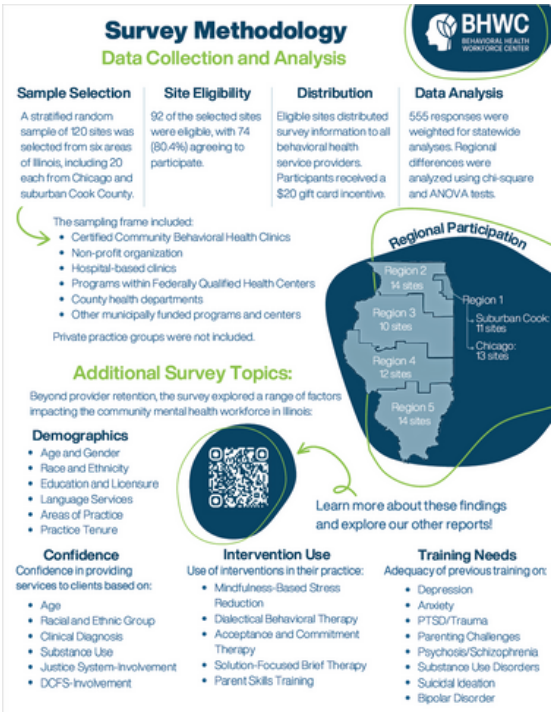
1 DATA COLLECTION AND ASSESSMENT

Retention Findings

- African American/Black providers were twice as likely to consider leaving their current position (26.3%) compared to their white counterparts (11.2%).
- Of providers at risk of quitting, those with fewer years of experience were more likely to quit their current position in the next year (47.3%).
- Providers at risk of quitting identified low pay as the most common reason for leaving their current position (72.6%).

Figure 2: CMH Providers at risk of leaving current position: Endorsed reasons for leaving current position (%) (N = 194)





Integrated Care (IC) (N=132)

Medical providers or behavioral health providers were eligible to participate in the integrated care survey if they served people with mental health challenges in integrated care environments such as federally qualified health clinics (FQHCs) and hospital-affiliated health systems in which most referrals for behavioral health services made by a primary care provider (medical doctor, physician assistant, nurse practitioner).

1 DATA COLLECTION AND ASSESSMENT

Confidence and Training Findings

- Providers reported lower confidence serving children aged 0-12 (M = 3.0) and older adults aged 60+ (M = 3.2) compared to adolescents (12-18) (M = 3.6) and adults (18-59) (M = 3.7).
- The lowest level of confidence by client type was reported for serving undocumented/refugee/immigrant clients (45.8%), veterans (38.2%), and individuals with limited or no English proficiency (29.8%).
- Providers felt less adequately trained to treat chronic medical conditions (48.8%), schizophrenia or other psychoses (53.7%), and bipolar disorders (65.4%), compared to adult depression (94.2%) and adult anxiety (94.2%).
- Providers reported they were likely to participate in evidence-based training, particularly on Solution-Focused Brief Therapy (SFBT) (88.5%), Mindfulness Based Stress Reduction (MBSR) (85.5%), and brief intervention (84.1%).
- Time constraint was the primary barrier to attending training (53.1%), followed by cost (44%), and productivity expectations (37.7%).

Retention Findings

- Latinx providers were reportedly more likely to leave their current position (37.5%) compared to their white counterparts (14.2%).
- Providers holding a bachelor's degree or less were at greater likelihood of leaving direct practice (45.5%) versus those with master's degrees (21.2%) or doctorates (22.2%).
- Of providers at risk of quitting, those with more years of experience (4+ years) in their current position were more likely to leave the field (69.9%) compared to those with shorter tenure (4 or less years) (31.7%).
- Productivity requirements (60.4%) and low pay (58.5%) emerged as the two most common reasons at-risk providers gave for considering leaving their current position.

Serious Mental Illness (SMI) (N=481)

Sites were eligible if they provided one or more programs that served only individuals with serious mental illness and accepted publicly funded health insurance, such as Medicaid and Medicaid managed care. Providers could be employed as therapists or as staff working in direct practice in other programs at that site. Institutions, residential programs, and private practices were not included in this survey.

Confidence and Training Findings

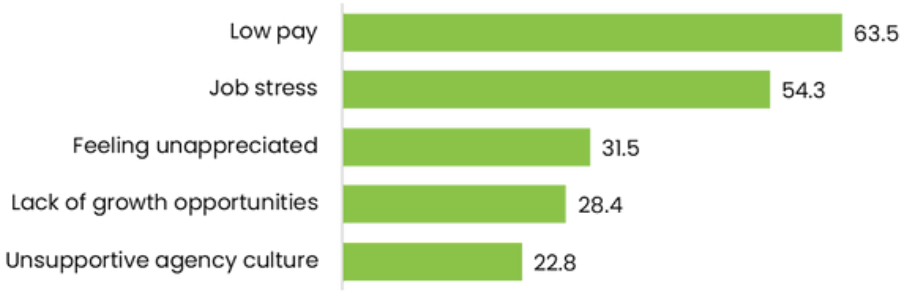
- Providers reported high levels of confidence in serving adults aged 18 to 30 (M = 3.69) and 31 to 59 (M = 3.66), but less confidence in working with those aged 60 years or older (M = 3.33).
- The lowest levels of confidence were reported for serving those with moderate to severe substance use disorders (68.2%), and those involved in the criminal justice system (68.9%).
- Providers' top 3 desired EBP trainings were trauma-informed care (87.7%), harm reduction treatment for substance use (85.5%), and cognitive-behavioral therapy (84.5%).
- The top 3 desired mental health-related training topics were complex trauma (93%), psychotic disorders (90.8%), and mood disorders (90%).

1 DATA COLLECTION AND ASSESSMENT

Retention Findings

- Black providers more frequently reported being likely or very likely to leave the profession (30.4%), compared to providers of other races (e.g., white counterparts, 17.3%).
- Providers employed for less than 1 year were at a significantly greater risk of leaving their positions (53.3%) compared to those employed 2 to 5 years (42.2%) and 5+ years (35.2%).
- Low pay (63.5%) and job stress (54.3%) were the two most common reasons given by providers at risk of leaving their current position.
- Providers with less than a bachelor's degree were more likely to cite unsupportive agency culture as a reason for leaving (33.3%), compared to those with a bachelor's degree (11.3%) or a graduate degree (27.6%).

Figure 3: SMI Providers at risk of leaving current position: Endorsed reasons for leaving current position (%) (N = 197)

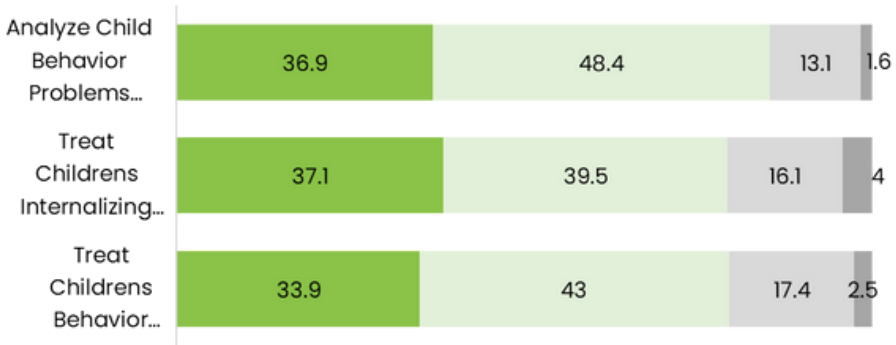


Early-Career Staff (N=311)

Supervisors and program directors in outpatient behavioral health services were eligible to participate in the survey if they oversaw early career staff. Early career staff were defined as staff with a bachelor or graduate degree in a behavioral health field and one year or less postgraduate experience providing direct services in behavioral health care.

- Overall, supervisors reported that most of their early-career bachelor degreed professionals (BA/BS) had low levels of preparedness to engage children (80.3% not/slightly prepared), adolescents (76.4% not/slightly prepared), and parents (79% not/slightly prepared).
- Notably low levels of preparedness were also identified in master's (MA) prepared staff's clinical engagement skills, particularly with children (68% not/slightly prepared) and families (67.6% not/slightly prepared).

Figure 4. BA Staff Preparation to Work with Children and Families

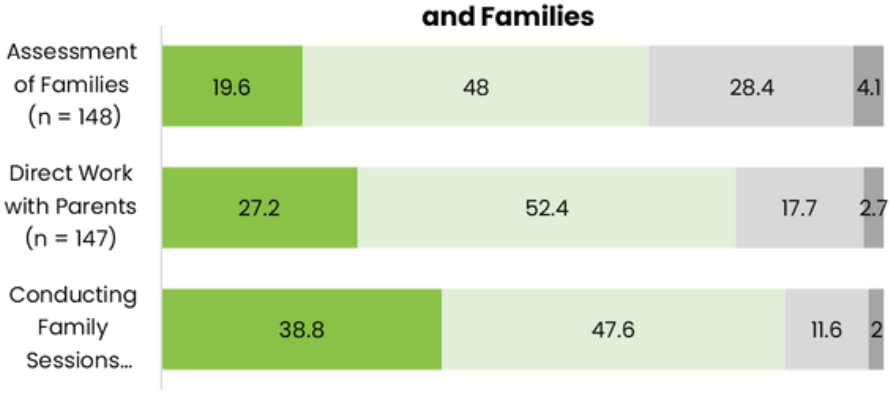


- For MA clinicians that provide services to children, supervisors reported that they were less prepared to address common childhood conditions like ADHD (73.8% not/slightly prepared), anger (60.7% not/slightly prepared), and behavioral issues in children (82% not/slightly prepared).

