BEHAVIORAL HEALTH
COMMUNITY COLLABORATIVE

Working together to promote quality lives

Chairs Bailey and Mathieson, and Good Members of the HCIFS committee,

My name is Betsy Sweet, and I am here on behalf of the Behavioral Health Community Collaborative. We are seven community-based agencies who provide mental health services to over 70% of the people in Maine who receive them. Today we are here before you in strong support of LD 1084.

As this committee is aware, there is a severe worker shortage – of crisis proportions – in all levels of behavioral health services. In the agencies I represent vacancy rates range from 20%- 35%, and this is across all levels of workers. Our retention rate is also challenging because the work is very demanding, the pay continues to be low and there are not clear and easy pathways to "move up" in this field.

As we work to address this crisis, we looked hard for solutions that are practical, that would really help and not cost the state any money – particularly regarding direct care, entry level positions. (Mental Health Technicians, Behavioral Health Professionals, Medication Management technicians for example). The training and "certification" of these positions is an area where we can achieve great efficiencies, actually save money and provide career pathways without sacrificing quality.

At the same time, this past fall, at a conference of direct care workers where people were asked to identify barriers to getting into this line of work and staying there – the challenges around certifications and training were at the top of their list.

A start to addressing this is LD 1084. In the early nineties and before, training for direct care workers was done "in house". People applied for jobs, and the agency employers were responsible to ensure that they were trained properly (according to a set of guidelines set out by the state) and then they provided and oversaw that training in the ways that were most efficient and effective for the workers. As employees, they were given continuous training and oversight to ensure they were doing a quality job and meeting the needs of clients and they got certification. Over time the responsibility for the majority of this training and certification moved to a third party (now Muskie). This has resulted in delays, additional cost for employees, employers and the state and has not resulted in an improvement in quality. It also has meant workers need to either take time off of their jobs or attend classes outside of the work day, which is often impossible due to family responsibilities, and often second jobs that workers hold. Many of these requirements have grown and training modules have not been revised in years. There have been few, if any, conversations between the DHHS, Muskie, employees and agencies who hire to identify barriers and solutions.

I have attached a detailed sheet with just a few examples to my testimony, but as a summary-

The certification process for MHRT1 and MHRTC positions presents significant challenges for both new hires and agencies. One major barrier is the requirement for someone who has worked in the field, but has taken time off, when they return they have to have new CPR/First Aid and crisis intervention training before being rehired, even if they have only been out of the field for a short time. Additionally, proving an individual's absence from the field requires employer verification, which can be difficult to obtain. Even when a provisional certification is granted, additional mandatory training adds to the complexity.*

Administrative delays further complicate the process. If key officials are unavailable, provisional certifications cannot be issued, preventing new employees from starting work. The MHSS Trainer certification process also poses challenges, as training sessions are infrequent, sometimes with gaps of 2–4 years, and provide little actual instruction on training methods. Similarly, requiring staff to take tests on computers or mobile devices can be problematic, as many agencies lack sufficient equipment, and some employees struggle with digital formats.

For MHRTC certification, the financial burden is substantial. There are three pathways – the Pathway C, the most common route, requires 120 hours of training within 90 days of hire, costing up to $900. Agencies either must fund this training or expect new employees to cover the cost and time off while managing their new job responsibilities. This unrealistic demand often leads to early resignations. Additionally, the certification pathways prioritize formal education over experience, making it harder for qualified professionals from out of state with experience to obtain certification.

If agencies were once again allowed to conduct the training without third party requirements, it would streamline the administrative processes, allow much more flexibility in providing the training and make it easier to hire and retain workers and allow them to get their certification. It would also save the state money.

We look forward to working with the committee to pass this legislation and help us overcome barriers to developing and sustaining efficient and effective pathways to address the worker shortage. Time is of the essence. Thank you and I'd be happy to answer any questions.

The members of the Behavioral Health Community Collaborative are Sweetser, Inc., Opportunity Alliance, Volunteers of America, Shalom House, KidsPeace, Spurwink, Community Concepts

*Glossary of terms

- **MHRT/C:**

  This certification is for individuals who work with adults living with serious mental illness in a variety of settings, including community integration.

