Behavioral Health Workforce Shortage
House Health Policy Committee
March 24, 2022

I am Kathryn Szewczuk, Executive Director for Lenawee CMHA.

Chair/Rep Kahle, Thank you for the opportunity to speak with you and the Health Policy Committee this morning about the workforce shortage we are facing in the behavioral health world.

We are struggling to recruit and retain clinical staff, particularly Master's level, across the state of Michigan. In our region in particular, our four counties have been experiencing a 20-30% staff vacancy rate. I invite you to take a moment to think about the impact that has on individuals needing to access services or even receive ongoing care to meet their needs. I would like to focus on 4 areas where I think we could work together to begin to address this critical need.

The first area is the increase in behavioral health need without infrastructure planning and preparation. A recent example would be the increase in revenue to school districts to increase behavioral health services. While we don't disagree that there is a need for mental health services in school, we recognize the infrastructure is not in place to support the number of clinical staff now being funded by the state and federal gov'ts., to provide mental health services in school, and therefore this has caused a shifting of the limited existing workforce. Currently, CMHs spend a significant amount of time and money to train our clinicians in evidence based practices, especially our child/family clinicians. These clinicians meet with the children/families in the greatest need, in their homes or wherever they're experiencing the most challenges, often in school. An unintended consequence of the infusion of funding for mental health clinicians in schools has been the loss of numerous therapists from CMHs and our provider networks to these new school positions. This has created a critical gap in availability of services outside of schools. This school year alone, I have lost 5 Master level clinicians to school/ISD and I am a small CMH. This has created increased burden on the few remaining staff to cover the needs for home-based, outpatient therapy, access and crisis stabilization. I simply cannot compete with the wage, benefits, schedules, and time off that schools can provide. The paperwork requirements in schools are significantly reduced compared to what we are required to provide to the Department. And, honestly, the work is not as intense as safety net services often provided in the family's home. Our staff often have to meet in the evenings, when crisis hits and deal with some truly difficult issues. We must find a way to build the infrastructure, encourage more high school students to go into the behavioral health field, and identify an effective process to share limited resources while that is in progress.

The second area needed to be highlighted is increasing CMHs ability to be competitive in the marketplace and viewed as a desirable long term employer. One retention strategy for rural CMHs has been HRSA (Health Resources and Services Administration) tuition reimbursement. I appreciate the speed with which Rep. Whiteford worked with the House to pass HB 5165 to address the misalignment with Federal Ability to Pay requirements – any suggestions on how to get the Senate to do the same would be welcome. The tuition reimbursement has been a valuable tool for staff that meet the requirements but we encourage consideration of how this can be expanded to cover more staff and disciplines.

Thirdly, the administrative burdens passed onto CMHs and our provider networks by MDHHS/Milliman have been another issue noted by staff in exit interviews. The amount of time, training, and monitoring of ever increasing documentation requirements detracts from the amount of time staff are able to directly provide services to individuals and, in fact, increases cost of services. There should be a way to reduce some of the duplicative reporting rather than add additional burdens.

Finally, the constant conversation about 'restructuring' the public behavioral health system has created increased instability for our system, from direct care workers to clinicians and Program Directors, even Executive Directors these days. We have had clinical positions and Program Director positions open for 6-12 months, unheard of 5, 6 years ago. I can understand why one would not want to take a chance on a job in a system that is consistently attacked, disparaged, and facing dismantling. As I listen to concerns about supporting the mental health needs of our Michigan citizens, I am struck by the needs of those with mild/moderate mental health issues, a population the public system doesn't typically serve. These individuals have expressed frustration with waiting lists and not having access to care. With that said, it is difficult to understand why there is push to move our most vulnerable and high need individuals into a similar system of care rather than directly addressing the current barriers to mild to moderate individuals.

I look forward to an opportunity to work with you and your colleagues on any, or all, of the areas I've mentioned. We can make an impact on meeting more of our communities' needs working together but not if the public system is taken apart.

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