1 DATA COLLECTION AND ASSESSMENT

- Early-career MA staff demonstrated lower levels of preparedness for working with adults with complex needs such as schizophrenia/psychosis (81.1% not/slightly prepared), eating disorders (86.9% not/slightly prepared) and substance use (80.3% not/slightly prepared).

Figure 5. MA Staff Preparation to Work with Children and Families



- Supervisors also noted less preparedness for both MA and BA/BS staff in crisis and safety planning (63.4%; 68.5% not/slightly prepared) and office-external services (81.3%; 75% not/slightly prepared) as well as significant deficiencies in documentation (76.4% not/slightly prepared) and home-based services (75.8% not/slightly prepared) specifically affecting BA/BS prepared members.

Ongoing Data Monitoring to Support Entry into Behavioral Health Positions and Quality of Care

DBHR's Certified Recovery Support Specialist (CRSS) Success Program undergoes data monitoring and evaluation support from the Center. The Center collects feedback from CRSS Success Internship supervisors to understand how well-prepared CRSS students are for practice in their internships. Data is collected in cycles from supervisors on each of their CRSS Student interns with the purpose of identifying how the CRSS Success Program can most effectively prepare students for practice in the CRSS/CPRS role.

Evaluation efforts also continue for BHWC programs such as CRSS Success Program, the Chicago Parent Program, Solution-Focused Brief Therapy, and for BHWC ECHO series trainings and events. Ongoing evaluation efforts ensure high-impact program development, responsiveness to provider needs and alignment with statewide goals. The results of these evaluations are discussed in the section on quality of care.

All BHWC trainings and events include a post-event evaluation. These evaluations collect feedback from participants regarding knowledge gain and general satisfaction with the session.

Feedback from these evaluations is regularly examined in order to monitor the effectiveness of sessions as well as ongoing provider needs. This ensures that the Center can develop needed support for provider quality improvement programs.

Provider Engagement and Partnership

From their launch in January 2023, the Provider Advisory Groups have informed the training and retention needs of community-based behavioral health providers multiple practice areas, including Community Mental Health; Child, Adolescent, and Parent Services; Integrated Care; Serious Mental Illness; Substance Use and Recovery; and Recovery Support Specialists (additional details on the composition of Provider Advisory Groups can be found in Partnerships). Transcripts and notes from Provider Advisory Group meetings are collected and synthesized to inform immediate decisions (e.g., questionnaire terminology, event logistics), as well as guide upcoming discussions.

1 DATA COLLECTION AND ASSESSMENT

Qualitative analyses are performed on Provider Advisory Group meeting summaries to support identification of the most pressing needs of the behavioral health workforce. These analyses have helped to identify provider needs, training gaps, and recommendations for solutions. Several key focus areas for the Center's work emerged from these analyses including: Supervisory support, workplace culture and retention, training and professional development, early career workforce preparation and financial and systemic challenges.

Supervisory Support:

- Effective supervision was identified as a critical need, with existing supervisors often underprepared.
- Agencies reported supervisor difficulties balancing administrative requirements with clinical support.
- Specialized supervision skills were needed, particularly for child and family, substance use, and SMI services.

Training and Professional Development:

- Agencies reported the need for mentorship programs, peer learning collaboratives, and structured professional development for both new and existing staff.
- Trainings should be short, skills-based, and reinforced through booster sessions or train-the-trainer models, with simulation labs, orientation programs, and "boot camp" formats were recommended to strengthen applied learning.
- Tailored training opportunities were suggested with resources tailored to different organizational settings and staff levels – mid-level staff often lacked training opportunities, especially in specialized practice areas.

> ***"There used to be an expectation of what preparation would happen when folks came out of a master's program... now it is really independently determined and hard to track."***
> **-CAP Advisory Group Member**

> ***"The lack of supervision or leadership on how to deal with scenarios that come up – that's where it all falls apart and leads to turnover."***
> **-CMH Advisory Group Member**

Workplace Culture and Retention:

- Retention was influenced by organizational culture and supervision quality, as well as by compensation.
- Frequent turnover among early-career staff was noted, along with a lack of clear career pathways and incentive for advancement into supervisory or administrative roles.
- Peer-sharing of retention strategies through tools such as retention toolkits and peer-to-peer learning were supported.

Early Career Workforce Preparation:

- New graduates with bachelors and masters degrees in behavioral health fields often entered the field underprepared, lacking soft skills, clinical readiness, and understanding of documentation and billing.
- Early career professionals showed gaps in clinical and professional skills, particularly in child-focused interventions, family engagement, substance use, and serious mental illness (SMI) services.
- Agencies highlighted the need for enhanced training programs and stronger alignment between academic training, field placements, and community mental health realities (i.e., hands-on, applied learning).

Financial and Systemic Challenges:

- Financial concerns, particularly related to administrative burden, billing complexities, and compensation – with discrepancies between what organizations can pay and what staff expect were expressed by group members.
- Agencies reported that ongoing Medicaid and Certified Community Behavioral Health Clinic (CCBHC) funding shifts created uncertainty in hiring and planning.
- Advisory groups emphasized the need for loan forgiveness programs, improved reimbursement processes, fair compensation advocacy, bridge funding, and alignment of state and academic requirements to mitigate administrative burden.

2 RECRUITMENT

The Center expanded its efforts to strengthen and diversify the behavioral health workforce through a range of outreach, training, and recruitment initiatives designed to connect emerging professionals with career opportunities across the state. This included strengthening educational pathways by developing partnerships with high schools, community colleges, and universities to promote behavioral health careers. Work to expand workforce entry points is ongoing.

Career Conversations

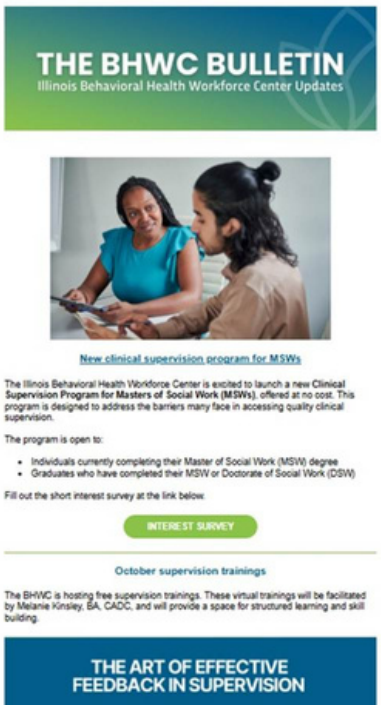
In FY25, the Center launched an integrated care mentoring pilot to support entry of new graduates into integrated care positions. This included a "Career Conversations" series with six virtual sessions for interested social work students statewide to explore integrated care with experienced providers from across the state. A 10-part ECHO series provided training to primary care physicians, advanced practice providers, emergency department providers and others to integrate behavioral health services into FQHC's, rural health clinics and other settings to provide comprehensive care to patients who present with behavioral health conditions.

Statewide Outreach and Engagement

Marketing and outreach significantly expanded the Center's presence and connections throughout the state.

Center staff presented at several conferences and events including career fairs and community workshops to raise awareness, distribute promotional materials, and share resources such as training materials and resources available through the Center (See Appendix D for the full list). The Center's statewide monthly newsletter was launched and grew to 605 subscribers to date.

In 2024, the Center launched a statewide Behavioral & Mental Health Jobs Board on the BHWC website, with 168 employers, 160 job positions, and 80 job seekers to date. The job board is a free resource provided by the BHWC to help connect behavioral health employers and job seekers across Illinois. Employers can create a company profile to post jobs, search for candidates via their profiles and resumes, and track applicants. Job seekers can create profiles to post their resumes and apply for jobs.


THE BHWC BULLETIN
Illinois Behavioral Health Workforce Center Updates

New clinical supervision program for MSWs

The Illinois Behavioral Health Workforce Center is excited to launch a new Clinical Supervision Program for Masters of Social Work (MSWs), offered at no cost. This program is designed to address the barriers many face in accessing quality clinical supervision.

The program is open to:

- Individuals currently completing their Master of Social Work (MSW) degree
- Graduates who have completed their MSW or Doctorate of Social Work (DSW)

Fill out the short interest survey at the link below.

INTEREST SURVEY

October supervision trainings

The BHWC is hosting free supervision trainings. These virtual trainings will be facilitated by Melanie Kinsley, BA, CADC, and will provide a space for structured learning and skill building.

THE ART OF EFFECTIVE FEEDBACK IN SUPERVISION

In November 2024, the Center expanded social media outreach through the creation of a company LinkedIn page. The Center's page accumulated 11,292 impressions[1], 581 page views, 263 unique visitors, and 369 followers, with followers located across the State: Greater Chicago area, Springfield, Urbana-Champaign, Peoria, Greater Rockford area, Quad Cities, Greater Evansville, Greater Danville, and Greater Bloomington. This page serves as a resource to share BHWC content and updates, including the BHWC Job Board, blog posts, events, trainings, Request for Proposals, and other relevant resources. The page also shares news, tools, and resources from other sources that can support behavioral health providers in Illinois.

[1]Impressions refers to the total number of views when the content is at least 50% on screen for at least 300ms, or the total number of times the content is clicked on, whichever comes first.