- **Community-Based Settings:**

  MHRT/C professionals work in settings outside of traditional hospital or institutional care, focusing on supporting individuals in their homes and communities.

- **MHRT I**

  Mental Health Rehabilitation Technician (MHRT I) provide daily living supports to persons with severe and persistent mental illness in residential settings.

- **MHRT/CSP**

  Mental Health Rehabilitation Technician/Crisis Service Provider (MHRT/CSP) certification is for individuals who provide Crisis Resolution Services to adults and/or children in Maine.

Detailed examples of unnecessary barriers/challenges with certifications.

MHRT1- **Barriers and Potential Solutions**
Most staff eligible for MHRT1 are high school graduates or have a GED, some have more education, but majority do not.
Rehiring former MHRT1 staff:

1. If an applicant has expired training (CPR/First Aid and Mandt or the equivalent) they must have been out of the field (unemployed, in school or in a position not requiring an MHRT1) for at least 6 months to be allowed to be rehired into a position requiring a MHRT1, without having to have all their training up to date **PRIOR** to starting job.

In addition, agencies must "prove" that the individual has have been out of the field with a letter from their employer covering the last 6 months (or proof they were in school). This creates another obstacle since sometimes companies/agencies will not provide this letter (why would they it makes no sense to let's say Walmart). If these "conditions" are met the employee is giving a provisional MHRT1 and has three months to get all their training back in place. In addition, these rehired MHRT1's have to do two additional online trainings not required of others.
BUT if the applicant has been out of the field (unemployed or in a position not requiring an MHRT) less than 6 months, and either of these trainings (CPR/First Aid and Mandt or the equivalent) have expired, they cannot be hired until they have been fully retrained and their certifications are again active. This translates to they cannot be rehired until all certifications are current.
Potential Solutions: Allow agencies to hire individuals who have held a MHRT1 in the past that it feels are qualified regardless of whether their certifications are still active. Offer a new MHRT1Provisional, with a three-month time period, for all training to be completed and certification active again.

2.
3. If the person in charge or his supervisor are out of the office, no MHRT Provisional certificates can be obtained for new hires. And since a new employee must have this in place prior to starting work with clients it means the agency cannot start the new staff until they both return. Scott

reviews request and his supervisor approves it this both must be in office for this to be done. (Translates to 4-5 times a year must delay a new hire from starting)

Potential solution: the current MHRT1 Provisional Process: Day one of employment the new employee reads the MHSS handbook and completes test to obtain a MHRT1 Provisional. It is graded by agency staff who then must send request form for the Provisional Certificate to Scott at Muskie. The above issue could be solved in a variety of ways including developing an online submission process that agencies use that allows them to do the process online and then print off the provisional certificate (this happens for the CRMA certification). Scott is just "rubber stamping" it as it now stands so why create a delay that negatively impacts everyone.

4. To be certified to be a MHSS Trainer an individual must submit an application and then go through a "MHSS Training the Trainers" class. These classes are not consistently offered and at times there has been a 2–4-year gap between when these trainings are held. In addition, the class itself provides little actual training on how to be a trainer and it is primarily everyone in the class picking one of modules and demonstrating how they would train to it. This creates multiple barriers to keeping agency's staffed with trainers they need for their work force and has little to no bearing on quality of training.

   Potential solutions: Allow agencies to control training their own trainers. The training as now stands offer trainers little education/help on becoming a trainer, agencies are already the ones assuring their trainers are qualified and do a good job training.

5. In past MHSS test was done with paper and now must be done on a computer, tablet or smart phone. For some staff this creates another barrier as agencies don't have enough computers available and thus staff are using phones which are small and hinder a positive test taking experience. (Many of our staff are already terrified of test taking for a variety of reasons.

Potential Solutions: allow options for taking tests

6. When MHSS was updated last year, it was sent out with numerous errors. There were inaccuracies in statistics provided as well as more than one wrong answers for test. This meant the agency's trainers had to go through it with critical eye to identify errors. The student manual was also not ready to go which caused issues for trainers.

Potential Solutions: Give agencies more control over trainings so they are responsible for materials and what is covered versus being fully dependent on what is provide to them so cannot correct issues.