3 EDUCATION

Education and Career Pathways

The BHWC's assessment of regional workforce and licensure shortage areas (see Workforce Data Report) identified priority areas for degree expansion and training, particularly in the southern half of the state. To address this need in areas with critical shortages as well as across the state, the Center has developed a high school behavioral health career awareness curriculum, complete with toolkits and video modules for Grades 9–12. Particular attention was paid to dual-credit partnerships between high schools and local colleges. These resources are designed to introduce young people to careers in the behavioral health field at an earlier stage in their schooling.

> *"Something that maybe the workforce center can help with is just preparing material...that can be incorporated into a career development class around options postgraduate."*
> -SMI Advisory Group Member

Peer Support Development and the Certified Recovery Support Specialist (CRSS) Success Program

The Center, in collaboration with the Illinois Certification Board and DBHR, hosted a series of three events throughout the state in May 2025 in celebration of recovery/peer support specialists and CRSS Success Students. These events took place across the state, at Heartland Community College (45 attendees), SIU Edwardsville (40), and Malcolm X College (167). These gatherings celebrated recovery/peer support specialists, providing a platform for CRSS students and uncertified participants to learn from their peers. It was an opportunity for those not certified to hear the voices of other's journeys, learn about the certification process, and bring others who may be interested in making their story into their career. CRSS students had the opportunity to meet employers and complete applications.

> *"Peers are a necessary part of the recovery field and we're valued more now than ever! Supporting each other and networking with each other is empowering and important!"*
> -Peer Support Event Attendee

Image from the Recovery Support Specialist: Up Close & In Person event at Malcolm X College May 23, 2025.

3 EDUCATION

Enhancing Educational and Clinical Training

Based on the findings from the early-career preparedness survey and feedback from providers on their training and confidence needs, the BHWC initiated efforts to strengthen and expand behavioral health curricula and clinical training experiences. An ad hoc committee of 15 academic programs and agency partners completed a four-meeting series, focused on reviewing and prioritizing skill gaps across practice areas. The committee also developed and endorsed an action plan, which includes creating supplemental curricula and content for a skills training repository to be made available to academic faculty and agency field site supervisors. A longer-term advisory group will be formed to assist with the development and dissemination of direct skills training curricula for use in academic settings. Work will also include collecting feedback on training preparedness directly from students pursuing master's and bachelor's degrees in behavioral health fields and will begin in FY26.

Expanding Postsecondary and Professional Training

Additionally, the Center began building infrastructure for post-graduate psychiatry training, telehealth education, and CRSS pipeline support. This included curriculum development, site coordination, and planning for supervision expansion in underserved regions.

BHWC also piloted an associate-level Child & Family Behavioral Health Specialist curriculum in partnership with community colleges, adapted from a Maine model, expanding accessible training opportunities. As part of this effort, the BHWC partnered with community colleges and behavioral health agencies to pilot an associate-level Child & Family Behavioral Health Specialist curriculum, adapted from a model developed in Maine. This pilot represents an important step in expanding accessible, high-quality training opportunities – particularly for regions and populations where traditional four-year programs are less accessible – helping to diversify and strengthen the behavioral health workforce across Illinois.

4 RETENTION

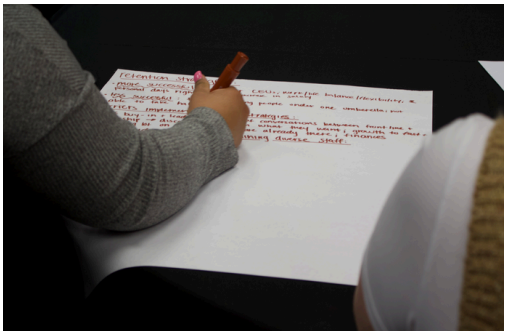
Retention Support

Workforce surveys identified contributing factors to provider turnover, including low compensation, lack of supervision, limited professional development, and high productivity demands. In response, the BHWC:

- Hosted three retention events in FY25, two in person and one virtual, engaging 281 providers.
- Developed an online Retention Toolkit.
- Expanded clinical supervision access for 16 social workers.
- Created a supervision request tracking system.
- Facilitated standalone supervision training and learning collaboratives for LCSWs and LCPCs.

Additional training needs were identified through learning collaborative participant feedback which included requests for additional training related to conflict management, team cohesion, ethics, self-care, and de-escalation skills. As a result, a standalone supervision training was held in FY25 Q4 on Conflict Management (N = 49) with the following feedback:

Based on strong participation and interest, additional learning collaboratives and standalone training will be facilitated in FY26. Content and training delivery will be based on evaluation data to identify priority needs and effective delivery.



> *"We started a recruitment and retention task force after that [BHWC Retention Event] in Chicago earlier this year."*
> -SMI Advisory Group Member

Center Information Dissemination through Presentations

The work of the Center and its available resources were shared with organizations across the State. Overviews of the BHWC and its work were presented to organizations such as the Chicago Department of Public Health, Illinois Association of Rehabilitation Facilities, U.S. Department of Labor's State Exchange on Employment & Disability (SEED), Community Behavioral Healthcare Association (CBHA), Illinois Primary Health Care Association, Juvenile Protective Association (JPA), National Council of State Legislators (NCSL), National Council of State Governments (NCSG), The Rural Health Summit, as well as a number of institutions of higher education and behavioral health service providers in Illinois.

National Workforce Initiatives:

In 2024, BHWC's CEO Served as Behavioral Health Workforce Database Technical Expert Panelist for the Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation and SAMHSA Policy Summit Participant for Re-Envisioning the Behavioral Health Workforce Focusing on Underserved Communities.

Behavioral Health Workforce Center Alliance:

The Center leaders are engaged with the Behavioral Health Workforce Center Alliance (BHWCA) made up of states that are developing behavioral health workforce programs. The alliance provides national leaders the opportunity to share success and challenges and collaborate on state and national behavioral health workforce projects.

5 QUALITY OF CARE

Supervision

The need for supervision training was a theme found throughout needs assessments and provider advisory groups, emphasizing that – in addition to new supervisors needing training – existing supervisors were also often underprepared. To address this critical need for increased access to high quality supervision, the Center developed three asynchronous supervision training modules that meet clinical social work licensing requirements for supervision training in Illinois at no cost to providers. These trainings have been completed by 561 supervisors, with another 983 in progress.

The Center's needs assessments and provider advisory groups highlighted the importance of skills-based trainings that are reinforced through multiple sessions. As there is strong evidence for the effectiveness of learning collaborative models[2], a series of Supervision Learning Collaboratives were launched to support new supervisors in building strong supervisory skills and effective practices. 40 supervisors have participated in one of the two FY23-FY25 cohorts, with 117 providers expressing interest in future participation. Additionally, to address the lack of clinical support available in Central and Southern parts of the State, the Center developed new partnerships to connect 16 social workers in Central and Southern Illinois with Licensed Clinical Social Workers (LCSWs) for supervision services to support their path to licensure and to address a key bottleneck in the workforce pathway.

> *"The key is having the opportunity to use that knowledge and then have somebody provide the feedback… the caliber of the supervisor can really make the difference."*
> -CAP Advisory Group member

BHWC advanced its commitment to quality care through training and supervision, especially in regions with a severe shortage of supervisors (Central & South). Across all three asynchronous supervision modules, 93% of participants completed an evaluation and indicated strong role relevance and knowledge gains.

Statewide Training

The BHWC expanded statewide training opportunities to strengthen the behavioral health workforce and enhance provider capacity across Illinois.

The BHWC developed and launched 10-part ECHO training series for primary care and behavioral health providers, focusing on integrated care, telehealth, trauma-informed care, and crisis intervention.

Delivered by experts from SIU School of Medicine, UIC, and community partners, the series included 20 CEU-bearing synchronous sessions, reaching over 100 participants across rural and urban regions. Evaluation results showed that 83% of participants rated the training as "very" or "extremely helpful."

In October 2024, the BHWC launched 9 asynchronous courses. By June 2025, the asynchronous training catalog had expanded to 12 free, CEU-eligible courses, with 783 learners completing 819 courses – totaling more than 1,250 hours of professional learning. (Full list of training topics in the appendix).

[2]Gotham HJ, Paris M Jr, Hoge MA. Learning Collaboratives: a Strategy for Quality Improvement and Implementation in Behavioral Health. J Behav Health Serv Res. 2023 Apr;50(2):263-278. doi: 10.1007/s11414-022-09826-z. Epub 2022 Dec 20. Erratum in: J Behav Health Serv Res. 2023 Apr;50(2):279-280. doi: 10.1007/s11414-023-09830-x. PMID: 36539679; PMCID: PMC9935679.

5 QUALITY OF CARE

In addition, BHWC facilitated career development opportunities for more than 200 students and incumbent behavioral health workers through targeted education and workforce initiatives.

> *"I've already used skills from the training and plan to apply them in meetings."*
> -Supervision Training Participant

Findings from the Center's needs assessments and provider advisory groups suggested that providers need training on trauma-informed care, CBT, MI, mindfulness, harm reduction, stress management, and supervision, as well as in treatment of serious mental health issues (e.g., psychosis) and treatment of complex conditions. These training topics were incorporated into the development of statewide trainings to reflect providers' pressing needs.

This diverse range of training topics are offered in asynchronous and synchronous formats to build the behavioral health workforce and advance recovery-oriented, integrated, and telehealth care.

Evidence-based Practices Training and Implementation Support

The BHWC strengthened statewide quality of care by providing training and implementation support for evidence-based practices, including the Chicago Parent Program, Solution-Focused Brief Therapy, and PracticeWise MATCH. These specific practices were identified by provider advisory groups and focus groups as effective strategies to support the current workforce needs.

These initiatives equip providers with proven strategies and tools to improve service delivery and outcomes for individuals and families across Illinois.

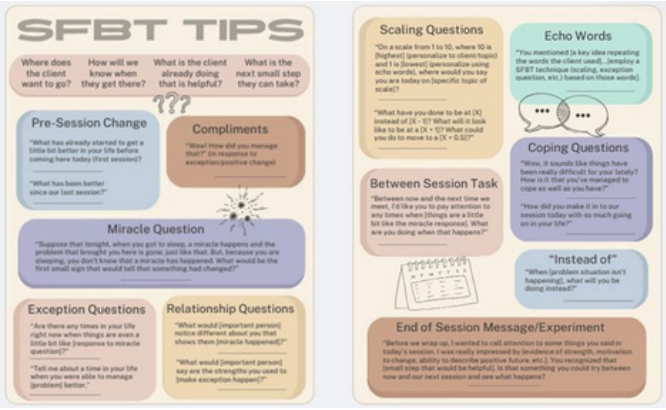
Solution-Focused Brief Therapy (SFBT) Initiative

The Solution-Focused Brief Therapy (SFBT) Initiative supported:

- 181 behavioral health providers at 21 integrated care agencies across Illinois received intensive SFBT training through the initiative.
- 145 medical providers/administrative staff in integrated care agencies received 2-hour SFBT overview trainings to support solution-focused agency culture at participating agencies.

SFBT Initiative Outcomes:

- Providers reported more efficient services when using SFBT compared to other approaches
- Client evaluation data showed that using SFBT with fidelity was associated with better outcomes at the end of a session
- Some providers indicated that using SFBT helped them feel less burned out by not focusing on problems
- Focus groups indicated that ongoing support was key for implementation, but other approaches besides local champions may be more beneficial and cost effective



> *"...from a therapist perspective, most of the time I feel better after a solution-focused session. I don't feel as burnt out."*
> -SFBT training participant

5 QUALITY OF CARE

Chicago Parent Program (CPP) Initiative

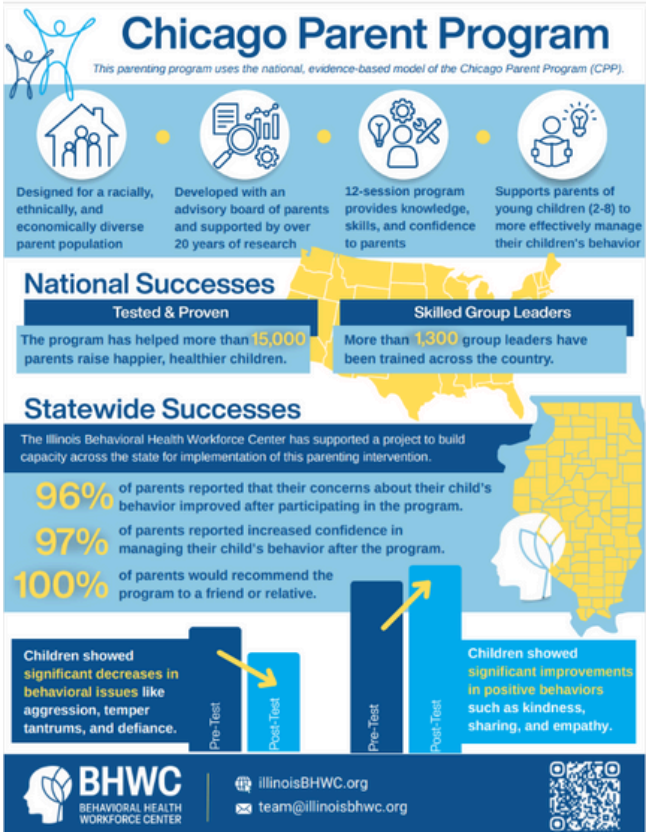
The Chicago Parent Program (CPP) Initiative supported:

- In FY24, 55 staff were trained in the CPP model from 17 unique organizations statewide.
- In FY25, 42 staff were trained from 10 organizations statewide.

CPP Initiative Outcomes:

As a result of the trainings, parents expressed confidence in addressing their children's needs and children demonstrated improved pro social behavior.

All BHWC trainings and events include a post-event evaluation. These evaluations collect feedback from participants regarding knowledge gain, application to their work, and overall satisfaction as a result of the training/event. Additionally, these evaluations provide the Center with ongoing feedback to continue to provide training resources to providers and those they serve.



"Since we are an integrated care setting, I don't think that we were equipped to do longer term therapy...We have been able to get people in and out faster."
-SFBT Training Participant

"With the group I learned new ideas that I put into practice in my daily life, and I feel that it is working for me."
-CPP parent participant

6 POLICY ENGAGEMENT & LEGISLATIVE SUPPORT

The Center continued its efforts to identify barriers to effective service delivery, staff retention, and workforce expansion that are shaped by statewide policies. These efforts included both targeted work by the Policy Project Team and broader Center-wide policy engagement activities. The BHWC provided technical assistance, testimony, and legislative consultation throughout FY23-FY25.

A Policy Project Team reviewed accreditation requirements and identified key policy-related workforce barriers and developed recommendations to support stackable credentials and clearer licensing pathways.

BHWC-Wide Policy Engagement

- Partnered with Community Behavioral Health Association (CBHA) and Illinois Association of Rehabilitation Services (IARF) that advance provider and service-related policies.
- BHWC staff and consultants participate in regular systems-level meetings.
- Staff actively attend statewide meetings to represent workforce priorities.
- Shared workforce data findings with DBHR to inform statewide decisions.
- Provided technical assistance, testimony, and legislative consultation

2025 Illinois Rural Small Town Health Summit presentation by Dr. Wolf.

During events like SIU System Day at the Capitol and Senate Licensing Committee testimony, the BHWC supported legislative changes tied to regional workforce needs – particularly the collection of more detailed geographic licensing data via HB3487, now signed into law with implementation to begin January 1, 2026.

Legislative Impact

- Testified before the Illinois Senate Licensing Committee (May 2025) in support of regulatory changes to improve workforce data transparency.
- Participated in legislative engagement events such as SIU System Day at the Capitol.
- Testified to the Medicaid Advisory Committee, the joint hearing of the Senate and House Mental Health and Addiction Committee, and participated in the Administrative Burden Reduction Task Force.
- Worked closely with legislators to draft HB3487, which passed in 2025 and mandates expanded data reporting for workforce planning.
- Contributed to policy briefs and proposals on licensure reform, workforce data collection, and supervision barriers.
- Through testimony, consultation, and direct collaboration with state leaders, the BHWC has positioned workforce challenges at the forefront of policy discussions. The passage of HB3487 reflects the impact of sustained engagement, and ongoing policy analysis and technical assistance continue to guide reforms that strengthen Illinois' behavioral health workforce.

IV. Strategic Plan: Vision, Goals & Objectives FY26-FY28

The Behavioral Health Workforce Center (BHWC) convened a strategic planning committee in 2025 to develop a comprehensive Strategic Plan to guide the Center's work for Fiscal Years 2026 through 2028. This plan builds on the foundational progress of FY23–FY25 and responds directly to data, community input, legislative priorities, and partner feedback gathered over the past two years. It sets a clear roadmap for addressing ongoing workforce shortages, improving workforce preparedness, and strengthening the education-to-employment pathway in behavioral health across Illinois.

Introduction and Development of the Strategic Plan

The Strategic Plan was developed through a six-month planning process led by the BHWC Strategic Planning Committee, with facilitation support from Afton Partners. The process included:

- Biweekly planning sessions with SIU SOM and Afton
- Regular feedback loops with UIC, IBHE, and DHS leadership
- Advisory Council consultation and stakeholder input
- Survey responses from BHWC Project Team members and partners
- Review of updated workforce data and regional needs assessments

Planning activities focused on ensuring that the plan aligned with legislative mandates, partner expectations, and the lived realities of learners and providers across the state.

The strategic plan, finalized in September 2025, outlines goals in education access, career development, diversity, and interprofessional training. Implementation efforts began with cross-hub coordination meetings, deliverable tracking tools, and a statewide marketing plan.

Partner Involvement

The development of the Strategic Plan was a collaborative process, involving over 50 individuals from:

- Public and private colleges and universities
- Behavioral health providers and membership organizations
- State agencies (IDHS, IBHE, IDFPR, HFS)
- Community-based organizations and regional workforce boards

Each of the five BHWC Project Teams contributed input on specific barriers, opportunities, and goals related to their focus areas. The result is a plan that is both actionable and grounded in the operational knowledge of stakeholders.

Vision

To ensure that all Illinois communities have access to a diverse, skilled, and sustainable behavioral health workforce. The vision reflects BHWC's commitment to both access and equity, while emphasizing long-term planning and sustainability in workforce development.

Strategic Priorities for FY26-FY28

The Strategic Plan includes six statewide priorities:

- **Enhancing access** to a diverse, prepared, and robust behavioral health workforce
- Developing **clear, accessible, and expanded career pathways** for behavioral health utilizing existing career pathways for health professions as well as pathways specific to behavioral health
- Providing **effective and accessible clinical training** and professional development
- **Reducing administrative burden** and **recommending policy improvements** for behavioral health workers
- Ensuring **adequate and substantial supports and reimbursement rates** for behavioral health services and providers
- Tracking Illinois behavioral health **workforce data and trends**

Challenges

The following challenges were identified:

1. There is **not enough diversity** in the workforce, particularly beyond entry-level and lower-paying positions.
2. There is a **lack of exposure** to behavioral health careers for young people.
3. There are **not enough paid internship** opportunities.
4. There are **not clear advancement paths** or opportunities.
5. There are **disparities in reimbursement rates** and low reimbursement rates in general.
6. **Training gaps,** including a lack of clinical placements, hands-on experience, curriculum on evidence-based strategies, and integrated substance use and mental health training, hinder the development of a robust and skilled behavioral health workforce.

The plan includes strategies to address these challenges through coordinated investments, pilot programs, and policy reform.

Goals and Objectives for the Next Two Years

6 goals from Strategic Plan include:

1. Strengthen and expand behavioral health curriculum and clinical training experiences.
2. Strengthen educational advancement across systems.
3. Build and utilize evidence to develop policy recommendations.
4. Strengthen pre-career programs and awareness.
5. Address financial barriers to behavioral health education and workforce entry.
6. Support and retain the incumbent workforce in providing high quality care.

V. Conclusion

Over the past two years, the Behavioral Health Workforce Center has moved from foundational planning to statewide implementation. Through the coordinated efforts of its offices at Southern Illinois University School of Medicine and the University of Illinois Chicago, the Center has tackled longstanding barriers in the behavioral health workforce pipeline and delivered targeted initiatives with regional relevance and statewide reach.

The accomplishments outlined in this report reflect a collective effort: project teams, advisory bodies, provider workgroups, state agency partners, higher education institutions, and legislative champions all played a critical role in shaping progress to date. From launching the state's first comprehensive behavioral health workforce data dashboard, to developing supervision pathways, to expanding access to training and career awareness across all regions of the state, the Center has laid a strong foundation for lasting impact.

Looking ahead, the FY26–FY28 Strategic Plan provides a clear and actionable path forward. It centers data-driven decision-making and collaboration as guiding principles. It also calls for continued investment in workforce development strategies that are responsive to the needs of employers, providers, and learners across Illinois. As the Center deepens its partnerships and broadens its impact, it remains committed to supporting the Illinois General Assembly, our state agency collaborators, and community partners in building a behavioral health system where every community has access to needed services.

The Center's funding from the Illinois Board of Higher Education allows the Center to expand its research, education and workforce expansion initiatives in every region of the state. The Center will continue to work closely with the Illinois Board of Higher Education and our partners to build the Behavioral Health Workforce in Illinois needed for the future.

VII. Appendices

Appendix A: Regional Comparison of Licensure Data

Figure 6: Psychiatrists per 100k for IDHS Regions

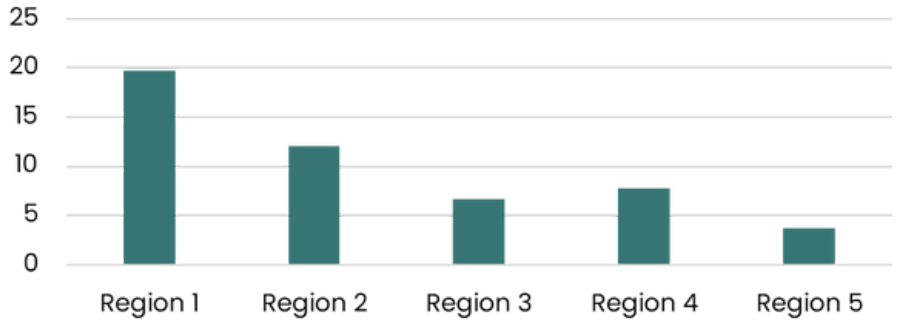


Figure 7: Psychologists per 100k for IDHS Regions

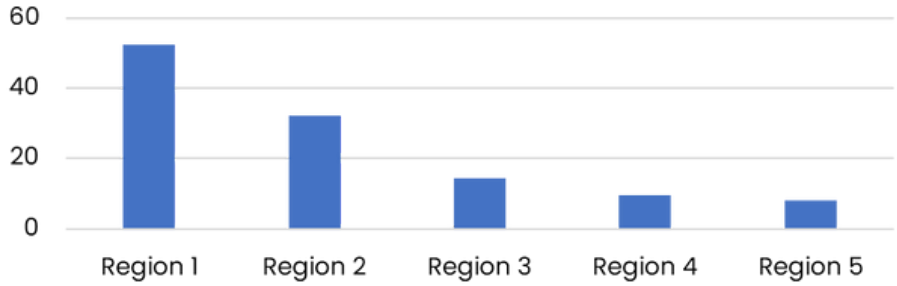
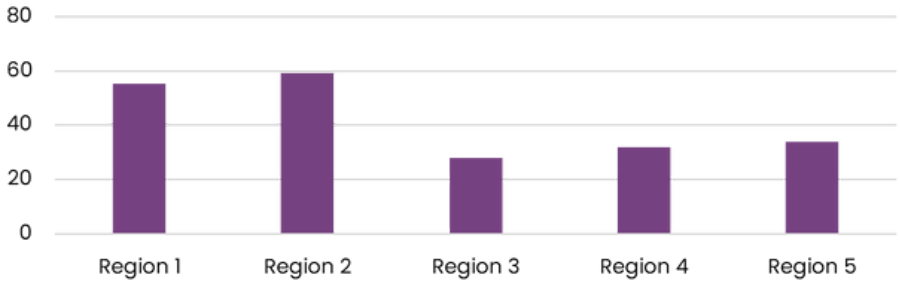


Figure 8: Occupational Therapists per 100k for IDHS Regions



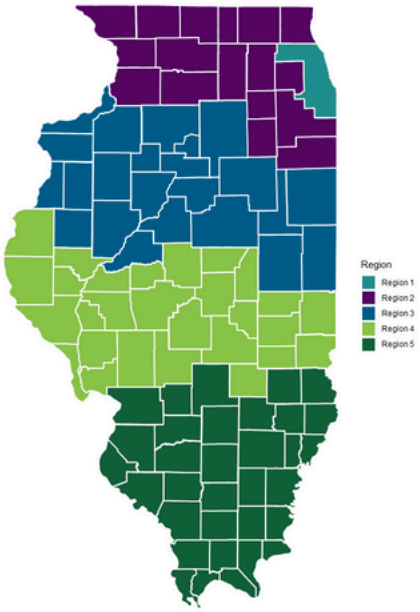


Figure 9: Clinical vs Non-Clinical Professional Counselors per 100k for IDHS Regions

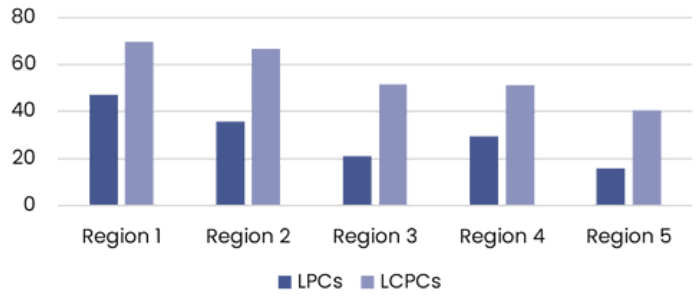
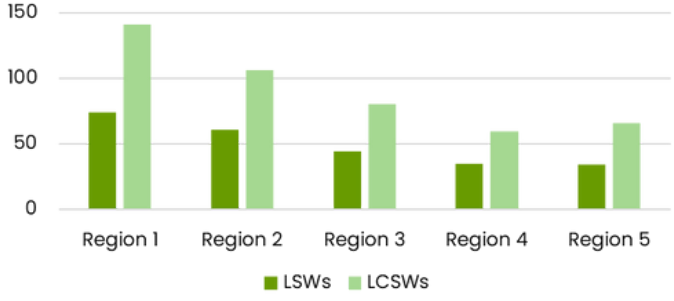


Figure 10: Clinical vs Non-Clinical Social Workers per 100k for IDHS Regions



There are critical workforce shortages in Regions 3, 4, and 5 across nearly all licensed professions:

Region 1					
Occupation	**National**	**Illinois**	**Region 1**	**Regional vs National**	**Regional vs Illinois**
LPC	109.59	48.79	47.23	-57%	-3%
LCPC	145.61	80.82	69.55	-52%	-14%
LSW	123.89	63.67	74.25	-40%	17%
LCSW	90.42	118.95	140.95	56%	18%
LMFT	19.11	7.23	8.06	-58%	11%
OT	43.7	54.98	55.21	26%	0%
Psychologist	21.64	38.43	52.25	141%	36%
Psychiatrist	7.49	13.57	19.75	164%	46%

Region 2					
Occupation	**National**	**Illinois**	**Region 2**	**Regional vs National**	**Regional vs Illinois**
LPC	109.59	48.79	35.65	-67%	-27%
LCPC	145.61	80.82	66.68	-54%	-17%
LSW	123.89	63.67	60.91	-51%	-4%
LCSW	90.42	118.95	106.55	18%	-10%
LMFT	19.11	7.23	6.55	-66%	-9%
OT	43.7	54.98	59.24	36%	8%
Psychologist	21.64	38.43	32.06	48%	-17%
Psychiatrist	7.49	13.57	12.05	61%	-11%

Region 3					
Occupation	**National**	**Illinois**	**Region 3**	**Regional vs National**	**Regional vs Illinois**
LPC	109.59	48.79	20.78	-81%	-57%
LCPC	145.61	80.82	51.42	-65%	-36%
LSW	123.89	63.67	44.35	-64%	-30%
LCSW	90.42	118.95	80.41	-11%	-32%
LMFT	19.11	7.23	2.86	-85%	-60%
OT	43.7	54.98	27.92	-36%	-49%
Psychologist	21.64	38.43	14.43	-33%	-62%
Psychiatrist	7.49	13.57	6.64	-11%	-51%

Region 4					
Occupation	**National**	**Illinois**	**Region 4**	**Regional vs National**	**Regional vs Illinois**
LPC	109.59	48.79	29.46	-73%	-40%
LCPC	145.61	80.82	51.23	-65%	-37%
LSW	123.89	63.67	35.04	-72%	-45%
LCSW	90.42	118.95	59.73	-34%	-50%
LMFT	19.11	7.23	1.86	-90%	-74%
OT	43.7	54.98	31.9	-27%	-42%
Psychologist	21.64	38.43	9.43	-56%	-75%
Psychiatrist	7.49	13.57	7.8	4%	-43%

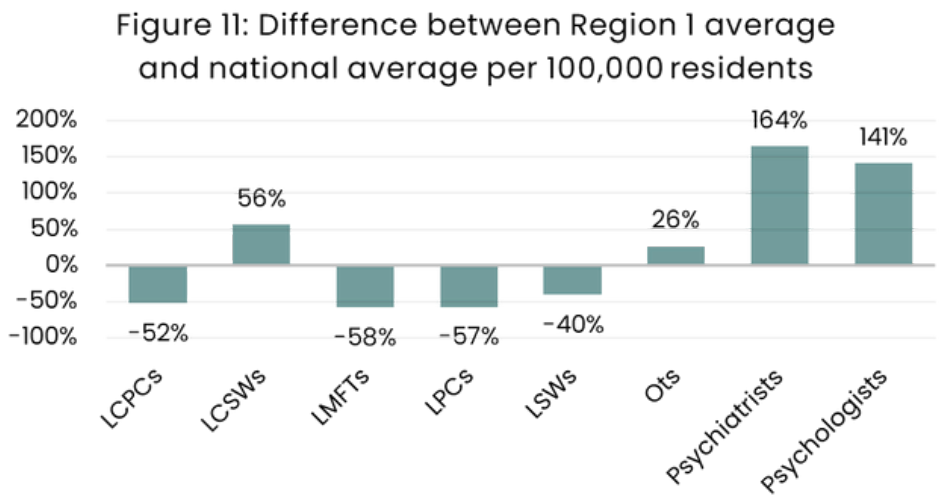
Region 5					
Occupation	**National**	**Illinois**	**Region 5**	**Regional vs National**	**Regional vs Illinois**
LPC	109.59	48.79	15.75	-86%	-68%
LCPC	145.61	80.82	40.64	-72%	-50%
LSW	123.89	63.67	34.11	-72%	-46%
LCSW	90.42	118.95	65.79	-27%	-45%
LMFT	19.11	7.23	1.65	-91%	-77%
OT	43.7	54.98	34.02	-22%	-38%
Psychologist	21.64	38.43	8.09	-63%	-79%
Psychiatrist	7.49	13.57	3.65	-51%	-73%

*Comparative data to national and state averages per 100,000 population
*Source Data: Professional Licensing, Illinois Department of Financial and Professional Regulation. Area Health Resource files, 2022- 2023 County Level Data, U.S. Census Bureau (2022). Total Population, American Community Survey, ACS 5-Year Estimates Detailed Tables.

- LPC estimate is a combination of 'Educational, Guidance, and Career Counselors and Advisors' & 'Counselors, All Other.
- LCPC estimate is a combination of 'Rehabilitation Counselors' & 'Substance abuse, behavioral disorder, and mental health counselors.
- LSW estimate is a combination of 'Child, Family, and School Social Workers' & 'Social Workers, All Other.
- LCSW Estimate is a combination of 'Healthcare Social Workers' & 'Mental Health and Substance Abuse Social Workers.

Appendix B: Regional Analysis

Shows percentage difference between IDHS regional average number of professionals and national average of professionals per 100,000 residents.

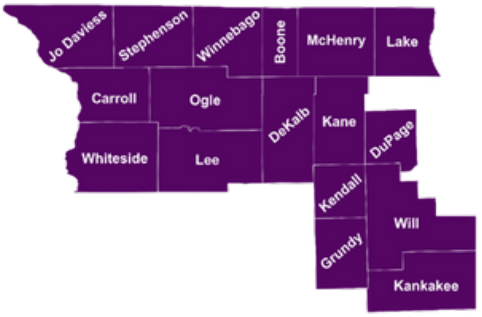


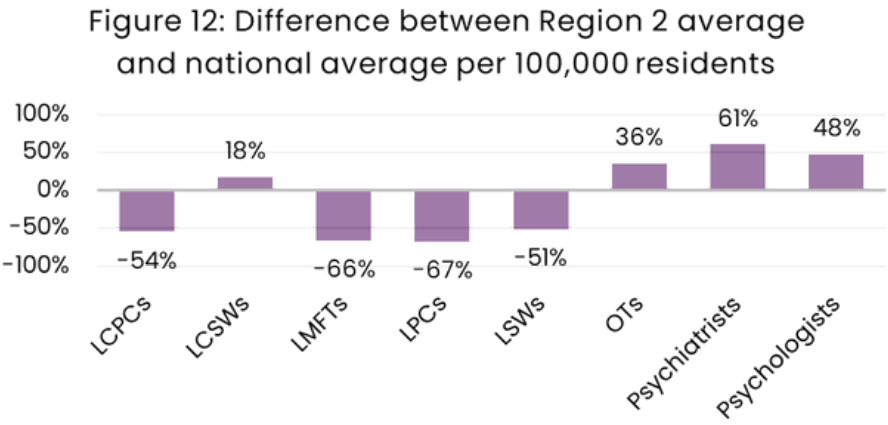
In Region 1, workforce trends show significant variation across behavioral health professions.

Psychiatrists and psychologists demonstrate the highest difference from the national average, with approximately 160% and 140% more professionals than the national average, respectively, indicating a strong workforce in specialized mental health services. Moderate standing is also observed among Licensed Clinical Social Workers (LCSWs) and Occupational Therapists (OTs).

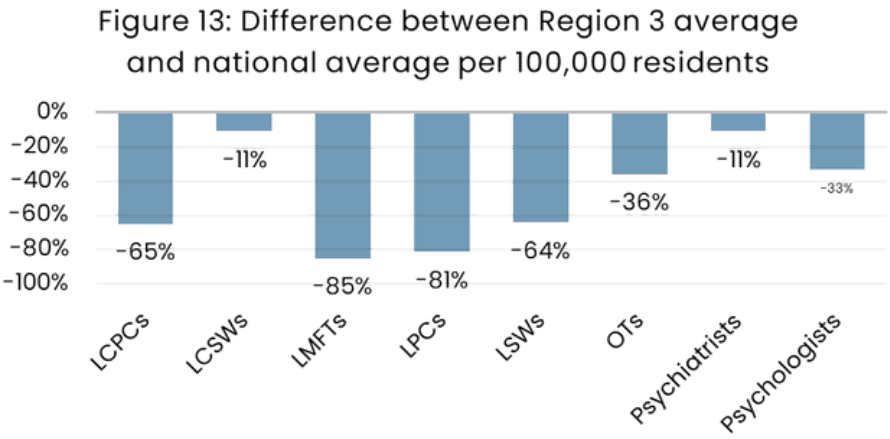
In contrast, counselor roles such as Licensed Clinical Professional Counselors (LCPCs), Licensed Professional Counselors (LPCs), and Licensed Marriage and Family Therapists (LMFTs) show notable deficits of 35% to 50%. Licensed Social Workers (LSWs) also reflect a mild deficiency.

Overall, these findings suggest an imbalance in region one's behavioral health workforce, with strong numbers in clinical and specialized professions but potential shortages in community-based counseling and social service roles.

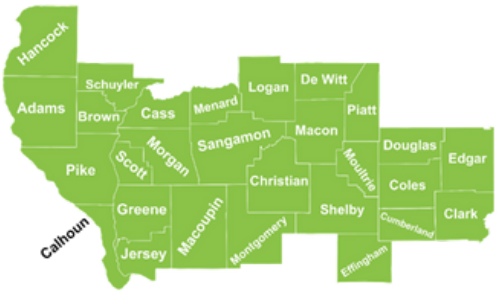


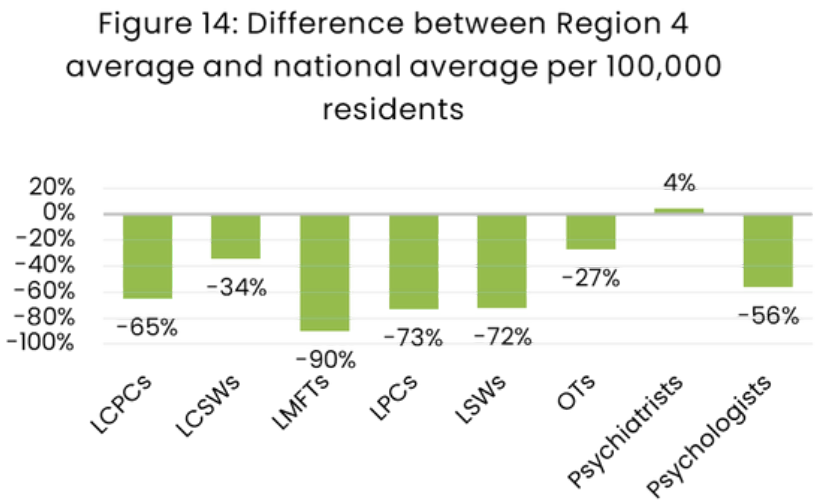


Region 2 shows a moderately strong workforce with notable differences across behavioral health professions. Psychiatrists and psychologists demonstrate the largest relative difference, with averages approximately 60% and 45% higher, respectively, suggesting a relatively strong workforce in specialized mental health care. Occupational Therapists (OTs) also show a positive margin of around 35%, while Licensed Clinical Social Workers (LCSWs) report a modest difference of around 15%. Conversely, substantial declines are observed among Licensed Marriage and Family Therapists (LMFTs) and Licensed Professional Counselors (LPCs), both of which are lower by nearly 60%. Licensed Clinical Professional Counselors (LCPCs) and Licensed Social Workers (LSWs) also show negative trends around 40%. Overall, Region 2 reflects a mixed workforce landscape with robust gains in clinical and therapeutic specialties but continuing shortages among counseling and social work professionals

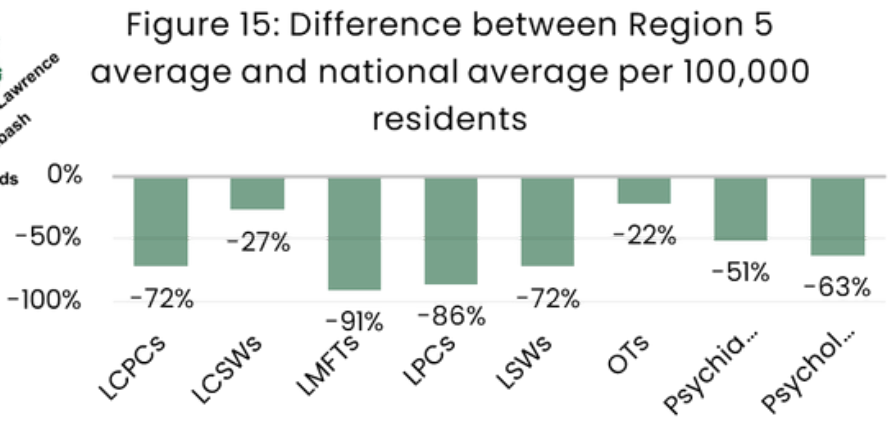


Region 3 demonstrates widespread deficits across nearly all behavioral health professions. The most significant differences are observed among Licensed Professional Counselors (LPCs), Licensed Marriage and Family Therapists (LMFTs), and Licensed Social Workers (LSWs), each of which is lower than the national average by approximately 60% to 80%. Licensed Clinical Professional Counselors (LCPCs) also show a substantial shortage of nearly 60%. Smaller differences are noted among Psychologists, Occupational Therapists (OTs), and Psychiatrists, ranging from 20% to 30%, while Licensed Clinical Social Workers (LCSWs) remain relatively stable with only a slight reduction. Overall, Region 3 reflects a region-wide contraction in the behavioral health workforce, suggesting potential challenges in service capacity and access across all professional categories.





Region 4 shows substantial deficiencies across nearly all behavioral health professions compared to national averages. The most significant differences are seen among Licensed Marriage and Family Therapists (LMFTs), Licensed Social Workers (LSWs), Licensed Professional Counselors (LPCs), and Licensed Clinical Professional Counselors (LCPCs), each with shortfalls ranging from approximately 60% to nearly 100% Licensed Clinical Social Workers (LCSWs) and Occupational Therapists (OTs) also demonstrate notable deficits, though to a lesser extent, around 30% to 40%. Psychologists show a similar decline of about 50%, while Psychiatrists are the only profession at or slightly above the national average, indicating relative stability in that category. Overall, Region 4 reflects a pronounced shortage in the behavioral health workforce, suggesting significant limitations in service access and professional availability across most disciplines.



Region 5 demonstrates significant differences in behavioral health workforce availability across all professional categories when compared to national averages. The most pronounced shortages are observed among Licensed Marriage and Family Therapists (LMFTs), Licensed Professional Counselors (LPCs), and Licensed Clinical Professional Counselors (LCPCs), each showing declines of approximately 75% to 90%. Licensed Social Workers (LSWs) also face major shortfalls, with a deficit of nearly 75%, while Licensed Clinical Social Workers (LCSWs) and Occupational Therapists (OTs) experience moderate decreases of around 20 to 30%. Psychologists and Psychiatrists are similarly affected, each reporting lower averages of roughly 50-60%. Overall, Region 5 reflects widespread and consistent underrepresentation of behavioral health professionals, indicating systemic challenges in workforce capacity and access to care across the region.

Appendix C: Asynchronous Training Topics

Trainings to Support High-Quality Behavioral Health Care

- Knowing Yourself as a Supervisor
- Providing Feedback and Addressing Conflict in Supervision
- Guiding Principles of Supervision
- Addressing Diverse Client Needs Through Person-Centered Care
- Foundational Clinical Skills to Promote Recovery & Resilience
- Healthy Eating and Physical Activity Skillsets Training

Recovery-Oriented Trainings

- Self-Determination Strategies for Promoting Service User Engagement
- Using Motivational Interviewing for Recovery Support
- Motivational Interviewing with People in Mental Health Recovery Using a Stages of Change Decision Aid
- Partnering with Clients to Promote Medication Adherence

Trainings to Support Telehealth Practice

- Introduction to Telehealth
- Health Equity and Accessibility
- Best Practices of Telehealth
- Evaluating/Assessing Telehealth Work with Clients
- Benefits and Barriers of Telehealth
- Telehealth Ethics
- IT & Logistics of Telehealth
- Prescribing Regulations for Telehealth
- Safety Considerations of Telehealth
- Transitions for Providers and Clients in Telehealth

Trainings to Support Medical and Integrated Care Providers

- Integrated Care Models
- Nuances of Psychiatric Diagnosis
- Medications & Treatments
- Caring for the DD Population – Adolescents
- Caring for the DD Population – Part 2
- Somatic Concerns
- Psychogenic Non-Epileptic Seizures
- Trauma-Informed Care
- Suicidal Ideation and Behaviors
- Diabetes Education and Online Toolkit for Providers

Appendix D: Evaluation Methodology

The Chicago Parent Program (CPP) Initiative maintains ongoing data collection through a pre-and-post-test evaluation for parent participants, which includes:

- A parent information form
- The Strengths and Difficulties Questionnaire (SDQ)
- The Parenting Questionnaire (PQ)
- End of Program Satisfaction Survey (post-test only)

Additionally, agencies are monitored through weekly facilitator fidelity forms, parent attendance forms, and facilitator evaluation of parent engagement. Agencies are also encouraged to attend monthly learning collaboratives to report on progress and challenges.

During the piloting of the Solution-Focused Brief Therapy (SFBT) Training and Implementation Initiative, the BHWC evaluated multiple aspects of the implementation, including:

- The fit between SFBT and integrated care settings
- The efficiency of services when using SFBT compared to other approaches
- Single-session client outcomes when using SFBT and other approaches
- Implementation outcomes when providing structured implementation support
- The effectiveness of local champions for improving implementation outcomes

Appendix E: Provider Needs Assessment Methodologies

Community Mental Health Needs Assessment

This assessment sought to obtain a statewide, representative sample of behavioral health providers working in community mental health agencies. The sampling frame was built by starting with the Illinois Division of Mental Health (DMH) list of Community Mental Health (CMH) agencies, which includes Certified Community Behavioral Health Clinics, non-profit organizations, hospital-based clinics, programs within Federally Qualified Health Centers, county health departments, and other municipally funded programs and centers. Research staff expanded the list to include all the physical locations within each organization that provide direct services across the state and added locations of any new and eligible programs. Sites were included if they provided traditional outpatient mental health services and accepted publicly funded health insurance, such as Medicaid and Medicaid managed care. Because separate surveys of providers working in substance use recovery programs and community-based programs for people with serious mental illness were being conducted, programs were only eligible if one component included traditional outpatient therapy. Providers could be employed as therapists or as staff working in direct practice in other programs at that site. Private practice groups were not included. After listing physical locations across the state, staff identified 444 potential sites in the sampling frame.

To ensure statewide representation, the Illinois Department of Human Services regional map was used as a guide, separating Illinois into five regions. Region 1 was then divided into two categories, Chicago and suburban Cook County, creating a total of 6 regions. A stratified random sample of 120 sites was selected. For each of the regions 2-5 identified by Illinois DMH, 20 sites were randomly selected. For region 1, 20 sites were randomly selected from Chicago and an additional 20 from suburban Cook County.

Each selected site was contacted by email and, if necessary, by phone to determine eligibility for the survey. As shown in Table 1, 92 of the selected sites were eligible. Of the eligible sites, 74 (80.4%) agreed to participate and had staff submit surveys. The exact percentage of eligible staff at each site who submitted surveys is unclear.

Site Selection, Eligibility, and Response by Region (*N* = 120)						
	1 (Chicago)	1 (Sub. Cook)	2	3	4	5
Agreed	14	13	15	10	12	18
Have Responses	13	11	14	10	12	14
No Response	1	2	1	0	0	4
Ineligible	4	6	4	6	6	2
Declined	1	0	0	3	2	0
Unknown	1	1	1	1	0	0

Reasons for ineligibility included reports that the site had no current providers, provided other services but not individual therapy, or provided only SUD services; that the location had been closed; and that the location was administrative only. Reasons for declining included that the administrator reported that they were not interested in the topic, did not have time to forward this survey, did not think their staff had time to complete the survey, or their agency's administration had denied the request for participation.

Once site eligibility was confirmed, the sites were provided with survey information to distribute to all their behavioral health service providers. Only staff providing services to people with mental health challenges were eligible, across levels of experience and education. Participants were given a $20 gift card as an incentive to complete the survey. The survey was completely anonymous, gathering no metadata about the participants. To receive compensation, participants were redirected to a separate form that was not connected to the actual survey.

A total of 555 participants responded to the survey. Responses for statewide analyses were weighted to reflect the state. Regional analyses are not weighted. For regional analyses, chi-square likelihood ratio tests were used to determine statistically significant differences between the regions on categorical variables (gender, race, education, etc.). For continuous variables (age, years of experience, and years at an agency), statistically significant differences were determined with independent sample T tests or one-way ANOVA tests. Similarly, differences between the sample and Illinois' population within different regions were tested using chi-square tests for categorical variables. All tests were two-tailed and used $p < 0.05$ to identify statistically significant differences. Statistically significant differences are differences that are unlikely to be due to chance and likely to be replicated in another similar sample.

Integrated Care Needs Assessment

This assessment commenced with a statewide, representative sample of medical providers and behavioral health providers working in integrated care settings. The sampling frame began with the State being divided into five regions and a stratified random sample of 170 sites being selected from 700 sites across the five regions. Of the eligible sites, 23 (13.5%) agreed to participate and had staff submit surveys. Sites determined to be ineligible were replaced with new randomized sites from the master list with care to replace sites in specific areas (north, central, south, urban, suburban, rural) with similarly located sites. Continual efforts were made to confirm sites' status as providers of integrated primary care behavioral health services.

A second round of survey outreach was attempted without randomization in an effort to obtain further feedback from this difficult-to-reach segment of the workforce. Questions were added to the survey to identify providers working in the type of integrated care settings described above, and only those that met the criteria were given the opportunity to take the survey. For this round, the survey email and link were distributed by the Illinois Hospital Association and the Illinois Primary Health Care Association to their Illinois members (at hospital-affiliated clinics and FQHCs across the state), as well as to every setting in our master list.

Sites were provided with survey information to distribute to all their behavioral health service providers. Only staff providing services to people with mental health challenges were eligible, across levels of experience and education, where most referrals for behavioral health services were made by a primary care provider (medical doctor, physician assistant, nurse practitioner). Participants were given a $20 gift card as an incentive to complete the survey. The survey was completely anonymous, gathering no metadata about the participants. To receive compensation, participants were redirected to a separate form that was not connected to the actual survey.

A total of 201 behavioral health and medical providers completed the survey, 132 of those respondents were behavioral health providers. These providers, not including medical provider respondents, were analyzed for this report. Table 1 shows the number of respondents per region.

Site Response by Region (*N* = 130)

	1 (Chicago)	1 (Sub. Cook)	2	3	4	5
Frequency	44	5	15	10	22	34
Percent	33.8	3.8	11.5	7.7	16.9	26.2

Quantitative data were subjected to standard data cleaning techniques and missing data review. Descriptive statistics were run to delineate the respondents' characteristics in terms of gender, race, ethnicity, education, licensure and Medicaid credential status, years in current position, and years working in the field. Descriptive statistics also were computed to further describe the sample of providers and the clients they serve. These characteristics included referral source, types of services provided, languages spoken at the site, average number of appointments and length of visits, ways clients access behavioral health services, type of integrated care program, number of providers working at site, perceptions of integrated care delivered by the agency, and how beneficial certain changes would be in improving effectiveness of integrated care.

Outcome variables were calculated such as turnover intention regarding currently held position and likelihood of leaving the mental health field. Statistically significant differences were determined with chi-square tests, independent sample T tests, or one-way ANOVA tests. For regional analyses, as well as analyses related to being at-risk of leaving current position and at-risk of leaving the mental health field, chi-square tests for association were used to determine statistically significant differences on categorical variables, such as race/ethnicity, educational level, Medicaid credentials, primary area of practice, licensure status, reasons for leaving current position (i.e., low pay, lack of professional development opportunities, productivity requirements, etc.). For continuous variables (number of years employed, years working in the mental health field), statistically significant regional differences were determined with independent sample T tests or one-way ANOVA tests. All tests were two-tailed and used $p < 0.05$ to identify statistically significant differences. Statistically significant differences are differences that are not likely to be due to chance and would be likely to be replicated in another similar sample.

Qualitative data were extracted, organized, and coded according to question content. A qualitative thematic analysis was conducted to understand patterns among training and support needs reported in the open-response portion of the survey. To organize and analyze the data, all responses were manually assigned to numerical codes based on categories that emerged from the data. Once categorized, the same person coded the data a second time without looking at the initial results. Then, both sets of results were compared to evaluate intracoder reliability and amended as needed.

Serious Mental Health Needs Assessment

- Inclusion
  - Providers offer community-based treatment such as ACT, CST, Outreach & Engagement
- Exclusion
  - No inpatient units
  - Intensive outpatient
  - No primary diagnosis of depression, anxiety, DD/ID, substance use disorder, personality disorder
  - Living Room Programs
  - SUD, only

Early Career Staff

To understand the training needs of the workforce as they enter behavioral health positions, the BHWC conducted a survey of supervisors and program directors in outpatient behavioral health services focused on the preparation of early-career staff. Early career staff were defined as staff who (1) have a bachelor or graduate degree in a behavioral health field and (2) have one year or less postgraduate experience providing direct services in behavioral health care.

This survey used a convenience sample of supervisors and program directors who reported supervising early-career staff in community mental health settings. The survey was distributed through multiple listservs and DMH emails to supervisors and program directors in community mental health settings. Participants were eligible if they supervised clinicians. A total of 311 responses received from 129 agencies. Participants were instructed to select all counties their agency provided service in. The table below shows the number of respondents per region.

Site Response by Region					
	Region 1	**Region 2**	**Region 3**	**Region 4**	**Region 5**
Number	131	112	69	49	51
Percent	31.8	27.2	16.7	11.9	12.4

Of those that participated in the survey, 24.4% supervised high school/GED level staff, 16.7% supervised associate's level staff, 45.3% supervised bachelor's level staff, and 63.3% supervised master's level staff.

Appendix F: Statewide and National Conference Attendance

Center staff presented and served as panelists at multiple statewide and national conferences:

- Illinois Certification Board (ICB) and Alcohol and Other Drug Abuse Professional Certification Association (IODAPCA) (3/19/2025)
- Community Behavioral Healthcare Association CBHA Annual Conference (12/2/2024)
- NAMI IL Statewide Conference (10/19/2024)
- Cook County Behavioral Health Workforce Symposium (10/1/2024)
- Carle Health's Behavioral Health Symposium (8/28/2024)
- Illinois Association of Rehabilitation Facilitates (IARF) Educational Conference & Expo (8/29/2024)
- Institute for Government and Public Affairs Summit (4/23/2024)
- John Hopkins Nursing Chicago Parent Program Futures Event (3/21/2025)
- CRSS Success Program Learning Collaborative (4/12/2023)
- Coalition for Spiritual and Public Leadership (5/7/2024)
- Faculty Roundtable 29th Karen J. Honig Memorial Lecture- UIC Jane Addams College of Social Work (3/19/2025)
- Behavioral Health Primary Care Integration Learning Collaborative (3/6/2025
- National Council of State Legislators (9/9/2024)
- The Rural Health Summit (10/15/2025)
- IBHE Board Presentation (11/12/2025)
- National Council of State Governments (12/12/2025)

Center staff served as exhibitors at the following statewide conferences and events:

- Illinois Certification Board Fall Conference (10/2024)
- Illinois Certification Board Spring Conference (3/2025)
- Community Behavioral Healthcare Association (CBHA) Annual Conferences (2023 & 2024)
- Rural Health Summit (5/15/2025)
- 2nd Annual African American Conference on Gambling (2/2025)

National Workforce Initiatives:

In 2024, BHWC's CEO Served as Behavioral Health Workforce Database Technical Expert Panelist for the Health and Human Services (HHS) Office of the Assistant Secretary for Planning and Evaluation and SAMHSA Policy Summit Participant for Re-Envisioning the Behavioral Health Workforce Focusing on Underserved Communities.

Behavioral Health Workforce Center Alliance:
The Center leaders are engaged with the Behavioral Health Workforce Center Alliance (BHWCA) made up of states that are developing behavioral health workforce programs. The alliance provides national leaders the opportunity to share success and challenges and collaborate on state and national behavioral health workforce projects.

BHWC

BEHAVIORAL HEALTH WORKFORCE CENTER

Thank you to staff at IDHS, IBHE, and the BHWC in providing input to this report. Final design produced by Afton Partners. LLC.

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